Care Quality Commission

# Comfort Call Limited

# Comfort Call Gateshead

## Inspection report

7-8 Blue Sky Way
Monkton Business Park
Hebburn
South Tyneside
NE31 2EQ
Tel: 0191 495 9542
Website:

Date of inspection visit: 5 February 2015, 13 and 31 March 2015
Date of publication: 07/07/2015

## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

## Overall summary

Comfort Call Gateshead is a domiciliary care agency which is registered with the Care Quality Commission to provide personal care for people in their own homes. The agency operates in the Sunderland, South Tyneside, Gateshead and Chester-le-Street areas. The agency also provides a domiciliary care service to people who live in an extra care housing scheme. At the time of this inspection there were approximately 1,300 people using the personal care service provided by this agency.

The last inspection of Comfort Call Gateshead was carried out on 2 May 2014. The service met the regulations we inspected against at that time.

This inspection was carried out on 5 February, and 13 and 31 March 2015.

The agency had a registered manager who had worked for the provider for several years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

# Summary of findings

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.

We found the provider had breached Regulations 13 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found improvements were required to the management of medicines. People were not always supported with their medicines in a safe way. People did not always receive the right support and medicines records were not always completed.

Also, the agency did not always manage complaints in the right way. Some people felt their complaints were not listened to, some people felt their concerns continued to reoccur even after their complaint had been investigated, and the records of how some complaints were managed were not always completed. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe with the staff who supported them. Staff completed training in safeguarding adults before they started to work with people and had annual refresher training. This meant they knew how to deal with any concerns about people's safety.

There were enough staff employed to carry out all the visits that were required, and the agency constantly recruited new staff. The agency made sure that staff were fully vetted before starting to work with people.

Some people had regular teams of care staff and this made them feel confident in the staff who supported them. Other people said they did not know which care staff would visit them and were not always told if they were going to be late. People and staff told us care staff were not allocated travelling time between calls, which meant they did not always get their full visit.

People felt the staff were suitably skilled to provide their care. Staff had relevant training and supervision to assist people in the right way. New members of staff received thorough induction training so they were prepared for their role.

People were involved in making decisions about their own care arrangements. Their care was planned and regularly reviewed. People who had a regular team of care workers felt staff were knowledgeable about their individual needs and preferences. People were supported with their meals if they needed support with their nutrition.

People were very positive about the caring nature of the agency staff. People and their relatives described care staff as caring, kind and helpful. People said their dignity and privacy were respected and maintained by the care workers. They told us staff supported them with closing curtains if they were getting washed.

A health care professional told us the care staff they had observed showed "compassion and kindness in their interaction with clients".

People felt they were fully involved in making decisions about their care package. All the people we spoke with said they (and sometimes a relative) had been present when their care plan was drawn up. People kept a copy of their care plans in their own homes so they and their care workers could refer to them at any time. The care plans were personalised and written in a sensitive way.

People, relatives and health care professionals who knew the registered manager made many positive comments about her professionalism and helpfulness. Staff said they felt valued and supported by the registered manager and by the organisation.

However some people did not know any of the management staff and had no information about this. Some people felt there were not enough office staff to support the running of the agency, because they did not always receive a response when they requested return phone calls.

The provider had systems to check the quality of the service such as questionnaires, spot checks and audits. Although the system identified gaps these were not always addressed so the system was not always effective.

# 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?**

Requires Improvement

The service was not always safe. Medicines were not always managed in a safe or consistent way for people who needed assistance with this.

People said they felt safe with the service and the care staff who visited them. Staff had training in safeguarding and were aware of the procedures to follow to report abuse.

There were effective recruitment and selection procedures in place to make sure staff were vetted before they started working for the agency.

**Is the service effective?**

Good

The service was effective. Staff were appropriately trained and supervised to provide care and support to people who used the service.

People said they received help to manage their meals and nutrition where this was required.

Staff worked with health and social care professionals to make sure people's health was maintained.

**Is the service caring?**

Good

The service was caring. People were very positive in their views about the kind and friendly nature of the care workers.

People felt they were treated with dignity and respect. They said their privacy was maintained and their independence promoted.

People felt they were fully involved in making decisions about their care package.

**Is the service responsive?**

Requires Improvement

The service was not always responsive. People did not always feel their complaints were listened to or acted upon. Concerns that were investigated by the agency were sometimes repeated, such as missed visits, so the actions taken were not always effective.

People felt included and involved in decisions about the care service they received.

People's care plans were personalised to their specific needs and were regularly reviewed.

