Comfortcare Partnership Ltd

Comfortcare

Inspection report

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16 November 2017
28 November 2017
06 December 2017
13 December 2017
18 December 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 16, 28 November and the 6, 13 and 18 December 2017. On 16 November, we visited the office and looked records relating to people's care and the management and monitoring of the service. We also telephoned and carried out visits to people who used the service on 28 November and 6 December and returned to the office to meet with the manager and provide feedback of our inspection findings on 18 December. At the time of the inspection there were 30 people using the service.

Comfortcare is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults.

Prior to the inspection we received a number of concerns from the local authority and relatives of people using the service about the quality of service being provided, missed and late visits, poor care and poor meal provision. Because of these concerns, the inspection was unannounced.

At our last inspections on 27 February 2015, we found the provider to be in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not effective systems in place to assess and monitor the quality and safety of care that people received. Following the last inspection, we asked the provider to submit an action plan detailing what they would do and by when to improve the key question to at least good.
At this inspection, we found that there continued to be a shortfall in the quality monitoring systems and additional multiple breaches of the regulations were also found. You can see what action we told the provider to take at the back of the full version of the report.

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

At the last inspection on 27 February 2015, we asked the provider to take action to make improvements to how they assessed and monitored the quality of the service. During this inspection, we found the required improvements had not been made. There were widespread shortfalls in the leadership of the service. There was a lack of managerial oversight and the quality assurance systems in place were not effective in enabling the provider to continuously assess, monitor and improve the service.

The provider had not submitted notifications to CQC in line with statutory requirements.

A complaints procedure was in place. However, people were not always confident that the service would respond promptly or address the concerns and complaints raised.

The service sent satisfaction questionnaires to people who used the service and their relatives, asking them for their views and opinions of the service they received. Some of the responses were poor demonstrating that people had been dissatisfied; however, we were unable to see how this information had then been used to improve the quality of the service.

Risk assessments in relation to people's daily living lacked detail and were not always reflective of people's current needs.

Staffing levels were not adequate to meet the needs of people. Both people who used the service and relatives raised concerns about irregular call times, stating staff were not always punctual and missed calls had also occurred. The provider had failed to recognise the impact of late or missed calls upon people.

There was limited monitoring of people's medicines and effective systems were not in place to record how and when staff administered medication.

There were insufficient systems in place for the induction, supervision and appraisal of staff.

Staff received training to support them in their role in areas such as; safeguarding, infection control, equality and diversity and moving and handling. However, some people using the service had spinal cord injuries and one person had a stoma bag. Staff had not received training in relation to these conditions and there was no evidence of staff competencies assessments after completing training sessions.

Staff supported people in line with the legislation of the Mental Capacity Act (MCA) and during the inspection, no unnecessarily restrictive practices were observed. The 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, wherever possible, people make their own decision. 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

Staff did not have the necessary skills to meet people's nutritional needs.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'special measures' by CQC. The purpose of special measures is to; ensure that providers found to be providing inadequate care significantly improve. Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. Provide a clear timeframe within which providers must improve the quality of care they provide.

Services placed in special measures will be inspected again within six months. If the service has made insufficient improvements such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

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.

The service did not ensure that they kept people safe from harm. People using the service and their relatives did not always feel safe or confident in the presence of staff and gave examples of unsafe care.

People reported late and missed calls. The management had failed to recognise the impact that late or missed calls had on people.

The service did not have an effective call monitoring system to provide an accurate oversight of whether calls were being completed on time, were significantly late, or if a missed visit occurred.

Medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received training in areas, which were specific to the needs of people using the service, such spinal cord injuries and stoma care.

Staff supported people in line with current legislation.

Staff did not consistently meet people's nutritional needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Due to the shortfalls found within the service, people did not benefit from a caring culture.

Staff did not always respect people's dignity or treat people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always reflective of people's current needs.

People were not confident that concerns and complaints would be taken seriously and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not submitted notifications to CQC in line with statutory requirements.

Audits and quality assurance systems were not effective in monitoring the standard of care provided and had failed to identify concerns raised during the inspection.

Systems were not sufficiently robust to ensure that the registered provider had effective oversight of the service.

