

Comfort Call Limited

Comfort Call Northampton

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Inadequate



Is the service well-led?

Requires improvement



Overall summary

This announced inspection took place on 20 April and 21 May 2015. This is the first time that this service has been inspected.

Comfort Call Northampton provides domiciliary care to enable people with a range of care needs to continue living independently in their own home. At the time of our inspection service provided support to 184 older people living in Northampton.

The service had appointed a new manager who had recently begun the registration process to become a registered manager. 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.

Some people had not received their planned care, medication or meals. There was no system in place to identify people who had not received their care. People

Summary of findings

did not always have information about the service or how to contact staff if they had concerns. There was no action taken or learning from incidents as a result of a missed or late call.

People were at risk of harm as staff did not have the knowledge or skill to recognise when abuse had occurred and did not report it. Staff were not aware of their roles and responsibilities in protecting people from harm and not all of them had received training in safeguarding vulnerable adults.

Some people's risk assessments and personalised plans of care were over a year old. People could not recall being asked about their preferences for care.

There were not enough staff to meet people's needs and people did not know who was going to provide their care. Staff did not always receive spot checks, supervision or appraisals. There was an inconsistent approach to staff training and development.

People who had the same care workers on a regular basis had positive relationships with their carers who respected their privacy and treated them with dignity; and staff took appropriate action when they noticed that people's

health needs had changed. However where people did not have regular care workers the response was not so positive. People had made complaints but the provider did not log, investigate or respond to people's complaints. People also lacked confidence that the provider was listening to their feedback.

The provider had recently taken a range of actions to drive improvement in the management and leadership of the service, although these actions were in their infancy we saw that some improvements were already being made.

We identified a number of areas where the provider was in breach of Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 (Part 3) and you can see at the end to this report the action we have asked them to take.

The provider took a range of actions following our inspection. They stopped taking on new clients and new packages of care until they have enough trained staff and systems in place to ensure that people get their planned care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

The provider did not follow their own policies in safeguarding vulnerable adults. Staff did not understand their role in safeguarding vulnerable adults.

People did not always receive the care they needed because care workers did not always undertake the specified visits to provide the care that had been scheduled.

There was not sufficient numbers of suitably skilled staff deployed to meet people's needs.

People did not always receive their medicines as prescribed.

Requires improvement



Is the service effective?

The service was not always effective.

Staff training was not always provided or up to date.

Not all people had been regularly assessed for their care needs.

Staff sought consent from people before carrying out care.

Requires improvement



Is the service caring?

The service was not always caring.

People did not always have regular care workers and were not always treated with respect.

People were not always supported to express their views.

Requires improvement



Is the service responsive?

The service was not always responsive

People did not always have the opportunity to discuss their needs and review their care.

People did not have the opportunity to express their preferences, and their preferences were not adhered to.

The provider did not follow their own complaints policy and their complaints had not been adequately dealt with.

The provider was not always available to people in times of need.

Inadequate



Is the service well-led?

The service was always not well led

Requires improvement



Summary of findings

There was no effective system to ensure that care was provided to all the people using the service

There was no effective team working.

There was no effective quality monitoring.

Comfort Call Northampton

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 took place on 20 April and 21 May 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in when we visited.

The inspection team comprised an inspector and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who is elderly and requires care at home.

In planning for our inspection we reviewed the information that we held about the service, including notifications from the service about things that happened at the service and information provided by some of the staff that worked there.

We also contacted Nene Clinical Commissioning Group (NCCG). Clinical Commissioning Groups are groups of GPs who are responsible for designing local health services in England. They do this by commissioning or buying health and care services for Northamptonshire. We contacted Northamptonshire County Council Commissioners and the Safeguarding Team.

During our inspection we talked with 7 people who used the service and five relatives of people who could not speak for themselves. We interviewed 18 staff and managers.