**Is the service well-led?**

Requires Improvement

The service was not always well-led. The provider checked the quality and safety of the service but effective action was not always taken to address shortfalls.

# Summary of findings

Some people were not aware of the management arrangements at the agency and did not always feel they received a response from the office staff.

The agency had a registered manager who had worked for the agency for some years and was well regarded by people, staff and other care professionals and commissioners.

# Comfort Call Gateshead

**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 started on 5 February 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the registered manager would be available. The inspection continued on 13 and 31 March 2015.

The inspection team included an adult social care inspector, a bank inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at all the information we held about the service. We did not send the provider a Provider Information Return (PIR) as we carried out this inspection at short notice following some concerns. (A PIR 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.) We contacted the commissioners of three relevant local authorities before the inspection visit to gain their views of the service provided by this agency. We also contacted a community nurse and spoke with a training officer who had involvement with the agency. We contacted the local Healthwatch groups in each of the three local authority areas to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we visited six people in their own home with their permission, held telephone interviews with 20 people who used the service and spoke with 10 relatives. We spoke with the registered manager, two managers, a quality assurance manager, three care co-ordinators, an administrative staff, a trainer, and 14 care workers. We also looked at the care records of 12 people and looked at the recruitment records of six staff.

# Is the service safe?

## Our findings

Medicines were not managed in a safe or consistent way. The provider had a comprehensive medicines policy and procedure that set out the arrangements for supporting people with managing their medicines, where this was applicable. People or their relatives were involved in assessing and agreeing the level of support, if any, they required with medicines. Where people needed support with medicines, the agency recorded the assessed level of support they required. For example, whether someone needed a simple verbal reminder to take their medicines (prompt), physical assistance only (assistance) or whether they needed full support to take their medicines (administered).

However, some people or relatives told us they did not feel their medicines were managed in a safe way because they did not receive them at the times they were prescribed. For instance, one person described how the care workers were supposed to support them with strong pain killers at specific intervals. However sometimes the timing between visits was too short so they were not supported with their second dose.

Some people's assessment of whether they could manage their own medicines did not correspond to the guidance in their care plan. For example, one person who was living with dementia and did not have the capacity to manage their own medicines, had a care plan which stated "prompt me with my medicine". Some people or their relatives told us that there had been several occasions where medicines had not been given in the right way so the person had not taken them. For example, staff had left the medicines in a glass rather than supporting and observing that the person had taken them. This placed those people at risk of harm as the medicines were for significant health conditions.

All staff had completed training in the safe administration of medicines and received annual refresher training. However, the medicine administration records (MARs) were not completed in a consistent way by care workers. For example we found several gaps in some people's MARs where it was not possible to tell if someone had been provided with their medicines or not. We saw there were inconsistent 'codes' used to denote whether a person had declined to take their medicines.

One person had 20 boxes of an unused medicine. The MARs stated this medicine should be taken twice day. The person told us they did not like to take the medicine so they declined it but staff had only sporadically recorded this as 'refused' and mainly left the MARs blank. The agency was responsible for ordering this person's medicines but staff had not stopped the prescription so each month more boxes of the medicine arrived. In discussions the office staff we spoke with acknowledged that the biggest challenge to the service was the inconsistent management of people's medicines.

These matters were in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they felt safe with the staff members who visited their home, particularly with regular care staff. One person said, "Undoubtedly, yes I am safe with my carer, she is very good." One person commented, "Yes, very safe. They come to help me and I would not be without them." Another person told us, "I certainly do feel safe with the girls; I have no problems in that direction."

Staff told us, and records confirmed, that they had completed training in safeguarding vulnerable adults as part of their induction training and then annually. Staff were able to describe the procedures for reporting any concerns and told us they would have no hesitation in doing so. One care worker commented, "We all get regular safeguarding training. There are always care co-ordinators and on-call staff to report any concerns to at any time of the day or night." Another care worker said, "We definitely know what to do if we have any concerns about people's safety. We can ring the office at any time. I have made a safeguarding report before and it went straight to the local authority."

Staff also had training and written information about their duty to report any poor practices of other staff, which is called whistleblowing. In discussions the registered manager and care workers confirmed that they were fully aware of their responsibilities to protect people in this way.

# Is the service safe?

Commissioning officers in the three local authorities all told us that safeguarding concerns were managed well by the agency. They told us, “Any issues raised with the service are dealt with promptly” and “Safeguarding alerts are raised by the company when they become aware of any issues”.