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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 site visit took place over five days and was unannounced. We visited on the 16, 28 November and the 6, 13 and 18 December 2017. On the first day of the inspection, the team consisted of one inspector and an inspection manager. One inspector completed follow up visits and telephone calls to people using the service and their relatives.

Before the inspection, we liaised with the local authority quality improvement and organisational safeguarding teams. We also reviewed the information we held about the service including information from previous inspection reports and notifications of incidents sent to us by the provider and other agencies. A notification is information about important events, which the service is required to send us by law.

During the inspection process, we spoke with three people using the service, three relatives and five members of staff. The local authority also spoke with eight people using the service and we used this evidence to support our findings. We spent time with the registered manager discussing the service. We also looked at nine staff files to see whether the service had recruited staff safely and looked at complaints and compliments received by the service.

We looked at six care plans and associated care documentation and at the management of medicines. We also looked at documentation relating to the management of the service including policies and procedures, staffing rotas covering the last six weeks, staff training records, a range of audits and the results of quality assurance surveys.

Prior to the inspection, the provider did not submit a Provider Information Return (PIR). The 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.

Inadequate

Is the service safe?

Our findings

The service did not ensure that they kept people safe from harm. Some people using the service and their relatives told us that they did not always feel safe or confident in the presence of staff and gave examples of unsafe care such as staff leaving people in profiling beds in raised positions with the cot sides down.

At the previous inspection, we found that although individual risk assessments were in place the information within them on how to minimise the identified risk was basic and inconsistent. During this inspection, we found this to be an on-going concern. This was because although risks to people's daily lives had been reviewed the assessments were often generic in detail and in some instances did not accurately reflect the needs of people. There were also no details or risk assessments for specific health conditions to guide staff as to how they could best support people. For example, the service supported people with a spinal cord injuries and a person with a stoma bag. Care plans did not contain guidelines for staff about how to monitor and manage potential risk factors relating to these conditions such as Autonomic Dysrefelexia (AD) or specific guidelines for staff about how to change stoma bags. AD is a potentially dangerous complication of spinal cord injuries. In AD, an individual's blood pressure may rise to dangerous levels and if not treated can lead to stroke and possibly death.

Staffing levels were not always adequate to meet the needs of people and keep them safe. We looked at staffing rotas for the previous four weeks and found they did not portray an accurate record of which staff members had worked that week. For example, staff members appeared on the rota under more than one name and the care co-ordinator, who the manager told us supported new staff members during their induction, did not appear on the rota despite providing care to people.

People using the service and their friends and relatives raised concerns about missed calls, late and irregular visit times and staff not staying for the required time. Comments included, "Always different staff, you never know who is coming." And, "They were supposed to stay for half an hour but never did." Another person told us, "They are not reliable." They went onto explain to us that staff were supposed to visit them in the morning to assist with medication and personal care, but that staff often did not arrive until 12pm and at times did not arrive at all. The registered manager told us that a system was in place to monitor the timings of calls. However, this involved staff calling into the office in the morning but did not monitor the time that staff arrived at visits throughout the day.

People we spoke with and their relatives told us they were not informed when staff were running late or were not going to arrive. In some instances when missed calls had occurred people had not received personal care that day and meals, fluids and medicines were given at the appropriate time, placing people at risk. We visited one person who received two visits a day, one in the morning and one in the afternoon, to assist with personal care and medication. We looked at the call log and saw that on the 24 November and 2 December 2017 they had not received a morning call. The person told us they had not been informed that staff were not coming. During the inspection, the manager told us that the service was in the process of implementing a new electronic call monitoring system. However, prior to this the manager had failed to effectively monitor calls to ensure that staff were completing them as scheduled and did not recognise the

impact that late or missed calls had on the safety of people using the service.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems in place to monitor the administration and recording of medication were not robust enough to keep people safe. Some people using the service had the need for time specific medication; however, relatives and people told us that due to late or missed calls medication was not always received as prescribed. Medication administration records (MAR) were not always kept in people's homes; this meant that there was no accurate record of what medication had been administered and equally no clear record of when it had been omitted.

