Comfort Call Limited

Comfort Call - Beechfield

Inspection report

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22 January 2016
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01 February 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 22, 25, 26 January and 01 February 2016.

The registered provider was given 48 hours' notice prior to inspection because the service provided domiciliary care services. This meant we could be sure that the registered manager and people's care records would be available for inspection. This also gave the registered provider time to gain consent from people who used the service for us to speak to them by telephone.

Comfort call Beechfield provided domiciliary care services for people living in Beechfield Court in Middlesbrough. The building was managed by Group Thirteen and care provided by Comfort call Beechfield, both based at the service. At the time of our inspection there were 70 people using the service and 35 staff.

Comfort call Beechfield was a new development which had been running for less than one year. This meant all of the staff and the management team were fairly new in post. Staff were recruited when care needs increased or when new people were moving into the service. The registered manager was responsible for two services, one in Middlesbrough and one in Hartlepool. 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. At the time of our inspection, the registered manager was in the process of recruiting for a manager for Beechfield Court. They told us they would remain responsible for the two services but each would have a manager who would be responsible for the day to day running and as the registered manager they would oversee this.

There were insufficient staff to deal with the demands of the service. Staff were appropriately recruited.

People used call bells to alert staff when they needed assistance. The service said people abused this because call bells were for emergencies only. The volume of calls put increased pressures on staff.

People did not always have the medicines they needed. Some people who needed support with their medicines were not always given it.

People who used the service and staff had concerns about the security of the building at night.

Some safeguarding alerts had been made. Staff had not always informed the management team of potential safeguarding alerts which meant they had not been made.

Staff understood procedures to follow when they suspected abuse and told us they would whistle blow [tell someone] if they needed to.

People had detailed risk assessments in place which included information about how to reduce risk and where appropriate equipment needed to reduce risk.

Each person had a personal emergency evacuation plan in place. Staff told us they felt confident to deal with an emergency.

Safety certificates were up to date. Maintenance repairs were carried out quickly.

Training, supervision and appraisals were up to date.

People who needed support with nutrition and hydration were given it.

Staff followed the guidance given by health professionals and supported people to attend healthcare appointments if they needed it.

Each person lived in their own accommodation at Beechfield Court and had access to communal areas and outside space.

People spoke positively about the care and support they received from staff. People told us they felt rushed at times because of staff workloads.

People told us they were involved in all aspects of their care and made their own decisions.

People told us staff respected their privacy and dignity when care and support was provided to them.

People were able to negotiate their calls and were involved in assessments of their care.

People were able to make complaints. We could see that complaints were investigated; however outcomes were not always clear.

Staff told us they were happy working at the service.

We heard mixed reviews about the management team from staff and people who used the service.

The registered manager was responsible for two services; this meant their time was shared. However recruitment for a manager who would be based at the service everyday was taking place.

The registered manager was aware of their roles and responsibilities and had submitted notifications to CQC when needed.

The registered manager openly discussed their achievements and challenges about the service and was motivated to continue in their role.

Quality assurance processes were in place. Feedback from people, their relatives and staff was regularly sought. However feedback from this, such as the recent survey had not been given.

We found four breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the premises and equipment and records. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Safeguarding procedures were not always followed by the service.

People had concerns about the security of the building at night.

People did not always take their medicines when needed. Medicine audits failed to highlight gaps in medicine records.

There were insufficient staff to meet the needs of the service.

Is the service effective?

Good

The service was effective.

Supervision, training and appraisals were up to date.

Staff understood the importance of consent and understood the action they needed to take if they suspected someone may not be able to consent.

Staff supported people to eat healthy and keep hydrated.

Is the service caring?

Good

The service was caring.

People spoke positively about the care and support they received from staff.

People told us staff protected their privacy and dignity at all times.

People were given the information they needed to make decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were gaps in the records.

People were involved in planning and reviewing their own care.

Complaints had been made and investigated appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were mixed reviews about the management team.

Quality assurance processes were in place, however had not highlighted many of the concerns highlighted in this report.

Information was shared and feedback was sought during meetings for people and staff.

Comfort Call - Beechfield

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.

One adult social care inspector carried out this announced inspection on 22, 25, 26 January and 01 February 2016.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning office from the local authority commissioning team about the service.

The registered provider was not asked to complete a provider information return (PIR). 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.

Group Thirteen [local authority housing provider] was the landlord for Beechfield court and responsible for the maintenance of the building. Comfort call Beechfield were based at the service and provided care and support to people living in these local authority buildings.

During this inspection, we spoke with the regional manager, registered manager, clinical support manager, two care co-coordinators and ten members of care staff. We also spoke with ten people face to face and one relative over the telephone. We participated in an informal group discussion with six people, one relative and one private carer to discuss the care and support people were receiving from the service.

We reviewed four care records in detail and we reviewed twelve staff records and records relating to the day to day running of the service.

At the time of this inspection there were 70 people receiving care and 35 staff employed at the service.

Inadequate

Is the service safe?

Our findings

Nine members of care staff were on duty during each morning shift to provide care to people and five care staff on the afternoon/evening shift and two care staff during the night. We heard mixed reviews about whether there were enough staff on duty to attend to people's planned and unplanned calls.

Each person who used the service had an emergency call bell in their room. The registered manager told us that this emergency call bell was only to be used when people needed emergency assistance. From speaking to people during inspection and to one social worker over the telephone we found that this was different from what people had been told. Everyone we spoke with during inspection told us that they thought they could use this call bell when they needed assistance. Examples included assistance with going to the toilet, with medicines or if they had dropped something and were unable to pick it up. A social worker told us they thought this service was located in between a residential care home and living independently in the community. Their understanding was that people could have assistance when they needed it because of the flexibility of care and they told us this was how they sold it to potential people considering a move to Beechfield Court. The registered manager told us that people who used the service were abusing this call system. They told us that people were using this to alert staff when they needed support, such as assistance to go to the toilet or when they had dropped something and couldn't pick it up. In the weeks before our inspection, the registered manager told us the service had received between 60 and 100 calls per day. These calls had to be completed by care staff and fitted into their planned calls whenever gaps became available. There was no 'floating' member of staff who could have responded to calls. Staff told us they thought they could manage their calls, but needed an extra person to cover emergency calls. One staff member told us, "The system is being abused. We don't know what we are or who we are meant to be responding to." The registered manager told us they were working with the local authority to address this.

