Comfort Call Limited

Comfort Call - Liverpool

Inspection report

Linksview, 102 Vale Road
Woolton
Liverpool
Merseyside
L25 7FB

Tel: 07551157262
Website: www.comfortcall.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection of Comfort Call Liverpool took place on 14 December 2017.

This inspection was announced. We gave the provider 24 hours' notice that we would be coming as the service delivers domiciliary care to people in an extra care setting, and we wanted to be sure people would be available to talk to us.

This was the service's first inspection at their new location.

The inspection was carried out by a three adult social care inspectors.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This service provides care [and support] to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care [and support] service.

Comfort Call Liverpool provide care and support at three separate extra care sites across Liverpool. They are Milachip Court, Meadow Court, Latham Court, and Linksview, which is also the registered location were the care is managed from. We conducted our site visit at Linksview, however, we visited the other four schemes during our inspection.

Everyone across of the four schemes told us that they felt safe being supported by Comfort Call.

Staff we spoke with were able to describe the course of action they would take if they felt someone was being harmed or abused, this included reporting the abuse to their manger, the Local Authority or CQC.

Risks to people's health, safety, and welfare were assessed and clearly explained to enable staff to support people to stay safe.

There were enough staff deployed throughout all of the four schemes to support people safely. Staff told us they felt that they had enough time to spend with people and did not feel rushed or pressured.

We spoke to the registered manager about any learning they had implemented across the service as a result of feedback from safeguarding's or complaints, and saw evidence that 'lessons learned' was regularly

discussed as part of the culture of the service.

There was personal protective equipment (PPE) available for staff to use such as gloves and aprons. Additionally, there were hand washing facilities at each scheme.

Staff recruitment procedures were robust and we saw that staff were only offered positions within the company once all satisfactory checks had been completed on their character and suitability for the role.

Medication was managed safely. People were supported to store their medication in a safe place within their home. People who required support from staff to take their medication were supported only by staff who had been trained to do so. These staff also underwent regular competency checks to ensure they were still able to complete this task safely.

People had undergone a pre-assessment before offered a care package from comfort call. This was to ensure the service was able to meet people's individual needs.

All staff were trained in a variety of subjects which were classed as mandatory in the provider's training policy. Staff were also trained in specialist subjects to help their understanding when supporting people with complex medical needs. All staff were regularly supervised, and had undergone an annual appraisal.

People had their own kitchen in their own property, however staff would support them to make meals and snacks if this was part of their care plan. People told us staff made sure they ate well, and staff were knowledgeable regarding any specialist diets people were required to follow.

The staff across the four schemes worked well together to ensure shifts were covered. The provider worked alongside the different housing providers and the local authority to ensure people were offered the best possible support package. Additionally, in situations where anti-social behaviour was reported, we saw the provider had contacted and appropriately reported these events to the police.

People were supported to access the GP when needed, staff would accompany people to appointments if this was required.

The Mental Capacity Act and associated principles had been considered for some people who were found to lack capacity. Decisions were made in people's best interests, and the registered manager was able to demonstrate a good understanding of when people required assessment due to a change in their capacity.

People lived in their own apartments, and had access to communal areas of the scheme for socialising. Each person had a call bell in their apartment they could use if they required support or assistance.

We observed staff treating people with kindness and respect and people were complimentary regarding the staff's professionalism.

Staff we spoke with were able to describe how they protected people's dignity and right to choose how they wanted their care delivered.

People told us they were able to get involved in how their care was coordinated and overall felt satisfied with the provision of care in the scheme, and their own individual care packages.

There was a high level of personalised information in each person's care plans. Each care plan went into

detail regarding what the right care and support should look like for the person, including any medical needs they had, emotional needs or hobbies and interests. There was information about people's backgrounds and past histories which had been collated with people's permission, to enable staff to get to know them.

There was a complaints procedure in place. The service had logged and responded to all complaints in accordance with their own policy and procedures. There was one complain on-going which we did not see an outcome for because it was still being looked into.

Staff had received training in end of life care and were able to support people and their families. As people lived in their own homes, we saw that where possible, people had chosen to remain at home until their final days.