We looked at 8 peoples' records to check whether their needs were being met, we also looked at nine staff records. We inspected the on-call rota log book for March and April 2015, the complaints and safeguarding files and the system used for booking carers for care visits.

Is the service safe?

Our findings

People were at risk of harm as staff did not have the knowledge or skill to recognise when abuse had occurred and did not report it. We were told about two incidents where it was alleged that staff have behaved inappropriately and these behaviours should have been reported under the safeguarding processes but had not been. We raised these two safeguarding alerts into these allegations. When we spoke with staff they were not aware of their roles and responsibilities in protecting people from harm and not all of them had received training in safeguarding vulnerable adults. Safeguarding alerts had been raised by other care providers for example the local hospitals and ambulance service, these related to people who had not received their care as planned, and as a result required urgent medical attention. The provider had been made aware of people not receiving their care by care workers, relatives and people who used the service, however, they had not raised any safeguarding alerts relating to this. The provider had a safeguarding policy and procedure whereby they would report any safeguarding concerns to the local safeguarding team; the provider had not followed their own safeguarding policy or procedure. The new manager was implementing procedures to investigate previous safeguarding alerts.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

People did not always receive their prescribed medicines as planned and the manager did not have systems in place to investigate this. Only one third of staff had received training in administering medicines. Where people required help with their medicines some had not had a risk assessment for staff to assist with their medicines in the last year. People did not always receive their medicines as prescribed; the on-call duty log demonstrated that five people had not received their medication in the first two weeks of April 2015. None of these missed medication incidents had been logged as an incident, and none had been investigated or reported as a safeguarding alert. The manager showed us that there were a further seven incidents involving medicines since April 2015. The manager showed us that these incidents had been logged, but could not tell us what action had been taken as they

had not been investigated and there was no timescale for them to be investigated by. Medicine Administration Record sheets (MAR) were in place however not all medicines had been signed to show they had been given.

This is a breach of Regulation 12 (2g) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

The provider had not ensured that there was enough staff deployed to meet peoples' needs. During our first visit the manager could not tell us how many staff worked at the service, or how many people received care from the service. The manager was not able to tell us whether they had enough staff to meet the needs of the people who used the service as there were no systems in place to calculate how many staff were required to meet people's needs. The provider had appointed a new manager in January 2015; they had recently taken over from a previous care manager who had left no access to computerised information about the people who used the service or the staffing arrangements. The provider had placed a senior management team in the branch to support the new manager in April 2015. During the first day of our inspection the management team were reviewing all paper records to ascertain who was still receiving care and who the current staff were. During our second visit the management team had established and the details of the people receiving care and the staff. We saw that the provider identified that there was insufficient staff employed and was actively recruiting more staff.

Staff told us there were not enough staff to meet people's needs. People did not know who was going to provide the care and staff did not know their rotas in advance. The service employed co-ordinators to allocate staff to people who required care, however we saw that there were not enough care workers to cover all of the visits required. The on-call log showed that people continued to complain of missed care visits. On 21 May 2015 we saw that five staff had left the service and that the co-ordinators were struggling to find enough staff to cover all of the visits over the bank holiday weekend.

Staff did not always receive spot checks, supervision or appraisals. Supervisors who were responsible for carrying out staff spot checks and supervisions did not have access

Is the service safe?

to the information that told them who was due to receive a spot check or supervision. The new manager has now arranged for the supervisors to have access to the staff information.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

Robust recruitment systems were in place to reduce the risk of unsuitable staff being employed. Staff confirmed that checks had been undertaken before they were allowed to start work. Staff files confirmed that pre-employment checks had been carried out before staff started their induction training. The checks included obtaining of references and checks with the Disclosure and Barring Service (DBS), their work history and their fitness to

undertake the role. The DBS check helps employers make safer recruitment decisions and identifies if staff have any criminal records or are barred from working with vulnerable adults. New staff underwent an induction period where they received training and shadow experienced staff during their first calls.