From speaking to staff we could see that when staff had too many planned calls in place they became overwhelmed. When people moved into the service they were given a timetable of planned calls for care and support by the local authority. The registered manager told us this was only a guide which meant people would not necessarily receive calls at the times indicated on their timetable. One staff member told us, "We have too many calls in at the same time. We are told it's a guideline and to be flexible but residents expect us at specific time. This means we are late. We have too many people to look after. We have set calls but also deal with the emergency buzzer." Another staff member told us, "I enjoy my job when I have time to breathe. It's too stressful at times. The work expected during calls and the volume of calls." Some staff told us that there was a lot to do during planned calls and this could put them behind on other planned calls in the day. One person told us, "They [service] should keep up to the times they agree to." One staff member told us, "I do domestic calls between 3pm and 4pm. But I also have three dinner calls during this time and help people with medicines. This puts me behind with my calls." One person told us, "I have a morning call and during this time two staff are meant to assist me in the shower and help me get ready as well as carry out a domestic call for me. It's too much for them." A staff member told us, "Sometimes people are waiting too long because we don't always have time to respond. If we are using a hoist to move someone, then we can't just leave. The other day [service user] had to wait for one hour to be assisted to the toilet." Another staff member told us, "There are enough staff in the day but sometimes we are rushed. Our calls overlap, for

example we can have a 'double up' call [requiring two staff] between 09:00 and 10:00 but then I have another call to do between 09:30 and 10:00. This means I will be late for this call."

During a group discussion, one person told us, "People can wait thirty minutes to an hour for staff [when emergency buzzer is pressed]. Staff say they are busy and people don't like that." One staff member told us, "Calls are more of a negotiation to fit in with staff and the system we use. We try to accommodate people." One person told us, "Staff generally turn up on time. They have been a couple of times when staff have failed to turn up. The longest I have waited for staff is about 30 minutes." One person told us, "Staff are often late. At least twice per week. Some do phone and say they will be late. One person told us, "I go to bed at 21:00 because it would be after midnight. It's fine because I have my television. The changeover [of staff] is at 22:00 and there are only two staff at night." A relative told us, "There have been a couple of missed calls because they [staff] are very busy. A couple of weeks ago no-one came to help [relative]. We reported it. A friend helped [relative] to the toilet." We asked the registered manager to make a safeguarding alert about this.

There were two members of care staff on duty at night. The registered manager told us that these two staff members would have pre-planned calls in place until midnight and then they would be responsible for attending to any calls bells and emergency buzzers between midnight and 07:00. During inspection we requested a breakdown of unplanned calls at night. We received a breakdown of calls between 30 October 2015 and 19 January 2016; from this data we could see that there were between three and 13 calls each night. However the data did not provide information about the length of calls. The registered manager told us that people needed to wait for up to twenty minutes for assistance from staff between 22:00 and 23:30 and they would look at having a staff member to do a twilight shift to provide support to night staff. People who used the service and staff thought they were insufficient staff on duty at night. One person told us, "There are only two staff at night. The staff are busy between 22:00 and 00:00 helping people to bed. Two staff is not enough." One person told us, "Two staff on a night is really dangerous."

Staff told us that when emergencies occurred at night, they were not always able to respond to unplanned calls. A member of staff told us, "There are only two of us at night. We can't deal with people in an emergency. We need three staff at least. We have asked lots of times, but we get told 'No'. We can't respond to people in their flats when we are in the bungalows. The [call bell] phones don't work properly. Another reason why we need a third member of staff." Another staff member told us, "We had an emergency the other day. We had to wait with a service user until the ambulance came. This was from 3am until around 5:50am. A service user rang during this time but they had to wait. The service user needed two members of staff, but we couldn't go." Another member of staff told us, "If the call bell goes at night and we are supporting someone, then people have to wait. A few months ago we had two people on the floor in separate flats. We rang 111 and they asked us to sit with those people until the ambulance arrived. This meant we could not support any of the other residents." One staff member told us, "If an emergency happens in a bungalow we can't respond to the main building at night."

This meant there was a breach of regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I was left for two hours waiting for the toilet, during which time I was incontinent. I pressed the buzzer but staff were busy. On the fourth time, the senior answered. I told her what happened and she came to me straight away." We spoke with the registered manager about this. They told us they had not been made aware of this and had therefore not put in a safeguarding alert to the local authority. Following our request the registered manager made a safeguarding alert straight away. During our inspection, the registered manager told us there was no evidence of any missed calls relating to this. One

staff member told us, "If someone uses the emergency buzzer for assistance to use the toilet we need to find another staff member to assist [requires two staff]. People have accidents in this time."

During a group discussion, people told us, "Bedtime is a busy time here. The staff are very busy. [Waiting for staff] can prevent people from going to bed." When we spoke to people and staff they told us that staff couldn't always attend to calls at night which had impacted upon people's dignity. We spoke to a relative, they told us, "The biggest issue for me is with going to the toilet. They [relative] need to go straight away but the manager said they need thirty minutes notice. This impacts upon [relatives] dignity because they have been incontinent a couple of times. More staff are needed."

