Comfort Call Limited

Comfort Call - Beechfield

Inspection report

Beresford Crescent
Middlesbrough
Cleveland
TS3 9JW

Tel: 01642246843

Date of inspection visit:
30 January 2017
13 February 2017

Date of publication:
18 July 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 January and 13 February 2017 and was announced. This meant the registered provider; staff and people using the service knew that we would be carrying out an inspection of the service. 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 provides domiciliary care services for people living in their own flats and bungalows at Beechfield Court in Middlesbrough. The communal areas of Beechfield Court include a café and hairdressing salon which are also open to the public. People have emergency buzzers in their homes which they can use to alert staff if they require emergency assistance outside of their care packages. Staff are based on-site at all times.

The service caters for people who have physical and mental health conditions and those who have a dementia type illness. The building is managed by Group Thirteen and care provided by Comfort Call Beechfield, both based at the service. At the time of our inspection there were 56 people using the service and 35 staff employed.

The registered manager was responsible for ensuring people received their care packages at Beechfield Court in Middlesbrough and another service in Hartlepool. A manager was based on site to oversee the domiciliary care provided to people. 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 of the service, carried out 22, 25, 26 January and 1 February 2016, we found that the service was not meeting all of the regulations which we inspected to meet the needs of people safely. Missed and delayed calls had impacted . We found that there were insufficient staff upon the dignity of people. People who needed support with their medicines had not been given it and some people did not have the medicines they needed. Safeguarding alerts had not always been made; a lack of communication meant that there was a delay in making some safeguarding alerts. We identified gaps in all records reviewed during inspection.

After the inspection, the registered provider submitted an action plan which identified the action they were going to take to make improvements.

At this inspection, although we noted that improvements had been made to procedures in place to manage safeguarding concerns and safeguarding alerts had been made. We found the service was not meeting all of the regulations which we inspected to meet the needs of people safely. This meant people's dignity

continued to be compromised; medicines were not managed safely and there were not enough staff to deal with people's planned calls and emergency call bells effectively. Staff had not received regular supervision and people's care records did not always contain the information needed or had inaccurate information contained within them. We wrote to the registered provider about our concerns about the continued breaches. They responded to our concerns and provided a detail action plan which included the action they had already taken and included dates by which any outstanding actions would be addressed.

At this inspection, people and relatives gave mixed reviews about the care and support which they received.

Some people spoke highly of staff, gave many positive examples and told us staff provided them with time, the support they needed and meaningful conversation. However, some people told us they felt rushed and felt they knew too much information about other people and staff because confidentiality was not respected or maintained. People told us that staff talked to them about the care they had carried out or were going to carry out with other people. People also told us about specific incidents where their dignity had been compromised.

People told us they were involved in their care and there was evidence of this in people's care records. However, people gave mixed reviews about feeling listened to. Some people told us they felt their concerns were not taken seriously or had not been given information when they requested changes to their care package.

Some people had excessive quantities of prescribed medicines. Some people we spoke with told us they didn't know what their prescribed medicines were for and during our observations staff did not provide information about this when they were dispensing medicines to people. Some people had not been given their medicines, eye drops and topical creams as prescribed. There were gaps in medicine records and in audits. Risk assessments were not in place for people who administered their own medicines.

We were concerned that one person had been not been given their medication appropriately and this may had adversely affected their health. We advised the person and their relative to contact their GP for advice. They GP recommended that the person visit accident and emergency which they did and were discharged the same day. We asked the registered manager to make a safeguarding alert which they did.

Care records did not reflect all of people's actual needs and some information looked at was inaccurate. We also found care records contained limited information about the support people needed, what they could do for themselves and their personal preferences. This meant that staff did not have the information they needed to provide the care people wanted.

Quality assurance measures in place had not highlighted the levels of concerns which we had received from people and their relatives during inspection. Staff kept records which showed people were dissatisfied with the service, however, there was no evidence of staff taking action to make improvements. Although there was evidence of regular audit taking place, they were not identifying all of the concerns which we found at this inspection.

Staff had not received supervision and appraisal in line with the registered provider's policy. Staff training was up to date, however we received mixed reviews about the knowledge, skills and experience of staff from people and their relatives.