There was a strong emphasis on team work and the culture of the service was to support people to do as much for themselves as possible. This was evidenced during our conversation with staff and when we visited people in their own homes within each of the four schemes.

People spoke positively about the scheme managers and most people knew who the registered manager was.

People who lived at the schemes and their families were involved in any decisions regarding their care and support, and feedback was requested to judge how the service was performing as whole across the four schemes.

The registered manager frequently had to engage with other professionals such as the housing provider, police and local safeguarding teams to ensure transparency and people were protected from harm.

The service had recently won third prize at the older people's awards, which was an external award ceremony and regularly looks for ways they can improve their services.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medication was stored in people's homes in accordance with their wishes and administered by staff who had completed appropriate training.

Staff were able to explain how they would ensure abuse was reported and actions they would take to keep people safe from harm.

Risk assessments were detailed and contained clear guidance for staff to follow to minimise the risk.

Recruitment and selection of staff was robust. Staff were only offered positions once all checks had been completed.

Is the service effective?

Good

The service was effective.

People were supported to prepare individual items of food in their apartments when required.

Supervision records showed that staff underwent regular supervision with their line manager.

Staff told us they enjoyed their training. We saw from the training matrix and certificates staff had attended regular training.

The service was working in accordance with the principles of The Mental Capacity Act 2005 (MCA) and other associated legislation to ensure people were exercising their rights to make choices and decisions regarding their care.

Is the service caring?

Good

The service was caring.

We observed kind, friendly and familiar interactions between staff and the people they supported. The staff we spoke with

clearly enjoyed supporting people.

People we spoke with told us that the staff were caring and nothing was too much trouble.

Contact details for local advocacy services were made available to people if they required this support.

Is the service responsive?

Good

The service was responsive

People's care plans were centred on their wishes and needs and kept under review. Staff were very knowledgeable about people's needs and preferences and supported people to remain as independent as possible.

There was a complaints procedure in place and people told us they would not hesitate to raise concerns about the service if needed.

Staff were trained to support people who were on an end of life pathway to remain comfortable in their home with additional support from medical professionals. There was information recorded in people's care plans which detailed their wishes after their death.

Is the service well-led?

Good

The service was well-led.

Everyone we spoke with was complimentary regarding the registered manager and the team/scheme managers.

Tenant meetings took place in the communal areas of the scheme.

There was a system in place for auditing (checking) service provision. This included regular checks undertaken by the registered manager, and the team/scheme managers.

Feedback was gathered and analysed.

Comfort Call - Liverpool

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 14 December 2017. The inspection team consisted of three adult social inspectors.

Before our inspection visit, we reviewed the information we held about Comfort Call Liverpool. This included notifications we had received from the provider about incidents that affect the health, safety and welfare of people who used the service. We accessed the Provider Information Record (PIR) we received prior to our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we conducted most of our inspection activity, such as the checking of records and care plans at the location registered with CQC, which is Linksview. However, due to the service providing personal care across three other schemes we also spent time visiting these schemes, speaking to people who lived in the schemes and the staff, and made some general observations.

During our inspection we spoke with 10 staff, this included the team managers of each scheme, the regional manager, and the registered manager and visited six people in their apartments. We viewed a range of records including 12 care plans, four staff files, and other documents relating to the running of the service.

Good

Is the service safe?

Our findings

People told us they felt safe receiving care from staff. Comments included; "I have this pendant, when I fell, I pulled it and they came straight away", "I feel safe, I have my own front door, my own keys and nobody can come in unless I answer the door", "There's staff on duty 24/7" and "I feel very safe, there's no need to worry about being safe here." People had 'pull cords' within their accommodation to alert staff in the event of an emergency and felt confident that staff would respond immediately. One person told us, "I sometimes have to pull the cord because of my breathlessness, they [staff] come and stay with me until I feel better or will call an ambulance."

Everyone told us there was always enough staff. The regional manager explained the breakdown of staff levels in each scheme which included six members of staff working a variety of shift patterns between the hours of 7am and 3pm with a reduction to five members of staff between the hours of 4pm and 10pm. There were two waking night staff on duty between the hours of 10pm and 8pm. We reviewed staff rotas and saw that there were sufficient numbers of staff deployed to meet people's needs. Staff told us there were enough of them to enable them to complete their roles effectively. One staff member told us, "I don't think there's been an occasion this year when we were short staffed."