Risks to people’s safety and health were appropriately assessed, managed and reviewed. We looked at the care records of 12 people both in their own homes and in the office. Supervisors who were trained in assessing risk had carried out and recorded risk assessments before the agency provided the care service. These included an assessment of the safety of the person’s home and equipment, and any potential risks relating to falls, medicines, skin care and nutrition. The risk assessments were regularly checked to make sure they were still relevant. Any accidents or incidents that occurred during the delivery of care were reported by care workers to the office staff so that these could be logged on the agency’s computer system. In this way these events could be checked for any trends.

A district nurse commented, “I feel that the clients’ safety is always first with Comfort Call and they would alert the GP or our team if there were any concerns.”

Before people received a service from the agency, an assessment of their individual needs were carried out to establish how much support they required and at what times. The assessment included a review of people’s mobility and whether they required two staff to support them with mobility equipment. This meant the agency tried to make sure the correct number of care workers would be available to carry out care.

The people and relatives we spoke with felt that there were enough staff employed to carry out the visits, although for some people there was no consistency in the staff who attended to them. Some people were concerned about the number of new care workers who turned up without any introductions or notice from the agency. People who did not have regular care staff said this created difficulties in having to explain what they should do. Their comments included, “I had six or seven different carers in one week - you don’t know them and you have to start and teach them what to do” and “Strangers just coming into your home without notice. It could be a burglar!”

Care co-ordinators were responsible for making sure there were enough staff in each of the geographic areas to meet all of the visits people required. In discussions, care co-ordinators and care workers said there were enough staff employed to provide the service but that it was difficult to provide consistency if several staff were on sick leave or holiday at the same time. Care co-ordinators told us that care workers were “flexible” and “helpful” when asked to cover visits for other staff. The care workers we spoke with said they were on ‘zero-hours’ contracts so their hours were not guaranteed and could change from week to week.

Some people told us that there were often late starts to their visits but understood that staff had to travel from one visit to another. Some staff were concerned about the lack of time given for travelling between visits. One staff said that when they had raised the issue of travelling time to their line supervisor they said they were told to just "knock 10 minutes off" the allotted time of the first call. Staff in the Gateshead area said this was “now a bit of a problem” because the local authority had insisted Comfort Call used a call monitoring service. (This means care staff have to ring the office to log when they have arrived and when they leave a person’s home.) Staff who worked in another area where there was no call monitoring told us they used a log book to record time in and time out. They also said there was not enough time given for travelling to other calls, but confirmed they had not been instructed to leave calls early, rather they just started their first call a bit earlier. We told the registered manager about this so that she could look into this.

People had mixed views about whether the agency kept them informed if staff needed to change at short notice so they knew who would be visiting to provide their care. During an office visit we observed care co-ordinators ringing several care staff trying to find a second staff member to support a ‘double-up’ visit call where the original care worker had rung in sick. During that time they also rang another person to let them know their care worker was going to be late.

People told us the agency rarely informed them if the care staff were going to be late. Their comments included, “I never get told they are going to be late, I have to phone in to find out” and “The office never tell me if she is going to be late”. Care co-ordinators acknowledged it was not always possible to inform people if there was going to be a change of care worker or if they were going to be late.

# Is the service safe?

There were robust recruitment practices in place. We looked at the records of the appointment of six care workers and asked staff about their recruitment experiences. Staff selection processes were thorough and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the agency had checks in place to make sure that staff were suitable to work with vulnerable people.

# Is the service effective?

## Our findings

People and relatives felt that regular staff who had been with them for some time knew what they were doing and in their opinion were competent in carrying out their role. For example one person told us, “They know exactly what to do, how I like things done, and they are excellent. If a new worker comes the others teach her. It’s a really good team.”

Another person told us, “She is fine. I know she has been for some training but I don’t need a great deal of help. I would say she does know what she is doing.” One person commented, “The girls who come to me are fantastic. I would not want to be without them. They are well trained and know what to do.”

People who did not receive regular care workers were less satisfied with the service. For example, some people felt that new staff had to be constantly told what to do and where to find things they needed to fulfil their role. One person commented, “If you get someone who has been to you a few times it is OK but if you get a new one you are left telling them where everything is and what to do – this is why I would like someone regularly.”

Staff told us, and records confirmed, that they received training in mandatory health and safety subjects including first aid, fire safety, food hygiene and infection control. New staff completed a comprehensive induction training course that included mandatory training in principles of care and health and safety before they could start working at the service. The agency employed three training officers and had well-equipped training rooms at its branch office. This meant staff could complete practical, classroom based training, for example in moving and assisting. The provider used a computer-based management tool to identify when staff had received their training and when their refresher training was due.