Staff told us there were enough staff on duty during the day when the shift was fully staffed. They told us

staff were not always replaced when they were off sick.

People told us they continued to experience a delay when they pressed their emergency buzzer and told us staff were regularly late for planned calls within their care packages. Nearly all of people and their relatives spoken to during inspection told us more staff were needed.

Staff told us that two members of staff on site during the night was sufficient to meet people's needs. However, staff told us that when emergency incidents occurred, they needed a third member of staff to be available to respond to emergency buzzers whilst they dealt with the emergency incident. Staff told us they had previously tried to contact on-call managers during the night without success. This is something the management team disputed during inspection.

Procedures to safeguarding had improved since the last inspection, however staff had not always raised concerns when people had missed their prescribed medicines. We found this to be a training issue.

The registered provider had an effective recruitment and selection procedure in place and carried out robust checks when they employed staff to make sure they were suitable to work with vulnerable people.

Staff were aware of the emergency evacuation procedures they would need to follow if they were in people's property at the time of an incident. People had risk assessments in place and these had been regularly reviewed.

Staff participated in an induction programme when they started working at the service. This included shadowing more experienced staff, attending training and participating in reviews.

People told us staff assisted them with shopping and the preparation and cooking of food. Staff understood the procedures which they needed to follow if people experienced any deterioration in their health because of inadequate nutrition and hydration.

People told us they had regular involvement with the health and social care professionals involved in their care. People told us staff arranged transport and attended appointments for them.

The registered manager responded when people's needs changed by putting extra calls in place for people when they became unwell or during the Christmas holiday period.

Outside of people's care packages, regular activities took place at the service which relatives and friends could attend. Group Thirteen, Comfort call and people using the service worked together to plan these activities. People told us they were happy with the activities at the service.

Everyone we spoke with told us they knew how to make a complaint. Records in place showed that complaints procedure had been followed and the service had acted appropriately.

People and relatives gave mixed reviews about the management team. Many told us that the management team needed to be stronger.

The registered manager and manager understood the responsibilities of their role. They had submitted notifications to the Commission when required to do so. During inspection, they investigated all concerns which we asked them to when people had raised their concerns with us. They responded quickly when one person's GP recommended that they visit accident and emergency following our findings and they put new

procedures in place to minimise the risk of reoccurrence.

People and staff told us meetings were in place, where they were informed about any changes taking place at the service or any important communications.

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 registered 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?

Requires Improvement

People's medicines were not managed safely.

Staffing levels at night were unsafe when incidents occurred. Appropriate support for staff at night was not in place.

People told us there continued to be delays in answering their call bells (located in their accommodation) and staff were regularly late for planned calls.

Procedures to managing safeguarding alerts had improved since the last inspection and safeguarding alerts had been made. However staff had not always raised concerns when people missed their prescribed medicines.

Is the service effective?

Requires Improvement

Staff had not received supervision and appraisal in line with the registered provider's policy.

Staff training was up to date; however people and their relatives gave mixed reviews about the knowledge, skills and experiences of staff.

People told us they attended appointments and the service arranged appointments and travel for them if they needed.

Is the service caring?

Requires Improvement

People's dignity was not always maintained or respected.

Some people described staff as 'kind' and 'brilliant.'

The registered manager responded when people's needs changed by putting extra calls in place for people when they became unwell or during the Christmas holiday period.

People and their relatives were involved in planning and reviewing care.

Is the service responsive?

Requires Improvement

There were gaps in care records. They did not always reflect people's actual needs or some contained inaccurate information.

Some care records lacked information about how to provide person-centred care, however others contained the information needed.

People told us they knew how to complain and records were in place to show they had been dealt with appropriately.

Is the service well-led?

Requires Improvement

There were continued breaches to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Audits had not highlighted all of the concerns which we had during this inspection. We noted the same areas for improvement had been highlighted in audits during the last year.

People and relatives gave mixed responses about the management team in place at the service and told us they needed to be stronger.

The service had developed good links with the local community. People and staff told us they had been kept informed about changes taking place at the service.

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 registered 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.