This put people at risk as errors, omissions could not be accurately identified, and in some instances meant people were not receiving their medicines as prescribed. For example, one person's care plan informed staff that they required assistance with the administration of eye drops. They had been prescribed three different types of drops, two of which to be administered in the morning and all three to be administered in the afternoon with a 5-10 minute interval in between each medication. However, their care plan did not contain this detail and the person told us there had been an occasion when they had to stop staff from administering them with no gap in between. There was also no MAR in the person's home, staff simply documented "administered eye drops" in the call log. This meant there was no accurate record of which eye drop had been administered. We saw that on 2 and 11 December 2017 there was no record that any medication had been administered.

The manager had completed medication audits; however, they had failed to address these concerns. For example, the medication audit in October 2017 identified that medication records were not present in people's home. The manager had arranged a meeting with staff to discuss this issue however, we saw during the inspection we that MAR were still not in place.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a safeguarding policy in place to keep people safe from the risk of abuse. Staff knew how to recognise different types of abuse and what action to take to report this abuse and throughout the office, there was information detailing how to report concerns externally. However, the manager had not notified the local authority of safeguarding concerns such as missed medication or complaints from people and relatives about the poor quality of care.

The manager recorded accidents and incidents. However, it was not always clear what action the provider had taken to address issues or how lessons learned from incidents or accidents had been used to develop and improve the quality of the care provided.

The service had a system in place for the safe recruitment of staff. Appropriate checks were carried out before staff began working at the service to ensure they were suitable to work with vulnerable adults. Each staff file had completed application forms, Disclosure and Barring Service (DBS) checks and evidence of references from previous employers. DBS is a way of checking whether staff have any previous convictions, which allows employers to make safer recruitment decisions The manager had completed all of these checks before staff started working for the service. This evidenced to us staff were recruited safely.

We looked at the systems in place with regards to infection control. We saw that staff had undertaken

training in this area and the staff we spoke with said they had access to sufficient amounts of PPE (Personal Protective Equipment) and could go into the office for additional supplies.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection, we found that the provider needed to make improvements to ensure staff had the knowledge and skills to carry out their roles. During this inspection, we found this to be an on-going concern. This was because effective systems were not in place to monitor staffs knowledge and performance.

The provider did not ensure that all staff had the necessary skills to support people with their meals. This meant that there were occasions when staff did not effectively meet people's nutritional needs. For example, on one occasion a staff member had given a person a frozen pork pie thinking that it was a teacake. On another occasion, staff had defrosted but not cooked microwave meal. A relative had made a written complaint to the service about the standard of food provided by staff. This included an occasion when staff had given a person a microwaved cheese scone with jam on it for their lunch. T

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Existing staff were trained in a variety of topics which included; manual handling, the mental capacity act, medication and safeguarding. However, they largely took the form of e-learning sessions and we saw no evidence to show that following the training the manager had completed competency assessments to ensure that staff had understood and were able to put the training into practice.

Staff supported some people with specialist health needs including Parkinson's Disease, Spinal Cord Injuries (SCI), stoma care and mental health needs. Staff did not receive training specific to these areas and therefore, at times lacked the knowledge they needed to support people. One main carer for a person with Parkinson's Disease and dementia explained how staff's lack of understanding regarding how their loved ones condition affected them meant that staff sometimes acted or spoke in a way that they found upsetting.

All staff should receive an annual appraisals and regular supervision sessions to help with their professional development and monitor their performance. The manager showed us a list of when staff's annual appraisal was due; it simply had the name of the staff member and the month that appraisal was due. However, there were more names on the list than appeared on the rota and we saw no evidence in staff files that previous year's appraisals had taken place.

The manager told us that an induction programme was in place to support new members of staff when they first joined the organisation. As part of the programme, staff completed training sessions, which were linked to the care certificate. However, following the training staff the manager had not assessed staff. This was a particular concern because several of the new staff members had not previously worked in care. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. The manager also explained that in order for new starters to get to know people's care needs they worked alongside more experienced colleagues before they provided care for people or worked alone. However, when we looked at the staffing rotas it was not clear that new members of staff had been 'buddied' up with

another staff member before working alone. The manager told us that this was because they had been working alongside the care co-ordinator whose name did not appear on the rota. Staff had told us that they had been buddied with another member of staff when on their induction but this was brief and they could not confirm if this was on every visit.