Staff told us they had good opportunities for training to support them in their roles. Care workers told us, “They are spot on with training - it’s updated all the time and any requests for extra training are dealt with” and “the training is really good here”. After completing a probationary period all care workers were expected to achieve a relevant care qualification, such as the diploma in health and social care. A visiting training assessor told us, “All the staff are willing and enthusiastic about their training.”

In discussions, staff said they felt supported in their role. There were managers and care co-coordinators who arranged the service within each of the three local authority areas and supervisors who supported care workers in the community. Staff described how they received regular individual sessions with their line supervisor as well as six monthly spot checks. One staff member told us, “I feel supported both professionally and personally.” A care worker told us, “Even though I do nights, I still get the chance to have supervisions with my supervisor.” We saw that staff had also received themed supervision sessions on at least a six monthly basis, which included topics such as care plans, confidentiality and safeguarding and medication. Each member of staff had an annual appraisal with a manager. In this way staff were supported with their professional development.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their ‘best interests.’ Mental capacity assessments were carried by the local authority if people appeared to have difficulty making some decisions. These assessments were used to establish if people were able to make decisions about their care and health needs. In these cases arrangements were made for health and social care professionals, agency staff and a relative or advocate to make decisions in their 'best interest'. This meant where people did not have the capacity to consent, the provider acted in accordance with the MCA requirements.

People told us they were always asked for their consent before care staff carried out care and support. Their comments included, “My carer always asks what I need doing” and “they always do whatever I ask them to do”. People’s capacity to be involved in their own care planning was evident in their care records. People had signed any risk assessments and care plans where they were able to show their agreement and consent to the agreed support. For example, people who had the mental capacity to do so were asked to show whether they consented to their support with medicines set out in their care plan by signing the plan.

Each person who used the service had had an assessment about their nutritional well-being. Where people had needs in this area they were supported with nutrition and making

# Is the service effective?

meals as part of their individual care package. The people we spoke with felt they received the right support in this area. One person said, "I am a diabetic and I have my breakfast done for me. My carer does me some toast and scrambled egg." Another person told us, "My carer does my breakfast and lunch and a sandwich for tea. She knows what I am able to have and she does it for me." One person commented, "My carer helps with my meals. I can't have much sweet stuff and she helps me to stick to the right things to eat." One person's relatives felt that the staff made meals but did not always provide the right encouragement to make sure a person ate their meals, and this was raised with the manager for attention.

People said any changes in their health needs were referred to the relevant health care services. Care staff also described how they worked in liaison with healthcare professionals who also visit clients they are attending, such as the district nurse and the speech and language therapists.

The health care professional we spoke with said the agency responded appropriately to people's well-being. They commented, "In my position as a district nurse I have had to liaise many times with the service. If I have ever asked for assistance from Comfort Call they have been supportive and carried out tasks effectively."

# Is the service caring?

## Our findings

People who had regular care workers were very positive about the care and support they received. Their comments included, "I have a good carer who helps me and is so kind" and "I have carers who are wonderful".

People who did not have regular care staff felt they were unable to get to know staff. Their comments included, "I don't have a regular carer, but I would like one", "one coming who I knew would be lovely" and "nice enough girls but you don't have any kind of relationship with them. I have had six different ones in a week".

People felt their relationship with members of care staff was essential to whether they received support in the way they wanted it. One person described the importance of having a regular care team because of the specialist tasks they needed support with. They told us, "My care staff are like family now." Another person told us, "We get on well together. We chat about our families and what they are doing."

People told us the care staff treated them with kindness. One person commented, "They are very kind indeed, really nice girls. They make sure I don't need anything else doing before they go."

Another person said, "Very kind and thoughtful girl. Nothing is too much for her, never leaves me without asking if I have everything I need." One person told us, "[My care staff] is kindness itself. She called into the care home when I was in respite care, and she did this in her own time."

A district nurse told us, "Any Comfort Call staff I have met in clients' homes have demonstrated a good rapport with [people] and shown compassion and kindness in their interaction with[them]."

Staff received training in dignity and respect as part of their induction package with the agency.

People said they were treated with respect by their care staff. For example, one person told us, "I have always been treated with respect by all the workers who come to help me. I was asked if I wanted to be called by my Christian name or Mrs. I chose to be called by my Christian name and I call them by theirs." Another person said, "I have been treated very well by the care staff. They have been respectful to me, and never come in without calling a greeting and asking if I am alright."