Before the inspection we reviewed all of the information we held about the service. The information included notifications that we had received from the service and information from people who had contacted us about the service since the last inspection, for example, people who wished to compliment or had information that they thought would be useful about the service. We also contacted Middlesbrough local authority commissioning team.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

One adult social care inspector, two pharmacist inspectors and one expert by experience carried out this inspection on 30 January 2017. One adult social care inspector returned for a second day of inspection on 13 February 2017. Two experts by experience spoke with people and their relatives by telephone. The experts by experience involved in this inspection had experience of working with adults and older people or had experience of using services.

We spoke with 21 people and four relatives during our visit to the service and six people, plus13 relatives over the telephone to access their views about the service they received. We also spoke with the registered manager, regional director, quality team, manager, deputy manager and nine care staff.

We reviewed 11 care records, five staff recruitment records, the training summary records for all staff and four staff supervision and appraisal records as well as records relating to the management of the service. We looked around the service and went into some people's flats and bungalows (with their permission) and visited the communal areas.

Requires Improvement

Is the service safe?

Our findings

At the last inspection, we found the service did not have appropriate arrangements in place for the safe management of medicines. People had not always received the support needed with their prescribed medicines and topical creams. We asked the service to make improvements.

At this inspection, we found that staff supported some people with their prescribed medicines. We found that the arrangements for managing these medicines did not always keep people safe. We looked at eight medicines administration records (MARs) and spoke with the care co-ordinator and a senior carer about medicines and reviewed the provider's medicines policies. We visited each person in their own homes to make sure that appropriate arrangements were in place to manage medicines safely.

The level of support that individual people needed was clearly recorded in their care plan. We reviewed MARs and found gaps in five out of eight records where staff had failed to sign or enter a code to explain why a medicine had not been given. This meant MARs did not accurately reflect the treatment people had received. Some people were administering their own medicines, for example inhalers. However, risk assessments had not been completed for these people in accordance with the provider's medicines policy. This meant we could not be sure people were being supported to look after their own medicines safely. Controlled drugs (medicines which require extra checks and special storage arrangements because of their potential for misuse), were not recorded on the controlled drug record sheet as stated in the registered provider's policy.

Medicines were not always given as prescribed. One person was prescribed a long acting pain killer to be given 12 hours apart. On six occasions staff did not administer the next dose as the previous dose had been given late and the recommended 12 hours had not elapsed. This meant staff were not giving medicines in a way which met with the individual needs of the person and there was a risk of the person suffering from pain. Staff had not contacted the person's GP to review the appropriateness of this treatment. In addition, one person had not received any doses of their medicines on two days between 1 and 30 January 2017. We found these medicines were still in the blister packs, but care staff had signed the MAR on every day in January to say they had been given. Staff had received no training on how to safely use the 'medipack' blister system.

A third person was prescribed a medicine used for blood thinning. This medicine requires regular blood tests to ensure the person gets the right dose. The record book showed the last blood test had been carried out on 21 December 2016 and the next test was due in two weeks. Staff could not provide us with evidence that the blood test had been carried out which meant we could not be sure the person was getting the right dose of this medicine. It was not clear from the person's support documents who was responsible for this. A fourth person was prescribed a medicine which should be taken with food; however the person told us it was being administered one hour before their breakfast. Not administering medicines as directed by the prescriber increases the risk of the service user experiencing adverse effects from the medicine.

One person was prescribed two types of eye drops to treat an inflammatory eye condition. This person told

us they were not receiving these eye drops as prescribed and they needed support from staff to administer them. There was no documentation to state how the service would respond to the changing needs of this person when the eye drops were prescribed. We looked at the person's MAR between 14 and 30 January 2017 and on 11 occasion's staff had written in the notes that they had administered the eye drops but had not signed the MAR. In addition, on 75 occasions the MAR had not been signed to confirm the eye drops had been given. We were concerned the person had not received the eye drops as prescribed and we contacted their GP who advised the person should visit the local accident and emergency which they did and they were discharged the same day. We asked the registered manager to make a safeguarding alert, which they did. The registered manager also reviewed the person's planned calls to ensure they were supported with their eye drops.