Some people using the service were not able to make independent decisions about how they received their care or how they lived their daily lives. Care plans showed that, when necessary, relevant people such as their relatives or an appropriate health or social care professional had been involved in making decisions about their care. Staff had completed training in respect of the MCA and understood their responsibilities to ensure people were given choices about how they wished to live their lives.

Requires Improvement

Is the service caring?

Our findings

The lack of oversight and governance arrangements within the service meant that staff did not consistently meet people's needs and a caring culture was not always evident. Missed calls and the irregular timings of visits meant that people's day-to-day choices were limited and people did not always receive care in line with their expressed preferences and wishes.

There were some inconsistencies in the feedback that we received regarding the care provided to people. Two relatives told us that staff were kind and caring when providing care to their family member. One relative said, "Staff are kind and caring on the whole. Some are better than others." However, other people told us that staff did not always respect their privacy or did not treat them with dignity. For example, one person told us that during visits staff frequently took personal calls on their mobile phones.

Another person told us that they felt uncomfortable when staff spoke to each other in their native language at times and felt staff were talking about them in a derogatory way. A person who received assistance with personal care told us a staff member had brought their child into work with them. We visited one person who suffered with anxiety; they told us they had specified to staff that they wished them to access their property in a certain way, but they had not always done so. We discussed our concerns with the registered manager who informed us that would address our concerns with staff.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans contained information about people's life histories, their families and details of significant events that had happened in their lives. However, this information was kept in folders in the office and it was not always evident that staff had the opportunity and time to read them. People told us that they did not always feel confident that staff knew them well. This meant that rather than empowering people and enhancing their independence the care provided by staff was often functional.

Staff did not always support people to make choices about their day-to-day lives or how they received their care. People were not given a choice about what time they got up, when they went to bed or when they wanted to eat their meals. One person told us they had expressed a preference for female staff; however, a male staff member frequently supported them with their care needs. A relative told us, "My one criticism would be the irregularity of the visits." They went onto explain that part of their loved ones care package, involved staff supporting them to go to bed at night. Staff were then supposed to return later in the evening to see if the person needed further assistance with personal care. However, because the timing of the bedtime call was inconsistent the two calls were often too close together to meet the person's needs.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection, on 27 February 2015 we found a breach of regulation 10 of the Health and Social Care Act 2008. Although a complaints procedure was in place it was not clear how the manager listened to and addressed people's feedback, concerns and complaints in a timely manner. During this inspection, we found this to be an on-going concern.

Continued improvements were needed in how the service monitored and responded to people's concerns and complaints. A complaints folder was kept in the office, which recorded written complaints made by people using the service and their relatives. The registered manager had not always taken appropriate action to address the issues raised. For example, one person told us that they had met with the registered manager to discuss their concerns but felt that no changes were made following the meeting. Another person had raised concerns about late visits and staff not being familiar with their care needs. The registered manager had visited the person in their home to discuss their concerns; however, the initial response to the person was via an email, which stated, "Weekends and bank holidays had largely contributed to our late visits."

It is the responsibility of the provider to ensure that staffing is adequate throughout the week and on public holidays and the response did not outline how the provider intended to address the issue.

People told us that they knew how to raise concerns or complaints however; some people told us that it was not always possible to speak with either the care co-ordinator or the registered manager. People and their relatives said they were happy to make contact with the office but were not confident the registered manager would adequately address their concerns. The registered manager kept a log of written complaints. However, staff recorded verbal complaints separately in a communication book and there was no evidence what action the manager had taken to address these issues. For example, several of the people using the service and their relatives that we spoke with told us they had raised verbal complaints with staff. Although we saw some of these conversations recorded in the communication book, they did not form part of the complaints matrix. There was no record the manager had investigated verbal complaints or used the information to drive improvement in the service or how the service.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to using the service people had their care needs assessed. In some instances, a hospital social worker or the local authority completed the initial assessment they then contacted the service to see if they were able to meet the person's needs. The manager or care co-ordinator then visited people in their own home to meet the person and complete the assessment. Copies of these assessments were within people's care plans. This helped the service establish what people's care requirements were and how they could meet their needs. Each person who used the service had their own care plan with a copy held both at the head office and in people's houses. During the inspection, we looked at care plans, all of which provided an overview of people's care needs at each call, how many staff members were required and the time and