This meant there was a breach of regulation 10 (1) Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we made a safeguarding alert about staffing levels because people had to wait to receive care and support and this impacted their dignity.
One person was prescribed Predsol four times each day for eye inflammation. This person told us they were not receiving these eye drops as prescribed and they needed the support from staff to administer these eye drops. We looked at the person's medical administration records between 07 and 31 January 2016 and there were 22 occasions when these eye drops were not administered. Mydrilate eye drops prescribed three times per day had not been administered on 12 occasions and Dorzolamide and Apraclonidine, both used in the treatment of glaucoma had not been administered to this person on five occasions between 09 and 20 January 2016. We discussed this with the registered manager and a senior carer. They told us that this person had been risk assessed as a being capable of being able to administer their own medicines. We could see from this person's risk assessment that this person could take their own medicine however the risk assessment stated, "On occasions I may not remember to take my medicines and require support to check I have remembered." The record stated that care staff were required to prompt at each visit to reduce the risk. There was no evidence to suggest that staff took action to ensure this person had taken their medicines on the above occasions. When we spoke with staff, they told us that if this person was not in at the time of the call no further action would be taken to check if this person had taken their prescribed medicines. Care staff had not raised any concerns at the number of missed medicines for this person and it had not been picked up in a medicines audit. There was no procedure in place to deal with missed medicines; a risk assessment for missed medicines and a discussion with the person's GP had not taken place. No safeguarding alert had been made. We asked the registered manager to put a safeguarding in place for this person.

We visited one person during our inspection at lunchtime to carry out a check of their medicines with a staff member. This person did not have six prescribed medicines and one prescribed cream in stock. We could see that this person had run out of these prescribed medicines the previous day and their prescribed cream five days earlier. This person told us they were in pain and needed their medicines. This person told us that they had informed staff three days earlier that they were running out of their medicines and this had happened before. When we spoke with the management team, they told us that staff from the previous three days had not alerted them that medicines were running out. We spoke with the registered manager and care co-ordinator who told us that they had been a delay with the pharmacy. We asked the care co-ordinator whether anyone had sought medical advice because of the missed medicines and they told us they had not. We asked the registered manager and care co-ordinator to go and collect the prescribed medicines from the pharmacy straight away and to seek medical advice about the missed medicines. We asked the registered manager and care co-coordinator if a safeguarding alert had been made in respect of missed medicines and running out of medicines and we were told one had not been made. We asked for a safeguarding alert to be made straight away. They confirmed this had been done at the end of our

inspection on this day.
Medicine audits were carried out individually on each person every month. In a medicine audit [November 2015] for one person, a gap had been highlighted and supervision had been carried out with the staff member, however there was no information in the audit to show that an investigation had been carried out. A medicine audit [October 2015] for another person showed that a medicine had been crossed out but the reason for this had not been recorded. There was no evidence of any action taken to investigate this. A medicine audit [02 December 2015] highlighted gaps in medicine records and staff had stated that this person had not been in their property on these ten occasions. There was no evidence of any action being taken to investigate this, this meant that we did not know if these missed medicines were detrimental to the person's health condition. In an audit [07 January 2016] for this same person, an audit checklist was incomplete; we could see that eight missed calls had resulted in missed medicines however no actions had been identified. A medicine audit [07 December 2015] for one person found that the checklist was incomplete; gaps had been highlighted where medicines had been given but not signed for. The audit stated that an investigation would be completed, however there were no details about this included in this audit.

We looked at the MAR for one person between 22 August 2015 and 30 August 2015 who was prescribed Double base cream which needed to be applied four times per day. The records showed that during these dates there was only one day where this cream had been applied for four days. An audit had not been carried out which meant that the gaps in these MARs had not been picked up. A medicine audit [24 August 2015] for this person had highlighted gaps in the records and staff received supervision. However no further monitoring of these records had taken place.

People's medicines were kept in a locked cupboard in their own private accommodation. An up to date medicines policy was in place at the service and signed consent forms were in place to allow staff to support some people to take their medicines. This support could be prompting people to take their medicines or to dispense medicines. One person told us, "The staff just prompt me with my medicines. I wouldn't let them near my medicines. One person had a risk assessment in place which showed that they had full responsibility to take their own medication; we could see that this person had signed the risk assessment. All staff were observed administering prescribed medicines every three months. We could see that there had been a small number of medicine errors. Each case had been appropriately investigated and staff had gone through the disciplinary process and had received supervision to minimise the risk of further harm to people.

This meant there was a breach of regulation 12 (1) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding alerts had not always been made when needed. We could see that the service did not always understand when a safeguarding alert should be made. During this inspection we had needed to ask the registered manager to make several safeguarding alerts because they had not done so. Staff had received up to date safeguarding training and could give example of the signs of abuse they could potentially observe in the people who used the service. Staff were able to detail the procedure which they needed to follow if they suspected abuse was taking place. All staff we spoke with told us they felt able to raise a safeguarding alert with the management team and would whistle blow [telling someone] if they needed to. However we could see that staff had not always raised potential safeguarding alerts with the management team. This also meant that safeguarding alerts had not been made when needed or there had been a delay in making a safeguarding alert because of a lack of communication.

This meant there was a breach of regulation 13 Safeguarding of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Safeguarding records include the reason for an alert being made, details of the investigation, findings and action taken. Records did not always show if people had been updated following the outcome of an investigation. The registered manager told us that safeguarding information was sent to the registered provider and they carried out analysis of this information to look for any patterns or trends in alerts; however this information was not available for inspection. Of the 15 alerts looked at we could see that 7 of these alerts had resulted from medicine errors; we could see that staff had been spoken to as part of the investigation and themed supervision sessions had been carried out with the staff involved.