We reviewed personnel files for staff who worked at each of the four schemes. We saw that there were safe recruitment processes in place including; photo identification, a minimum of two references from the candidate's previous employment and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments. One staff file did not contain a second reference but a full employment history was provided. One staff member we spoke with confirmed they were unable to commence employment until all checks had been carried out. They told us they completed an application form and attended an interview. They could not start work until they had received clearance from the DBS. Staff also completed a minimum of 16 hours shadowing more experienced members of staff.

We saw people's medications were stored in their own apartments, and we spot checked some completed Medication Administration Records (MARs). We saw that on one of the MAR sheets, staff had used an incorrect code for recording why someone had not received their medication. This was brought to the attention of the registered manager during our inspection. We saw staff completed training via face to face training sessions and had to complete competency assessments before they could administer people's medications. One person we spoke with received support with their medication management and confirmed they were happy with how this was administered. One person commented, "They help me with my meds because I have vision problems and can't read the blister pack. I get my meds on time."

We looked at the adult safeguarding policy for the service and asked the staff about their understanding of their roles in relation to safeguarding. Staff were clearly able to describe the procedures they would be expected to follow to keep people safe from abuse. One staff member said, "I would report straight away, as I have in the past." We also asked staff about whistleblowing. All of the staff we spoke with told us they

would not hesitate to use this policy if they felt they needed to. Staff had received training in the principles of safeguarding, but also the practicalities of how to raise an alert with local safeguarding teams. Their responses were in line with procedures set out in the service's safeguarding policies. We saw information regarding safeguarding for people who used the service and relatives was readily available on the noticeboards and the service user guide. People we spoke with confirmed they knew how to raise concerns should they have any. This demonstrated the registered manager had ensured safeguarding principles were understood by staff and people who used the service.

People were responsible for the maintenance and cleanliness of their own individual apartments. People told us their accommodation was comfortable and that staff helped them to report repairs to the local housing department. Staff had received training in the prevention and control of infection. People's care and support plan reminded staff of the importance of infection control, for example, 'ensure the correct Personal Protective Equipment is worn'.

There was a process in place to monitor any incidents and accidents in the service. The procedure consisted of the registered manager going through any incidents/accidents forms checking for patterns and documenting any remedial action needed. This included a thorough investigation report with reference to; who was involved, what happened, was it notifiable, how was the matter investigated and findings. A manager signed-off on any corrective or preventative action in each case. The registered manager showed us an electronic record that captured important detail to support analysis

We saw that the service used lessons learned within the national organisation to improve service delivery at a local level. One example of this was lessons learned from a serious incident of choking within the organisation. The registered provider completed a serious case review which identified the need for further improvement within the service. As a result, we saw that a new 'themed supervision' had been developed to check staff knowledge around the risks of choking. We also reviewed a new PowerPoint presentation which was due to be rolled out across the organisation to encourage staff to consider the consequences of failure to provide safe care and treatment in respect of choking. The regional manager also completed an updated risk management audit in respect of three people who were considered at risk of choking.

Good

Is the service effective?

Our findings

People told us that they felt staff had the correct training and skills to be able to support them appropriately. Some comments we received from people included; "The staff are very good, they always act like professionals" and "They are good at knowing how to look after me. I try to do as much as I can myself though."

The staff we spoke told us they felt well supported by the provider and received regular supervision and appraisal. The records that we saw indicated that all staff had received an annual appraisal and had received a supervision or spot check every three months. We saw that 'themed' supervisions were held in response to any concerns identified to check and promote knowledge in respect of areas such as skin integrity, medication or record keeping. For example, we reviewed a themed supervision which was held following a staff member not administering someone's medication as per the care plan. The documentation showed the impact of this was explored in detail with the member of staff in order to improve their practice. One staff member told us they received regular training which was classroom based and was relevant to their role. "We've had training on the hoist and other equipment. When we get a new piece of equipment I ask the manual handling trainers (external) for additional training."