duration of each call,

Despite staff signing to show reviews had, taken place records were not always reflective of people's current needs. For example, at one person's review staff had recorded that the person had good mobility and dexterity, however previously in their care plan it was stated that they had a neurological condition affecting all four limbs, which caused fluctuations in their mobility. The review also looked at the person's continence, to which staff had simply documented 'yes' however, the person had a suprapubic catheter in situ. A suprapubic catheter is a surgically created connection between the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow. Whilst we were in the office we looked at one person's care plan which stated that they were living in accommodation, which when we visited them they had not resided in for approximately three months.

Inadequate

Is the service well-led?

Our findings

Prior to the inspection, the local authority informed us of concerns relating to poor care provision, late and missed calls and a lack of managerial oversight of the service. During the inspection, we found that people using the service and their families also raised similar concerns.

At the previous inspection, we found the manager was unable to demonstrate an understanding of the importance of robust quality assurance systems. Consequently, systems in place to monitor the quality and safety of the service were ineffective and had failed to identify shortfalls and reflect learning from vents or actions taken to improve the service. During this inspection, we found this to be an on-going concern. This was because; despite there being some systems in place to assess and monitor the service the provider had failed to maintain a clear oversight of the quality of the service.

Audits completed by the manager had failed to identify the continued shortfalls found during the inspection and where concerns had been raised, it was not always clear what action had been taken to address them. For example, the manager had not been effectively monitored missed or late calls and failed to recognise their impact on people's safety. In addition, whilst medication audits had identified concerns around the recording of medication administered; these issues were still seen during the inspection. This meant that the provider had not taken adequate steps to monitor and improve standards and ensure that people using the service were kept safe and received care, which met their needs.

The service had failed to ensure that staff received appropriate training to provide them with the knowledge and skills they needed to provide care which met the needs of people. For example, some people using the service had complex medical conditions including mental health related conditions and spinal cord injuries. Staff had not received adequate training in all these areas and where on line sessions had been completed, the manager had not reviewed staff competencies to ensure they could apply it in their roles. This meant that the care provided did not consistently ensure that people's needs were met and they were able to live full lives. Staff had not received annual appraisals and did not have access to regular supervision to support them in their professional development. Completion of staff appraisals and supervision sessions would have enabled the management team to identify some of these shortfalls in staff training and understanding.

The service sent satisfaction questionnaires to people who used the service and their relatives, asking them for their views and opinions of the service they received. We looked at a sample of surveys, which had been returned. This asked people if staff arrived on time, if staff were friendly, adhered to their care plan, listened and responded to their concerns, ensured continuity of care and ensured people's care needs were being met. People were then able to rate the service they received as excellent, very good, good, satisfactory or poor. One person had rated the quality of
service as poor, whilst another person had rated the service as only being satisfactory. However, we were unable to see how the manager had used this information to improve the quality of the service.

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

Providers are legally required to submit statutory notifications to CQC regarding deaths, serious injuries and safeguarding allegations. Whilst the provider had followed, the correct procedure to notify us of a change of location they had failed to notify us of safeguarding concerns found during the inspection. For example, the manager had not submitted notifications regarding missed medication or missed calls. We also saw people and their relatives had raised concerns regarding the conduct of a member of staff. In response, the manager had suspended the staff member pending the outcome of internal investigation. However, they had not submitted a safeguarding alert or notification in relation to the incident.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009,

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not consistently meet people's needs and a caring culture was not always evident. Missed calls and the irregular timings of visits meant that people's day-to-day choices were limited and people did not always receive care in line with their expressed preferences and wishes.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no record the manager had investigated verbal complaints or used the information to drive improvement in the service or how the service.