We heard mixed reviews when we asked people whether they felt safe living at the service. People told us staff helped them to feel safe by providing good care and locking their front doors when they left. However all people who used the service and some staff expressed their concern at the rear door to the building in the communal area being kept unlocked at night. One staff member told us, "When I have worked nights, we were told to sit downstairs [communal area]. I don't feel safe because the door isn't locked. We asked for a key for the door but we can't have one." Another member of staff told us, "I work nights and the security is pretty dim. We get asked to sit downstairs, but the door is not locked. I won't do this. I feel secure sitting upstairs because the doors are locked. At night we always go to the bungalows in twos to protect ourselves." Staff told us they were concerned that the main building was left unattended at night when they assisted people with care and support in one of the bungalows. This meant that they could not respond to any calls. One staff member told us, "At night when we go to the bungalows, the door to the main building is left unlocked because we don't have a key." Another member of staff told us, "If we go to the bungalows, we go in two's. We carry the phones with us but sometimes they go out of range." This meant staff could not respond to any unplanned calls from the emergency call system. We spoke with the registered manager about this. They told us they had consulted with Group Thirteen on numerous occasions about this and had been that they had taken the decision not to lock the door at night because, "It was the only form of access to the communal area for tenants who occupy the bungalows. The scheme itself is secure by design; therefore they wouldn't anticipate that it would be a requirement for the door to be locked in the evenings." The registered manager told us the communal area was monitored by CCTV. Despite this, there were continued concerns from people and staff and we have asked the registered manager to take further action to discuss these continued concerns with Group Thirteen to identify what action could be taken to make people and staff feel safe.

We discussed all of the concerns highlighted during this inspection with the local authority contracts and commissioning team, but in particular the ability of the registered provider to keep people safe. From our discussions, we could see that the local authority had taken our concerns seriously and were working with the service to determine the action which would be taken to make the improvements needed. We plan on visiting the service again soon to look at what improvements have been made to ensure the safety of people who used the service.

Accidents and incidents had been recorded. The registered manager told us that this information was sent to the registered provider for analysis to look for patterns and trends; this was not available for inspection. When we visited one person with a member of staff they told us about an incident they had been involved in. We could see that the staff member knew nothing about the injuries sustained so we immediately located the registered manager. The registered manager told us they were aware of the incident this person had been involved in and we could see that a safeguarding alert had been made and appropriate action had been taken to monitor the health and well-being of this person. However we could see that the staff member with us had not been informed about this during handover. This meant important information relevant to a person who used the service had not been communicated to staff. The staff member told us, if

they had been made aware they could have increased the number of visits to this person whilst on duty to make sure they were kept as comfortable as possible.

Each person who used the service had risk assessments in place for things such as falls, nutrition, medicines and skin integrity which were reviewed twice per year or more frequently if people's needs had changed. We could see that each area of risk was assessed and included information about how to reduce the risk. Where appropriate the assistance needed was also included, for example, one person was at risk of falls and needed the assistance of staff to put their socks on to reduce the risk of a fall. Important information, such as using specific equipment was highlighted in red. Each person also had risk assessments in place for the environment; this included their personal accommodation, lighting, slips, trips and falls, fire, pets and cleaning.

Personal emergency evacuation plans (PEEPs) were in place for each person who used the service and were carried out by Group Thirteen. These records detailed the support people required during an emergency, such as whether people could evacuate the building on their own or whether they may need the assistance of a staff member and the equipment needed such as a walking frame. Although these records detailed the support people needed, there was no information about whether each person had a medical condition or whether they required specific medication in an emergency.

The registered manager told us that the service followed the Thirteen Group [landlord for Beechfield Court] policies and procedures for fire. This policy stated that each flat within Beechfield court had 60 minute fire resisting walls in place which meant that people could safely remain in their premises until any danger had passed or until they needed to be evacuated by the fire service. The registered manager told us that there were no fire extinguishers at the service because staff were not trained to use them. They also told us that the fire brigade were responsible for evacuating people; we asked to see a copy of an agreement to support this, however one was not available. No planned emergency fire drills had taken place at the service since it opened in April 2015. We spoke with the registered manager and they were not aware that two planned fire drills with day and night staff were required each year. We asked them to address this immediately. Following our inspection, the registered manager confirmed that Group Thirteen had carried out a planned fire evacuation of the communal area on the ground floor during the day and had responded in under two minutes. Care staff in this communal area had attended, but not from other areas of the building. After inspection we received information from Group Thirteen who told us that all fire alarm call points were tested quarterly and weekly fire alarm tests were carried out.

The registered manager told us they were on-call on evenings and weekends should staff require assistance. They told us that staff could also gain assistance from Greenbank, a local authority housing service if they had any concerns. The registered manager also told us that a senior member of care staff was always on duty during the day [but not during night shift]. At the time of our inspection, staff told us there was no appointed first aider though all staff had received up to date training. The registered manager told us they would appoint a designated member of staff for first aid. All staff spoken to during inspection told us they felt confident to deal with a medical emergency. People spoke positively about the support they had needed from staff when they became unwell or during an emergency. One person told us, "Two carers came in one day and one of them asked me if I was ok? I was blue. She had picked this up straight away. They gave me lots of reassurance and asked me appropriate questions. I'd only been here a few weeks. I was more than happy with them."

We looked at the recruitment records of five members of staff. Each person had an application form in place and there was evidence of completed interview questions and signed contract. We could also see that two checked references and a Disclosure and Barring Service had been carried out prior to staff staring work at

the service. This a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. We identified gaps in these recruitment records.

There was CCTV in the communal areas of the service twenty four hours per day. This area was open to members of the public during the day, however access to private accommodation was via a key code security door. There was a door which provided access to the communal area and bungalows with the grounds. One staff member told us, "There are lots of people around in the day so we now have a signing in book to keep track of who is in the building."

All certificates relating to the day to day running of the service were up to date. This mean that checks had been carried out in relation to gas and electrical appliances and regular maintenance of the communal bath and general maintenance of the service was up to date.

Good

Is the service effective?

Our findings

Each new member of staff participated in an induction process; this included two days shadowing to understand the routines of the service and expected duties as well as to get to know people. Staff also participated in training and became familiar with the policies and procedures at the service. There was evidence of completed workbooks, questions and case studies to check staff knowledge and understanding. From speaking with the management team and senior carers, we could see that staff were supported during their induction process. The registered manager told us that staff should undertake two reviews during their six month probationary review, however there was no evidence of any probationary reviews during the induction period. When we spoke with the manager, they told us they would take action to address this.