We saw evidence of training certificates within staff recruitment files in respect of topics considered mandatory such as medication, health and safety and nutrition and hydration. We also saw that people had received training in respect of specialist topics such as diabetes, epilepsy, Parkinson's Disease, stroke and stoma care. Newly appointed staff were required to complete an induction aligned to the principles of the Care Certificate, which is a set of guidelines new care workers adhere to in their roles. This is designed to be completed within 12 weeks of staff starting work, and signed off by a competent staff member (such as a senior or manager) once completed.

People told us they were supported by staff in relation to having their nutritional needs met. One person told us, "My carer makes the most delicious bacon sandwiches, they're to die for. They cut off the crusts and toast it lightly, just the way I like it." We saw that consideration was given to people's nutrition and hydration within care plans and their likes and dislikes were recorded. People's intake was record in daily logs, for example, "[Person] chose a ham and cheese sandwich for lunch and a drink of tea and water served. Strawberry trifle served."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a legal framework to protect people

who need to be deprived of their liberty in their own best interests. There was no one subject to any DoLS due to the service being an extra care scheme and people lived in their own homes. However, where people may be subject to continuous supervision in their own homes a DoLs can be put in place if agreed by the Court of Protection (COP). The registered manager had identified where this may need to be used for a person living in one of the schemes, and had made all of the appropriate referrals to initiate a 'best interest process.' This demonstrated that the registered manager was aware of their roles in relation to the MCA and the legislation underpinning the act. We also saw that consent was well documented in people's care plans and where people were able they had signed their consent forms themselves.

Staff we spoke with told us they had often called the GP or the District Nurses for support and advice when they had been asked by the person they supported. We saw and staff confirmed that people mostly attended their own healthcare appointments, however, arrangements could be made for people who did not have anyone to take them. One staff member told us, "One lady hurt her leg. She had no family so I took her myself. You have to use your own initiative."

People lived in their own apartments, which were either bought or rented from the housing provider. The layout of the schemes was appropriate for people as there were lifts to all floors, and large communal areas which were used for socialising.

Good

Is the service caring?

Our findings

We received positive comments about the caring nature of the staff at the service. Comments included, "You don't know the depth of their kindness", "The carers go above and beyond for me, if my treatment is anything to go by, there's nothing to worry about" and " The girls are very nice." One person told us after every visit, the staff ask, "Is there anything else I can do for you?" Someone else said, "Oh the staff are fantastic, sometimes, they are the only people I see, they always come and natter away to me."

One person described how the 'little things' that staff do had a positive impact on their quality of life. For example, "They always check I've got enough provisions such as bin-bags or bread and if my regular carer is off the next day, they will ring another member of staff and remind them to bring me a loaf."

People's communication needs were also recorded within documents entitled 'How carers can support communication' within care files. For example, a record was made in one care file, "Being patient with me, by giving me time to respond and interpret what they are saying. My carers can also speak loud and clear."

Staff were able to give us examples of how they offered support in a dignified way, for example; by closing curtains or covering people with a towel when they were getting changed. One staff member said, "I try to cheer people up if they are feeling a bit down, sometimes though, people need space and you have to respect that."

Staff had received training in dignity, independence and choice. We spoke to the dignity champion within the service. They had completed specialist training and received a certificate of commitment to the 'Ten Dignity Do's'. They told us their role was to promote and encourage dignity within the service and share practice with other members of care staff.

Care plans demonstrated that family members and people using the service had been fully involved in their completion and had been involved in regular reviews about their care and support. Care plans had been signed by family members where legally allowed to do so or via a best interest process where people could not consent themselves.

We saw that advocacy information was available for people who required this type of support. No one was accessing advocacy support at the time of our inspection.

We observed people being supported by staff they were familiar with and who clearly knew and understood their needs and wishes. Staff accompanied us to people's rooms and asked permission for us to enter. Staff were made people feel relaxed and calmly explained the role of CQC and the purpose of the inspection visit.

We asked one person if they knew about their care plan. They told us they did. The same person also told us that scheme manager came to visit them often and discussed the care plan and whether they were happy with the care.

Good

Is the service responsive?

Our findings

People told us they received care and support which was right for them and met their needs. One person said, "I feel like I matter, they [staff] do things how I like." Also, "They have taken the time to get to know me and they know about my medication and other things that I can't quite manage myself."