Risks to people using the service were identified from the beginning of the assessment process. This included risks to the person and risks within the home. Records confirmed that risk assessments were undertaken to prevent the risk of accidents and injury to the people who used the service. Household and environmental risk assessments were completed and the outcomes were taken into account in helping to make the environment as safe as possible.

Is the service effective?

Our findings

There was an inconsistent approach to staff training and development and the provider did not have complete information about what training the staff had actually received. We established that those staff employed before January 2015 had not received adequate training and most of them did not have up to date training in safeguarding of vulnerable adults, moving and handling and medicines management. These staff told us that they did not receive any regular training or updates. In contrast those staff that had been employed since January 2015 had undergone an induction and had received relevant training.

People had varying view about staffs skills and experience to provide for their needs. Where people had regular care workers, they were happy with the service, for example one person told us “All the staff I have are trained and experienced.” However, most people told us that care staff did not have the skills to carry out their role. One person said “People have not necessarily got the skills for the job. In some cases I feel they definitely need more training, they have no idea of how to deal with anyone with dementia.” A relative told us “Some staff are not appropriate for the job. they are supposed to take [my relative] out for walk in wheelchair for an hour on certain days to get fresh air and change of scenery, one of the staff they send regularly says they can't push the wheelchair. I have mentioned this to the agency but they still come.” Another relative told us “staff are supposed to check if [my relative] is wet, a member of staff told us they had never changed a pad and that they did not know how to do it”. Another person told us that when they have a care worker that is new to them, they have to explain how to use the standing hoist to transfer their relative.

This is a breach of Regulation 12 (2c) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

People had mental capacity assessments in place to identify whether they had the capacity to self-administer medicine; these had been carried out at the time of starting the service, although these had not been updated regularly. Where people did not have capacity or chose not to self-administer this was clearly recorded in the care plan. People told us that care staff sought consent before carrying out care; they offered choice where appropriate and explained what they are doing at the time. For example one relative said “They ask before they do anything and it's [my relative's] choice if they have a bath or shower or if they need help with anything else, they never just do it.” However, Staff were had not received training in the Mental Capacity Act 2005 (MCA) or Deprivation of Adults Safeguarding (DoLS) and staff we spoke with were not aware of their roles in assessing peoples mental capacity to consent to care.

People told us that the care staff were very good at checking that their health needs are met and they notice any changes and take appropriate action. We saw that the on-call log book contained many entries where care workers had taken action where people had been unwell. One person told us “They notice if I am not too well and ask if I want them to get the doctor or phone anyone else.” One relative told us “They notice if [my relative] is not well and say they are not too good today.” Staff told us that they informed relatives and the GP if a person appeared unwell, and if necessary called an ambulance.

Some people required assistance with preparing their food and drink. Several people told us that they have assistance with the provision of meals and received support to ensure their nutritional and dietary needs were met. One person told us “I get out what I want to eat that day and they do it for me -whether it is sandwich or microwave meal or snack.” Another had their shopping done by staff told us “I do a list and they do the shopping and bring me the receipt. I make my own choice of meals, tell them and they prepare it.”

Is the service caring?

Our findings

Where people had the same care workers on a regular basis they were very complimentary about the care they received and the attitudes of staff. One person said “Mostly they [care workers] are lovely girls, they show respect, I can't say I've ever had one with bad attitude”, another person said us “They [care workers] are very nice girls, caring, careful and cheerful, my regular is always singing to herself as she does her work”, and another person said “My carer is very nice, she helps me such a lot. I am very lucky as I've got a good carer.... It's the best thing that's happened to me.” One person told us that the care workers were amicable and obliging and open, they ask if there is anything else they can do and, staff say “If it can be done it will be done”.

However, where people did not have the same care workers on a regular basis, the relationship was not always positive, for example one person said “Certain staff very good but others get irritated if I ask them to do something.” This person had reported this negativity to the staff on-call but they had not received any feedback.