An up to date supervision policy was in place which stated that staff should receive supervision every three months. We looked at the supervision records of ten staff and found that each of them had received themed supervision sessions; these themes included medicines, care plans and records. We could see pre-populated supervision records were in place for themed supervision sessions which this meant there was no evidence of any discussion. Actions which needed to be addressed had already been pre-determined which meant that supervision was not person-centred to each staff member. There were some supervision records in place which had not been pre-determined and we could see evidence of discussion. The registered manager told us they would take action to address this.

Each staff member was subject to a spot check every three months. This was an observation to check the staff member was on time for their call, to monitor their general practice, care skills, delivery of medicines and completion of care records.

All staff participated in training to make sure they kept up to date with the requirements of their role. Training included health and safety, fire safety, food hygiene, first aid, manual handling, safeguarding and dementia care. We could see from training records that most training was up to date; where training had expired planned dates had been put in place or the service were in the process of this. When we spoke with staff they told us they received regular training and felt that the training helped them in their roles. People we spoke with told us staff had the necessary training to be able to provide care and support to them. We asked people if staff had the right knowledge and skills to provide care and support to them. One person told us, "They [staff] are proving they are looking after me well. They are brilliant." Another person told us, "In the main, staff have the right knowledge and skills. New carers shadow staff which helps them to learn." However one person told us, "Some staff have no caring skills. They seem to have a 'just not bothered' attitude."

Not everyone required assistance with the planning, preparation and cooking of food. However assistance was provided as and when people needed. One person told us, "Staff always ask what I want for breakfast. My regular girls know me and just do it. I go to the Bistro every lunchtime, but staff always cook my tea. Sometimes they say they don't have time but I tell them they need to make my tea. They always cook me what I want to eat." Another staff member told us, "I would always report any concerns to the management team. I make some people a sandwich and wrap it up for them, then they can eat it when they want. I

would check up on them to see if they have eaten it."

People told us they were able to arrange and access their own healthcare appointments, however staff could assist them with this if needed. One person told us, "Staff take me to the Doctor when I have an appointment." Another person told us, "The staff always help me to access healthcare." Another person told us, "Staff take me to the Dentist. [Staff member] usually takes me. He is a good carer. He is great."

Everyone we spoke with confirmed that staff always sought their consent before any care and support was provided. One person told us, "Staff always ask for my permission." Another person told us, "The staff knock on my front door and open it. They shout 'Hiya [service user]' before they come in. A staff member confirmed this to be the case, they told us, "We always knock on people's doors and ring their door bell before we open the door. We always shout through to make sure it's ok for us to go in." Consent forms for a key safe had been signed by people. We could see that one consent form had been signed by the person's mother because they were not able to sign themselves [due to their health condition]. Records detailed the specific reasons for this and we could see that the person had been able to give verbal consent but not written. One staff member told us, "We seek consent for everything." At the time of inspection, staff told us nobody had a 'Do not attempt cardio-pulmonary resuscitation' certificate in place, although they said this could change in the future. All staff we spoke with understood the requirements of this certificate.

People lived in their own flats and bungalows at Beechfield Court. 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). Staff training for MCA and DoLS was up to date. At the time of our inspection everyone using the service had capacity to consent and make decisions about their own care and all aspects of their day to day life.

The service was made up of a block of flats with a communal area on the ground floor which included a lounge, hairdressers and bistro. These were also open to members of the public. During our inspection we saw people regularly using this communal area. There were a small number of flats on the ground floor which we accessible via a locked door. Flats to the first two floors were accessed via stairs or lift and included a communal lounge and bath and a flat for relatives to stay over. A relative told us, "[Relative] has a lovely flat, wide enough for a wheelchair. It's lovely and clean and warm."

Good

Is the service caring?

Our findings

People spoke positively about the care and support they received from staff. One person told us, "They [staff] look after me well. They cook me breakfast and help to wash and dress me. They are a lovely bunch." Another person told us, "The staff help me to get out of bed and do my breakfast for me." We could see that staff enjoyed working at the service. One staff member told us, "I enjoying seeing people who appreciate what you do." One staff member told us, "I love the place, love the staff and the residents." Another staff member told us, "I love caring for people. The residents are lovely." Another staff member told us, "I love my job. I talk to everyone that I come into contact with." One relative told us, "They [staff] are pretty good. They all chat and are open with us."

We asked people if they were given the time they needed when staff visited them. One person told us, "I get all the time I need." People confirmed that they received the care and support they needed but said they felt rushed at times because of the volume of calls staff had to carry out. One staff member told us, "Most people get the care they need; however some people's needs are greater than others." One person told us, "Some of the carers are really good. When calls are rushed, this doesn't make us feel valued."

One person told us, "I am very happy with the care I receive. It's very good. All of my care needs are met." Another person told us, "I can't fault them [staff]. The girls do a marvellous job. If it wasn't for them I wouldn't be able to live independently." Another person told us, "I am personally very happy with the care I receive. I am grateful for the things they do."

One person told us, "Some of the staff are first class." Another person told me, "My needs are met, even when time is tight. The staff are very caring and always give me the time I need. I have security calls, just to check I'm ok. I like that the staff do this." Another person told us, "I always make sure I get what I need. If my needs weren't met I would tell them." During a group discussion, people told us, "The carers are very good. We can't fault them. We have to give and take." One person told us, "[Staff member] will go above and beyond to make sure you are alright. Both [staff members] are brilliant." One person told us, "In most cases they are caring. They apologise when they are late."

Staff told us that people had choice about everything they wanted to do; they decided when to get up and go to bed and how to spend their day, for example. When we spoke with people, they confirmed this to be the case. People also confirmed that they were given explanations when needed, were not rushed and were given the time they needed to make their own decisions.