People's care plans were person centred. Care plans we looked at were individualised and contained information about the person such as their backgrounds, likes, dislikes as well as other areas of interest. They were respectfully written in the first person to emphasise choice and involvement. Some of the information in care plans for people under what was important to them included. 'I choose not to join in the activities at the scheme' and 'Remaining as independent as I possibly can because it is really important to me.' This showed that the service expected staff to respect people's choices.

We saw that one person required specific support with taking their medications at set time. We checked the rotas for this person and saw that the support provided as the person needed.

People were able to choose a gender specific carer. We spoke to one male member of staff who told us they only provide personal care for males. Another person we spoke with told us they had the same female staff going to see them in their apartment and they liked this because they liked to 'keep themselves to themselves.'

The provider had a detailed complaints policy in place which was reviewed annually to support people to raise concerns about the service. We saw that the service had received seven formal complaints between March and November 2017. These were diverse in nature and related to issues such as staff conduct and individual concerns regarding consistency of carers. We saw that a detailed register of complaints was kept and a summary was compiled of all complaints outlining the reason for the complaint, the outcome and what remedial action was taken in response. Each complainant was sent an acknowledgement of their complaint and the timescales for resolution. The findings of the investigation were also shared with the complainant. We saw that one complaint involved the request that a specific carer was not sent to the person's calls. This was implemented in accordance with the person's request.

The service provided a domiciliary care service but also provided additional support for people to access activities. People told us they enjoyed activities such as 'Bingo' and 'Tea and Toast mornings'. The regional manager told us that care staff currently assisted with the provision of activities but they were in the process of recruiting additional members of staff for this sole purpose. We also saw the schemes arranged some activities for people to join if they wished, such as a fish supper night, and a Havana themed night.

The service supported people at the end of their lives. The training matrix showed that staff had received training in palliative care. We saw evidence of 'Do Not Attempt Resuscitation' (DNAR) forms within files in accordance with people's wishes.

Good

Is the service well-led?

Our findings

There was a registered manager in post who had been in position for a year.

People who used the service and staff spoke positively about the management of Comfort Call Liverpool and said that the managers were approachable. Comments included, "Yes, I like [registered manager] they are very approachable." Some people said they had met the registered manager, but did not know at the time that was their role.

Our conversations with staff clearly indicated that they embraced the culture of supporting people to do as much for themselves as possible. Staff gave us some examples of where they felt they had gone above and beyond. However, they also had a good understanding of the remit of their role. One staff member said, "It's not a care home here, we try and get people to do rather than do for them."

The service had recently won third prize at the older people's awards which was an achievement they were very proud of. The registered manager was clearly knowledgeable about all of the schemes, and worked closely day to day with the scheme managers. We saw that the service also worked alongside other professionals, such as the housing providers, local authorities, and police to ensure that people received the best possible care and treatment.

We saw that the registered manager was well organised when certain incidents or occurrences had affected the service and there was clear guidance in place for staff to follow. For example, for the anti-social behaviour from outside the schemes. The service had dealt with these incidents consistently well.

We checked the service's process for gathering feedback. We saw that questionnaires were sent out. We saw the most recent questionnaires, which had been sent out in 2017, had received a good response. One hundred per cent of people who responded to the survey agreed or strongly agreed that the service was good at respecting their privacy. For lower scoring questions, such as involvement in care, an action plan was formulated and the progress was checked consistently. Everyone we spoke with said they would recommend the service to other people.

We saw highly organised and complex audits completed which encompassed the service provision as a whole. For example, audits were completed on support plans, there were monthly service reviews being completed by the scheme/team managers, the registered manager, and the regional manager. This was to check that all areas for improvement had been highlighted and suitable actions had been assigned to the scheme managers. We saw that medication audits were taking place weekly and had identified any issues, such as a missed signature, which we saw had been dealt with correctly.

The administration of all aspects of the service was well managed. During the inspection we asked for a variety of documents to be made available to us and these were promptly provided and well maintained. Policies and procedures were regularly reviewed. We found records to be well kept, easily accessible and accurate.

Team meetings were held regularly and were well organised on rotas. We saw the minutes of these meetings.

The service had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, independence, respect, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance. We saw that the policies had been reviewed recently.