People who had the same care workers on a regular basis were more involved with making daily decisions about their care. For example one person said that staff “Treat me as individual, they know my ways. She loves her job and does the best she can. I have a rapport, they don't have to ask if I want something as it's already done, but they always

ask. She sits and chats when writing her report and has cup of coffee.” Relatives also told us that the care workers were kind and would ask if there was anything else before they left.

Most of the people told us that they felt their regular carer respected their privacy and treated them with dignity. One person told us “I have never felt awkward or embarrassed as they help with bits I can't reach but they encourage me to do rest myself and dry myself, they also encourage me to shave myself.” One relative told us “They have a laugh with [my relative] and make a fuss of him which [my relative] loves. They take him into bathroom and hear them talking to him, explaining things. Kind of friends but respectful”.

Where people did not have regular care workers the response was not so positive. Two relatives told us that carers did not always respect their homes; one relative said “They don't leave the bathroom tidy; they leave it for me to do.” Another relative told us “We asked if carers could take their shoes off because we pray in that room (and we also have white carpet) but were told they cannot do this, also some carers do not leave the bathroom clean and tidy which upsets mum”. The care plans stated that staff should either remove their shoes or wear plastic overshoes. We observed that the plastic overshoes were available and were collected by staff from the main office, however, these were not always used by care workers. The complaints had been made to the care workers and the staff at the office, however, the relatives told us that things had not improved. There was no evidence that the complaints had been logged or investigated.

Is the service responsive?

Our findings

People had been assessed for their care needs by the authority paying for their care, the number and the times of visits had been agreed at the beginning of their package of care. People had met with the care staff' supervisors at the beginning and had undergone risk assessments and devised exactly how the care was going to be delivered. Some people had care plans, for example one person told us "Yes there is a written care plan and care workers do look at it if they have not been before". However other people told us that they were unsure if staff followed a care plan, for example one person told us "I've not got a care plan, [regular care staff] tell me what to do" and another told us "Not sure about a care plan, I have a record book they write in every visit and they do look at that when they come". We spoke with the supervisors who told us that until recently they did not have access to the information about who required a review of their care; they told us they relied on care staff coming back to the office to advise them that people needed a review. The new manager recently put processes in place to allow the supervisors access to the information.

The provider held records that demonstrated that people had risk assessments and personalised plans of care; the information in the files told the care workers what people required to meet their needs, however, some of these assessments were over a year old. We were told that people were to have yearly reviews with supervisors however; we found that not everyone had had their yearly review. One person did not realise that they could discuss their care, they said "I've not really seen or heard from anyone for long time but someone came last week and wrote everything down and gave me a copy".

People could not recall being asked about their preferences when their needs were assessed initially or at any time since. For example one person who received personal care said "I was never asked but often have a male carer; I would have preferred to have been asked. People who received personal care expressed concerns that they received male care workers when this was not their preference. One person told us "I only have one call a day.... but they sent a man once which I did not like, they never asked beforehand if this was OK".

People were at risk of not receiving their medication, meals and care as there was no system in place to ensure that

care that was planned and carried out. People told us that they had not always received their care as care workers did not always visit when expected. Staff and people who used the service had access to a person who was on-call to pass on any concerns. The person on-call completed a call log. The call log for the two week period at the beginning of April demonstrated that 12 people had reported that they had not had their care visits and 9 people had reported that the carer was late. One person we spoke with told us, "I've only had care for a month; I am down for morning and evening calls and so far they have missed one call every week." Another person told us "My call was due at 7am and yesterday they were two hours late." Staff told us that they had arrived at calls where the previous carer had not turned up; staff also told us as a result of their missed call people had missed their medication, meals and had not been able to go to the toilet. Although some people phoned the provider to inform them of a missed call, other people were not able to use the telephone. One person told us that they were unable to contact the office as they had not been provided with the number to call. Another person told us that even when they had rung the 'on-call' number they had been told that there was no-one available and no one visited to provide their care, this person did not receive their care. The manager could not tell us who had missed calls or how often this had occurred, as they had not analysed the information recorded in the on-call log. The provider had recently taken steps to install a system to record all carers as they arrived and left each care visit; this was being implemented and would be in place by June 2015.