Staff told us they always tried to maintain people's privacy and dignity and gave examples of this such as closing doors and curtains; asking people for their preference of male and female carers and making sure only the people needed were there to assist people with personal care. One person told us, "The staff always respect my privacy." Another person told us, "Staff are very respectful. They always cover me up until the last minute. They say, 'We are going to turn the covers back' and 'Can we take your t-shirt off?' It's the little things here that are thought off." A privacy statement and dignity charter was on display in the staff room. We found there was also information on pressure ulcer care, continence and nutrition.

People could have visitors to their own accommodation or within the communal areas at any time they wanted. There was also a flat available for relatives to stay over if they wished.

We spoke with the registered manager about end of life care. They told us, "We link with palliative care teams and have access to advice, equipment and support additionally from internal sources including nurses to support end of life care and support. We are sensitive to people's needs and wishes regarding end of life decisions and include DNAR, powers of attorney and advanced directives in our care and support planning including the involvement of family and carers."

Requires Improvement

Is the service responsive?

Our findings

We identified a number of gaps in the records looked at during inspection. This meant it wasn't always clear if people were receiving appropriate care and support or if care was person-centred. There were gaps in recruitment and supervision records.

We looked at the timetable of one person who was scheduled to receive four care calls per day every day and three calls per week for shopping, laundry and domestic duties. When we spoke to this person they told us, "I don't get the calls I am supposed to." From their local authority assessment we could see that they should have received between ten and 17.5 hours of care and support each week. We looked at the person's daily notes to determine the number of hours care per week this person was receiving. We found there were significant gaps in the daily notes which showed that this person was not receiving their minimum allocated care hours each week. From these care records we could see that there had been 13 occasions between 04 and 24 January 2016 where no calls to the person had been carried out. Between 04 and 10 January 2016, records showed this person received 4hours and 38 minutes of care and support, between 11 and 17 January 2016 they received 5 hours and 21 minutes and between 11 and 24 January 2016, they received 3hours and 46 minutes of care and support. The registered manager provided some documentation which showed that some calls had not been carried out because the person was out; however from this record we saw a small number of occasions where no carer had been allocated. We asked the registered manager to make a safeguarding alert about this and we shared this information with the local authority contracts and commissioning team.

Each person had a small number of goals which they wanted to achieve and what support staff should provide to help people to achieve these goals. We found that some of these goals were person centred and some were not. For example, the goals which some people had in place were the same, such as two people had a goal to 'Feel safe in their own home.' For both of these people, the records stated that this outcome had already been met because the person's "pendant was now working." For another person, the record stated "Living in extra care, I feel reassured that care staff are onsite 24 hours per day and the complex is covered by CCTV." We had a discussion with the registered manager about the goals for these two people and asked whether other aspects of safety and the support needed from staff to help the person remain safe should have been included into this goal. One person had a goal in place to maintain a clean appearance and stated that staff needed to encourage the person with personal care each morning to enable them to achieve their goal. From the person's records we could see that this information was incorrect because the person did not receive care and support from staff every morning. As part of this goal, the record stated that care staff should keep the person's kitchen tidy and empty their bins each day. We could not see how this was relevant to the person's goal of keeping a clean appearance.

Another person had a goal in place to remain independent; however there was no information about how this goal would be achieved. The record stated that "This outcome has been met." We questioned the relevance of this goal if it had already been met? There was no information to show how this goal had been met. Another person had a goal to avoid dehydration and urinary tract infections. This goal was individual to them and directed staff to prompt with fluids and to record all fluids taken. We could see that staff always

left a jug of water within this person's reach when they left the property. This meant staff were actively supporting this person and reducing the risk of ill health. Staff recorded the volume of fluids given to this person; however there was no evidence that the person had consumed these fluid amounts. This meant that we could not be sure if this person was receiving enough fluids in the day to avoid dehydration, however from speaking with staff we were told that this person had not displayed any symptoms of dehydration and had not needed to seek medical assistance because of dehydration.

People had information about their daily routines in their care records. This provided staff with the information they needed to provide appropriate support to people at different times of the day. In one person's daily routine, the information was exactly the same for their morning, middle of the day, evening and night routine. This meant that this information was not personalised and not did not reflect their routine at different times of the day. The information available in one person's record to direct staff about the care and support which they needed to provide to this person was the same for each of their planned calls. We found that the same paragraph had been copied for each of their four planned calls. This meant that support was not personalised and did not acknowledge that care and support needs may change throughout the day.

There were gaps in the care records for one person relating to 'Changes to important information.' This included care partners, communication, medicines, life stories and mental capacity; because this section had not been completed, we did not know if there had been any changes and if the records had been updated as a result. Daily records had been completed by care staff after each visit to people. We found that there was a difference in the information recorded. Some daily notes were detailed and were individual to people and the needs identified in care plans, however others were not, for example, in one entry a record states, "[Service user] fine. Plates washed. Nothing else needed."

There were gaps in recruitment records for five staff which we looked at. A 'Compliance and training' record to show if training had been booked and if recruitment documents had been obtained was incomplete for all five staff. Application forms for three staff members had not been completed to show if these people were suitable for an interview. All three of these staff were working at the service during our inspection. A 'Care worker selection record' was incomplete for two staff; there were gaps relating to identification, assessment and interview topics for example. From one person's interview record, we could see that answers to questions had been recorded however scoring had not been recorded. This meant we did not know if this person had achieved the required competency score. An interview declaration and clearance to work unsupervised had not been completed for three staff members.

There were gaps in supervision records. In a mental capacity act supervision record [22 January 2016] for one staff member, five areas had not been completed which included questions to check the staff members knowledge and understanding, employment related issues and health and safety concerns. There was no evidence of any discussion in this supervision record. In a supervision about record keeping [21 July 2015] for one staff member, there were gaps in employment and service related issues as well as questions designed to check the knowledge and understanding of the staff member.

This meant there was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to people moving into the service, an assessment of each person's care needs had been carried out by the local authority. This assessment included a timetable of support which the person needed and included a minimum and maximum number of hours which the person should receive each week. Two people had been assessed as requiring between one and nine hours of support each week by the local authority. There

were timetables of planned support in each person's care records and from reading daily records we could see that each of these people were receiving care and support within these recommended hours.