Other people's comments included, "I am always met with a smile; it starts the day off well" and "I have only had care for a few months but I can say I have been treated with respect and kindness".

People told us they received gender-appropriate support. One person was particularly satisfied because he mainly received care from male care staff which he preferred, especially with personal hygiene needs. He told us, "I'm very happy with them. I know two or three of the male staff best and they are champion. They always ask if I want anything else doing."

People felt their privacy was respected by the agency staff. For example, one person commented, "When I am being hoisted with the hoist from my chair into the bath they cover me up as much as they are able, and this retains my dignity." Another person told us, "When I am being helped to have a shower and my leg creamed, my care staff closes the curtains so that nobody can see in."

People told us their independence was promoted and supported by the agency. For example one person commented, "When I am having a body wash the carers leave me to wash as much of myself I can manage." Another person told us, "I have always been independent and done everything for myself. I accept a little help, and this is respected by my care staff."

People felt they were fully involved in making decisions about their care package. All the people we spoke with said they (and sometimes a relative) had been present when their care plan was drawn up. Everyone we spoke with said they had their own copy and had read it, understood it and signed it. For example, one person said, "I know what it says in the book and that is what I get. The girls sign it when they leave. I also had a review about it." A relative told us they had been fully involved in setting the care package for their family member. They told us, "We decided what my [family member] needs help with. They help him with bathing and getting out of bed and I do the rest. Then we reviewed it."

Where people had regular care staff they felt able to direct and manage the care they received. For example, one person told us, "I decide what I need doing and my care

# Is the service caring?

worker is lovely, she does what I ask of her." Another person told us, "I have a large team of staff and I think I'm very lucky because they are mainly very good. But I feel able to tell them how to do it better for me."

# Is the service responsive?

## Our findings

The agency had a procedure that set out how it would handle complaints. People were provided with written information that explained how to make a complaint if they were dissatisfied with the service they received. However half of the people we spoke with told us that the agency did not recognise complaints when they tried to raise them. For example one person told us, "I contacted the office staff about my concerns and the risks involved to my relative because of missed calls and not being supported with medicines. The office staff told me it was because the member of staff was just young. They did not seem to recognise that I was making a complaint."

Some people told us they did not have confidence in the agency to act on complaints. One person said, "It is no good complaining – they don't take any notice of you." Another person said, "The office staff can be a bit brusque so I don't feel able to complaint to them." People did not always feel they got a response to any issues they raised. Their comments included, "There is no point in complaining. They just do what they want and don't bother to give you an answer." In discussions, some people and some care workers felt that some office staff were "not very good at communicating with clients".

Two relatives felt that the agency did take initial action when they first raised their complaint (about missed calls and poor medicine support). However the issues had continued to reoccur so the action taken by the agency had not been effective in resolving the concerns.

We saw the agency kept a log of individual complaints. In six months prior to the start of this inspection the agency had recorded 20 complaints from the Sunderland area, 18 complaints for the Gateshead area and four complaints from South Tyneside despite this having the largest number of service users. The complaints were mainly about missed or late calls and missed medicines. In some cases there were clear records of the investigation, action taken and any retraining, supervisory or disciplinary outcomes. However for some complaints we noted there was no record of any action taken, nor the outcome or whether people were satisfied with this. Some of the complaints were that people did not feel that their complaints had been acted upon.

This was in breach of regulation 19 of the Health16 and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt included and involved in decisions about the care service they received. Each person's care records included assessments about their individual needs, the level of support they required and their involvement in managing daily living tasks. People, or their primary carers, had signed the agreements of their care assessments to show they had been involved in the decisions about what level of support they required.

Each person had care plans which set out guidance for staff about how to support each person with their assessed needs. People kept a copy of their care plans in their own homes so they and their care workers could refer to them at any time. The care plans were written from the perspective of the person and were reviewed on an annual basis or more often if people's needs changed.

The agency provided care for people with a wide range of needs including support of people with poor mobility, dementia, mental health needs and other disabilities. The care records were written in a sensitive way that promoted each person's individual support needs. For example, one person's care plan stated, "I would like care staff to put me in my bed and raise my legs. I would like care staff to ask if I need anything else." Another person's care plan stated, "I like a crack and always like to hear new jokes from care staff."

Staff were aware that people's needs could change from time to time and they felt the service responded to these changes. One care worker told us, "If there's any change to people we get the supervisor to update the care plan." Another care worker told us, "If we have any worries about people when we visit, we can ring the office and get advice."