This is a breach of Regulation 12 (2a and b) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

Although the provider had a complaints policy, this was not being followed and concerns raised by people were not be listened to or addressed. People did not have information about the service or how to contact staff if they had concerns. People told us that they had to ask for information on how to contact someone if care staff did not show up or they had a question about who would be doing next call. When people tried to contact the office they were not happy with the response they received. For example one person told us "If you ring, they sometimes don't answer if it is out of office hours as depends who has the

Is the service responsive?

phone” and a relative told us that even when they did contact the office the response was not helpful; for example, “I have asked for things but they don't listen. They say ‘We can cover you for anytime’ but then don't do it!”

The provider did not log, investigate or respond to people's complaints. People told us that they had complained to the on-call staff about missed calls, late calls and not receiving rotas showing that care workers had been allocated to them the following week. For example one relative told us “They have failed to turn up and not let me know in past [in February 2015] and I had to ring and they can be up to an hour late.” Another relative was very unhappy with the way that complaints were dealt with; they told us “There is no point writing as [the manager] will put it in bin”. We looked at the complaints file and found none of the issues these people raised with us had been recorded as a complaint. The manager showed us that they had received only one complaint in April 2015. However, we saw that the on-call team had recorded all calls to them in a call log; these listed many complaints of missed or late calls, but these had not been logged as a complaint. There was no indication of what action had been taken as a result of the missed or late calls. In response to concerns about people

not knowing which staff had been allocated to provide people's care, the provider had implemented a system to inform people who to expect on their visits in the form of a rota. People told us that this had not alleviated their concerns as the detail was often incomplete or stated that the call or the staff were unavailable.

People told us that carers did not always ensure that they had left people's property securely. Some people had agreed to have ‘key safe’ so that they could receive care in their homes; staff accessed their properties using the key safe. There had been complaints from relatives that staff did not always ensure that people's doors were locked when they left. There was no record of these incidents in the complaints folder, and there was no evidence that management had ensured that staff had been made aware or had learnt from these incidents.

The provider was supporting the manager to put processes in place to log, investigate and respond to complaints, however, this was in its infancy.

This is a breach of Regulation 16 (1 and 2) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

Is the service well-led?

Our findings

The provider had appointed a new manager in January 2015, who is in the process of applying to the Commission to be the Registered Manager.

The provider had recently taken a range of actions to drive improvement in the management and leadership of the service. They had directed additional managerial resources into the service to help the manager implement quality monitoring systems and a new telephone logging system to improve people's safety. At the time of our inspection we could see that this was beginning to have an impact of the quality and the safety of the service.

However, all of the systems were in their infancy and during our inspection on 20 April 2015 it was clear that the manager did not have an effective oversight of the service. They did not have an understanding of the needs of people using the service and did not have a clear picture of the levels and competencies of their staff team. They had relied on a care manager to run the service and when this person left in April 2015 the manager had no access to the information needed to ensure that people received the care they needed. However during the 2nd day of our inspection on 21 May 2015 this had improved and we found that the manager and the provider understood their clients' needs and were clear on the staffing requirements to enable them to deliver on their care commitments.

The manager had recognised that there was not enough staff to meet people's needs and was actively recruiting staff. They acknowledged that staff training and support systems were underdeveloped and had begun to strengthen the oversight and coordination of these processes. Staff meetings had begun to take place, staff told us that they were receiving more information about the running of the service. The supervisors were planning supervision times for all staff.

Despite this recent focused activity, people using the service and their relatives had experienced a number of concerns about the adequacy of the care they received and continued to lack confidence in the management team. One relative said "Well led-not at all. The whole thing is a minefield and feel like "fighting a war" and often not got time or energy to follow things up when know should do really. They never phone up to see if any problems or if things OK."