Each person we spoke with during inspection confirmed that they were involved in planning their care and making decisions about how they wanted to be supported. People told us this was done to make sure staff didn't take over and helped them to maintain their independence. When we reviewed care records during inspection we could see that people's choices and wishes had been identified. The registered manager told us, "Care planning is undertaken with the service user and is centred around their lives, choices and risks that they decide are appropriate or acceptable. We ask people how our care staff can be sure that we have achieved what we were asked to do."

The registered manager told us care plans were reviewed annually; this meant that no-one using the service had received a review yet. When people first moved into the service, an assessment of their individual needs took place and a review of this care was carried out every three months to make sure that the care being provided to people was right for them. This meant the people were able to voice their opinions about care and where changes needed to be made they could. People's care records included information about the person and their life and detailed any areas of difficulty, medical conditions and communication methods used. Each person who used the service had information in place which informed care staff about how to support the person. For one person this information told staff that they needed to wake this person up and prompt them to take their medicines and that they should put their shower chair in the appropriate place to minimise the risk of falls to this person.

Each person who used the service had choice about how to spend their day. The communal area at the service was open to the public and included a bistro and hairdressers. From speaking with people we could see that they were involved in arranging activities for the service with the aim of bringing people together and developing friendships. During our inspection we saw people spending time together chatting and eating meals within the communal area. It was clear to see that people knew each other. People told us that they often access their local community with and without staff and went out with relatives. One person told us, "I have a shopping call. The same staff member usually comes with me and we go out to the local shops. I always feel safe." Another person told us, "I haven't been able to get out recently because my legs been playing up. But the staff have gone out to the shops for me when I needed them to. I always get a receipt and staff write in the book."

When people had general complaints or queries, they didn't always access the most appropriate people which meant that people were turned away and felt dissatisfied or meant they was a delay in being listened to and responded to. For example, some people went to the Group Thirteen manager based in Beechfield court to discuss care when they should have gone to the management team for comfort call and some people went to comfort call to discuss housing related issues when they should have gone to Group Thirteen. The registered manager told us they were aware of this and action was being taken to address this.

An up to date complaints procedure was in place and all staff spoke with during inspection were knowledgeable about the action they needed to take should they receive a complaint. Each person who used the service had a copy of the complaints procedure in their care file which was stored in their private accommodation. Each person we spoke with during inspection told us they would speak to staff should they need to make a complaint. One person told us, "If I had a complaint, I would speak to a senior carer." We received mixed reviews from people who had made a complaint. Some people told us that they had felt listened to and their complaint had been taken seriously; other people told us that they had not felt listened and had not been kept up to date when a complaint had been made. One person told us, "I have put in

complaints, but have never had a response." Some people felt complaint forms were not accessible, One person told us, "I know how to make a complaint, but it is a waste of time because I can't see the form." The clinical services manager highlighted that there was not always evidence of an outcome following a complaint in the audit which they were in the process of carrying out at the time of our inspection.

Requires Improvement

Is the service well-led?

Our findings

All staff we spoke with during inspection told us they enjoyed working at the service and saw a future with the registered provider. One staff member told us, "It's good working here. It's flexible; I can swap shifts and change calls when I need to. There is nothing I would change." Another staff member told us, "We have lovely staff and service users. We are like a community." Another staff member told us, "I love working here." Another member of staff told us, "I love my job, I wouldn't change it." We asked people what they thought about the service. One relative told us, "The staff are nice. It's a friendly service." One person told us, "All of it is good, but the staff are pushed and busy." Another person told us, "The place is brilliant, but we've got problems. We are a family and we look after each other." At the inspection we asked people and staff what improvements they thought were needed at the service. One staff member told us, "The rota's need to be improved and we need an on-call system at the weekend." Another staff member told us, "We only get a few day's notice for our rota for the next week. This doesn't assist me with my family and plans in my time outside of work."

We heard mixed reviews about the management team in place at Beechfield court. Some people and staff felt able to approach the management team however others did not. From speaking with people and staff we could see that not everyone felt listened to. One person told us, "The management team are terrible. They just don't care. I don't feel listened to." Another person told us, "The management needs to be better." Another person told us, "The manager is not approachable. Loads of the staff are."

A staff member told us, "I used to like my job. I don't like the management. I don't think they are helpful. I couldn't go to them with a problem and some of them have a poor attitude." Another staff member told us, "I have no confidence in these [management team]. You can't go to them. The manager is not interested. I feel valued by the care staff and the seniors but not by the management. You should be able to go the [management team] office about anything." Another staff member told us, "They [management team] are ok. I can talk to them. It's difficult on a weekend. There is no on-call."

During our group discussion, people told us, "The manager is polite, he says 'Good morning' to us." And "We don't really know him." And, "He sorted my problem out for me straight away." And, "The team co-ordinators are very approachable." One staff member told us, the leadership "Is good. All three staff [management team] do a good job and will assist us with any changes." Another staff member of staff told us, "I don't see much of the manager." One relative told us, "I've not had a lot to do with the manager. They [management team] don't visit people in their homes – to keep in touch with them."

The registered manager was responsible for two services. This meant their time was shared between these two services. At the time of our inspection, the registered manager was in the process of recruiting for a manager for Beechfield Court. They told us they would remain responsible for their two services but each would have a manager based at the service and would be responsible for the day to day running of the service and they as the registered manager would oversee this.

We spoke to the registered manager about their greatest achievements during their time at the service.

They told us, "Setting up a large extra care scheme from start to finish and visiting each service user at home to carry out an assessment prior to them moving into the extra care scheme to ensure this is the right place for them and that we can meet their individual needs." We also asked the registered manager about the biggest challenges which they were facing at the time of our inspection. They told us, "Ensuring correct care level bandings are correct {[hours of care allocated to each person] to ensure the ethos of the scheme is maintained. Balancing planned care calls along with current high demands of the Tunstall system [internal call bell system] that is in place that service users are calling care staff on a high level."