The agency office was open from 7am to 10pm through the week. Overnight and at weekends there were on-call supervisors to support people and care workers if there were any changes in needs or emergencies. A healthcare professional told us the agency responded appropriately to changes in the needs of people who used its service. They told us, "They are always ready and willing to help us, and share information in the best interests of the patient."

# Is the service well-led?

## Our findings

The agency had a registered manager who was also responsible for the day to day management of the care service to the South Tyneside area. There were also two care managers who had day to day responsibility for the service to Sunderland and Gateshead areas. People who were aware of the registered manager had positive views about her management style. Their comments included, "I think she is a good manager. She listens to you and she does what she can to help" and "I have had no problems with the manager or staff. I have found them to be very helpful".

Several people we spoke with did not know the name of the registered manager. They had been given copies of a service user guide (information booklet) but this was out of date and referred to a previous manager. Other people knew the manager that covered their area (either Sunderland or Gateshead) but some people did not know the names of any of the management staff and did not know how to contact them.

Nearly all the people we spoke with felt they did not always get a response from the agency when they requested a call back from office staff. Their comments included, "Some staff say they will ring back – but they don't", "They don't care, they listen then ignore your request" and "They don't bother to return calls". Some people felt this was because there were not enough office staff to deal with the management of this large agency. One person told us, "The manager is a nice enough person and has been out to see me but I don't think she has enough staff to run it properly."

The health and social care professionals we spoke with made very positive comments about the "professionalism" and "approachability" of the registered manager and the provider. The commissioners from one local authority told us, "We do not have any specific concerns about the performance of Comfort Call at present. Their registered manager fully engages with any investigations and improvement plans." Another local authority commissioning officer stated, "The company strives to be transparent and will work with me to resolve any issues or improve the service quality if and when required."

Staff commented that they felt supported by their line managers and felt it was a good organisation to work for. For example, one care co-ordinator told us, "I have a good relationship with my manager, and there are plenty of other managers to ask if I needed advice. I feel appreciated and it's a lovely company to work for, very friendly and it runs really well." A care worker told us, "It's well organised and a very fair company to work for. If I have something to say they listen and take it on board. I feel supported."

All the staff we spoke with told us that staff meetings were held on at least a three monthly basis where staff attend the local office. Staff told us the meetings were used to inform them of expected practices and standards, and they also felt able to contribute their comments at the meetings, individual supervisions and appraisals.

Supervisors carried out 'spot checks' of individual members of staff to make sure they were carrying out their role and any support tasks in the right way, and the outcomes of the checks were recorded. For example, checks were carried out to make sure staff were following the correct procedures for moving and assisting, personal hygiene and assisting with medication. Where any staff members needed support to develop in any of these areas, this was recorded and discussed with their line supervisors at their next supervision. This meant staff were supported to improve and develop their practices.

The provider had a computer-based management system to record any events that could be used to monitor the quality and safety of the service. These included, for example, visit times and lengths, incidents, comments from people, staff training deadlines, supervisions and spot checks of each staff member. In this way the agency aimed to check for any gaps or areas for improvement in the service.

The 'home care report books' for each person (which included daily reports, medicines and meals records) were brought back to the office every two to three months. These records were checked by care co-ordinators as part of a care recording audit. In some cases we saw gaps in the records had been identified and a note made that the co-ordinator for that area would raise it with the relevant staff member as a reminder. However we also found gaps in the report books that were not identified or dealt with by the agency, for example to medicines records.

The agency used a questionnaire to seek people's views about the quality of the service. For most people the questionnaire was completed during a discussion with the

# Is the service well-led?

supervisor. For at least one person this was inappropriate as the supervisor was part of the person's care staff team. The person told us this made it awkward for them to be fully open about what they felt about the service.

The provider had a quality audit manager who carried out an audit of this agency branch in July 2014. The audit had identified a number of areas for improvement, for example around incomplete records. An improvement action plan listed the shortfalls and deadlines for completion but there was no evidence that these matters had been addressed or reviewed. We saw that some of the shortfalls identified by the audit related to incomplete complaints records and medicines records. At this inspection we found these were still incomplete. This meant the quality auditing process had not always led to the desired improvements. In this way, although the provider had quality monitoring processes in place, these were not always effective.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>People were not protected against the risks associated with unsafe or unsuitable management of medicines. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints<br><br>The provider's complaints system was not effective in addressing and resolving people's complaints about the service they received. |