People also lacked confidence that the provider was listening to their feedback and many told us that they had consistently raised concerns about the way in which their care was delivered. This was particularly in relation to the number of missed calls they experienced or the number of occasions where staff were late arriving. They felt that despite raising these concerns nothing was happening to improve the situation. The provider explained to us that they were in the process of introducing a system where the care workers logged in via an automated telephone service when they arrived and left people's homes. They felt that this would strengthen their ability to monitor the provision of care and that the system was to be available in June 2015.

The methods used to gather feedback from people who use the service were in need of strengthening. Staff from the office would telephone some people to ask them about their experience of receiving care. However there was no other method of collating peoples' views such as face to face contact or by letter or survey. This meant that people who were not able to communicate effectively via the telephone did not have the opportunity to express their views.

People told us they did not feel they were encouraged to make their views known about their care, treatment and support. One relative told us that they "never had a survey or anything, but interestingly they have rung up in past couple of weeks to ask how things were, the first time for months, but the service seemed quite irritated when they asked if you have any issues and you tell them what they are."

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014

The provider recognised that the instability of the management had had an impact on the quality and safety of the people's care. They had insight of the depth of the challenges they faced to make the improvements required. The provider recognised the need to not take on any new clients and new packages of care until they have enough trained staff and systems in place to ensure that people get their planned care .

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not meeting this regulation because: The provider was not preventing, investigating or mitigating the risks of missed calls. Regulation 12(2b) The provider was not preventing, investigating or mitigating the risks of not providing medicines as prescribed. Regulation 12(2b) People were not receiving their medicines as prescribed. Regulation 12(2g)

The enforcement action we took:

We placed a condition on the provider's registration that states:

The provider cannot take any new service users or packages of care at Comfort Call Northampton, and that you agree to this voluntarily until you receive our formal notice.

And

The provider must ensure that every service user at Comfort Call Northampton receives the packages of care that have been agreed with them and or the commissioners of the package of care.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider was not meeting this regulation because: The provider had been made aware of missed calls by families, the provider failed to notify safeguarding. Regulation 13(2) Staff had not received training in the last year in safeguarding. Regulation 13(2) Staff were unaware of how to access the safeguarding policy. Regulation 13(2) Staff observed abuse that they did not report to management or the local authority safeguarding team. Regulation 13(2)

The enforcement action we took:

We placed a condition on the provider's registration that states:

This section is primarily information for the provider

Enforcement actions

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Regulated activity

Personal care

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The provider did not respond to verbal complaints. Appropriate action was not taken to respond to any failures in care identified in the complaints. Regulation 16(1)

The provider did not have effective systems to make sure that complaints were investigated without delay. Regulation 16(2)

The enforcement action we took:

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The provider must ensure that every service user at Comfort Call Northampton receives the packages of care that have been agreed with them and or the commissioners of the package of care.

Regulated activity

Personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider was not meeting this regulation because:

The provider does not have the processes in place to assess, monitor and improve the quality and safety of the service. Regulation 17(2a)

The provider does not seek and act on service user feedback to continually evaluate and improve the service. Regulation 17(2e)

The enforcement action we took:

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And

This section is primarily information for the provider

Enforcement actions

The provider must ensure that every service user at Comfort Call Northampton receives the packages of care that have been agreed with them and or the commissioners of the package of care.

Regulated activity

Personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider was not meeting this regulation because:

The provider does not have sufficient suitably skilled staff to meet the needs of service users. Regulation 18(1)

The provider has not ensured that staff have been appropriately supported and supervised to carry out their roles. Regulation 18(2)

The enforcement action we took:

We placed a condition on the provider's registration that states:

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And

The provider must ensure that every service user at Comfort Call Northampton receives the packages of care that have been agreed with them and or the commissioners of the package of care.