The registered manager told that all data was recorded and shared with the registered provider as part of their quality assurance processes. They told us, "All events are recorded on our internal system to ensure correct and complete action is taken for each event whether it be an accident, incident, missed visit, medication error, safeguarding concern, complaint or compliment. There are analysed for themes in the branch and a regional and group level including the outcome of these events and report to the Board."

The registered manager told us, "The Quality Governance Group [within the organisation] picks up on themes from branch monitoring and reviews and considers actions that might be taken. These are then communicated through set staff meeting agenda's and action plans."

The clinical support manager was in the process of carrying out a provider audit at the time of our inspection. They told us this should be carried out twice per year [every six months]; however this was the first one which had been carried out at Beechfield Court. When we asked them why this audit had not been carried out during the first six months they could not provide us with an explanation for this. Although the audit was in process, we could see from the audit that areas for improvement had been identified and the clinical support manager told us that an action plan would be developed from this once the audit was complete. They told us that they would return to the service to check each of the identified actions had been addressed. At the end of our inspection, the regional manager told us that two new members of staff had been employed and these provider audits would be carried out every three months.

People's daily records were contained within a book, once these books were completed for each person an audit was carried out. We looked at ten medicine audits and found they had been signed and dated by the person completing the audit, however they had not been signed by the registered manager [as directed on the audit]. Evidence of actions taken were not always recorded. Medicine audits were carried out monthly. We would question the effectiveness of the audits carried out at the service because they had not highlighted the issues which we had identified during this inspection.

A 'Quality assurance visit record' was completed by care staff every three months to review people's care records, the care they received from staff, views on the management team and their overall satisfaction with the service. People told us that they had never seen any results from these or had received any feedback. Care staff told us they gave the completed records to the management team. There were gaps in these records and we could not see what action had been taken to address some of the comments made in these records by the people they related to. In a record dated 01 December 2015 we could see that the person had stated that care staff did not do as expected, that there were too many different care staff involved in her care which they were not happy with and that they were not told about changes to carers or late calls. In a record dated 14 September 2015 for this person we could see they had not been told when carers where running late or changed. We could see that they thought that office staff and managers did not always treat them with courtesy of respect.

There was no evidence that any of these actions in both records had been addressed. In a recorded dated 01 December 2015, the office section of the record asked if any follow up actions were required and the box

which indicated 'No' had been ticked. The record dated 14 September 2015 office section had not been completed. This meant that we could see that any concerns or areas for action identified during these meetings with people were not addressed. In another quality assurance record dated 01 December 2015, the person this record related to had ticked 'No' to a number of questions. This meant the person had said that staff did not encourage them to do things for themselves and were not happy with the number of different members of staff involved in their care. They also stated they were unhappy with the way the service managed care staff and were not told when carers were running late. We found that these had not been recorded in the action plan and these comments had not been followed up by the service. In a quality assurance record dated 22 October 2015, the person it related too had stated that they were not told when carers were changed or when they were going to be late. We found this information had not been put into the action plan and did not state if any follow up actions were needed.

The registered manager told us, "We regularly seek feedback from our service users about our services and how they meet their needs and aspirations. We undertake an annual quality questionnaire and collate the results to identify themes and ways to improve." An annual survey had been carried out in May 2015 [24 surveys were issued and eight had been returned. The results of the survey had been analysed and we could see that people had made comments about missed and late calls; 72% of people said that they were sometimes told which care worker was visiting and 14% said they were never told. 57% of people said they were never told us a care worker was running late. We could also see that people had made comments about areas for improvement. These comments included, "More staff at night." And, "More care staff at bedtime, then I would not fall asleep in the chair waiting for staff." And, "Missed calls." And, "Staff not staying for the length of time" [agreed]. We could not see what action had been taken as a result of this survey.

Regular meetings for people who used the service had taken and were attended by Group Thirteen and the in-house [external company] bistro. This meant that people who used the service could be kept up to date by all services available to them at Beechfield Court. Regular meetings for people and their relatives took place with Comfort call Beechfield and Group Thirteen. One person told us, "I am disheartened with residents meetings. They say allsorts but nothing happens." Regular staff meetings had taken place at the service and were well attended by staff. We could see that confidentiality, record keeping, safeguarding, medicines, missed call, accidents and security for example, had been discussed during staff meetings. Each staff member [whether they had attended the meeting or not] received a copy of the meeting minutes and had to sign to say they had read and understood the minutes of the meeting. This record was stored in each staff member's personal file. This meant we could be sure that information was communicated to every staff member.

An informal 'Coffee and cake' meeting was carried out every Monday at the service. We saw that some people regularly attended this and one staff member attended each session. On the first day of our inspection we attended this meeting. We saw that the staff member did not participate in this meeting and did not respond to the concerns and complaints which people made. We felt that this was a missed opportunity by the service to respond to people's concerns and offer feedback. We spoke with the registered manager about this and they told us they would look at this. One person told us, "The manager has only been to this meeting once or twice and didn't speak. There were no suggestions and they didn't join in. If you don't go to these meetings, you find out about things."

The registered manager was aware of their roles and responsibilities and had notified CQC when safeguarding alerts had been made. However we found safeguarding alerts had not always been made when needed; during inspection we had needed to ask the registered manager to make several safeguarding alerts. Policies and procedures had not been followed by staff in relation to safeguarding. Quality assurance processes had not always identified these missed safeguarding alerts of many of the

concerns identified in this report.

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 10 HSCA RA Regulations 2014 Dignity and respect Missed and delayed calls impacted upon the dignity of people.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who needed support were not always given support with medicines. Some people did not have the medicines they needed.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding alerts had not always been made when needed. A lack of communication meant that there was a delay in making some safeguarding alerts.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were gaps in the records looked at during inspection.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

There were insufficient staff to meet the needs of people.