Some people were prescribed medicines to be given as and when required, known as 'when required' or 'PRN'. These medicines can have variable doses and the number of tablets administered was clearly documented for each person. One person was prescribed two painkillers to be given when required, we observed the senior carer ask the person whether they wanted their medicines. The person answered, "Yes". We later spoke with this person who told us they didn't know what the medicines were for. The staff member did not explain what the medicines were for so the person may have been receiving medicines they didn't need.

We found stock control to be of concern during our inspection; excessive quantities of medicines had accumulated in some people's homes and there was no system in place to monitor stock levels. Staff were not following the registered provider's policy which stated staff should act if excessive quantities of medicines were found.

One person had not received the application of a topical cream used to relieve pain and inflammation between 02 and 27 January 2017, and another person had not been given a medicine prescribed for pain relief for five consecutive days between 01 and 06 January 2017 because these items were not in stock. Staff had documented that the stock of these medicines was absent on the MAR but had failed to ensure that an adequate supply was obtained from the pharmacy or organised a clinical review of the person with their own GP.

We saw records showing staff had received medicines training and supervision to ensure they were competent to administer medicines. The registered manager showed us four MAR chart audits which had been carried out in January 2017.Three out of four showed gaps in records and errors in recording. One of the audits had no actions or outcomes recorded. The quality team had also carried out an audit of records in November 2016. However, the audit only looked at a handful of service user's records and found similar problems to those we found during this inspection. Staff had received group training in January 2017 following this audit; however we found the same issues continued following this training.

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

At the last inspection we identified that staffing levels onsite were insufficient to provide safe care and support to people living in their own homes. We found people experienced a delay in waiting times when they pressed their emergency buzzers and people told us staff were often late for planned calls within their care packages. Staff told us they had too many planned calls in place which overlapped with one another and there were insufficient staff on duty at night to provider care and support to people when people required emergency assistance. People also told us they felt unsafe at night because of the lack of staff on duty.

At this inspection, the registered manager told us changes had been made to staffing levels and new procedures put in place. This included education about the use of emergency buzzers, monitoring of emergency buzzers, additional planned calls put in place and an on-call system outside of normal working hours.

Although the service provided domiciliary care to people living in their own homes, staff were based on site. This meant staff could respond to planned calls and emergency buzzers. The registered manager told us there were now nine staff on site from early morning until mid-afternoon and six staff until 21:00. Between 21:00 and 23:00 there were three staff and two staff from 23:00 until 07:00. They told us that the total number of care hours needed helped to determine the number of staff needed onsite.

Staff told us there were enough staff onsite during the day, however they became under pressure when there was staff sickness because staff were not regularly replaced. The registered manager told us that they did try to access staff from other services within the registered provider's portfolio and the care coordinator assisted with calls.

Staff told us that two staff on site during the night was sufficient to meet the needs of people who had planned calls in place. However, staff told us that when incidents took place where people required medical attention they were unable to respond to other emergency buzzers during these times. Staff told us that people pressed their emergency buzzers at night if they required support with personal care or if they were unwell. Staff told us that when these incidents took place, an extra member of staff was needed to respond to emergency buzzers whilst they were dealing with the incident.

One staff member told us, "Two staff at night is enough staff. If two emergencies happened we would be stuck. When there is an emergency we can't respond to [other emergency] buzzers. We need someone else to cover this." People and staff voiced their concerns about the safety of people at night. One staff member told us, "People are unsafe at night. People express their concerns with us about what could happen to us too." Another staff member told us, "If there is an emergency, it would not be safe [for people]. We don't have many [planned] calls [during night shift], but emergencies would make us short staffed. We used to have a third member of staff, but we were told they were not needed." A third staff member told us, "We need extra staff at night."

One person told us about an incident where they had needed the assistance of staff at night. Staff attended but told the person they needed to leave because they had planned calls in place. This meant the person did not get the care and support they needed. The person told us, "I blame the system. The staff are okay, but there is not enough of them at night. I felt under pressure because they needed to leave. I couldn't think straight about what I needed from them. We spoke with the registered manager and manager about this; they told us, "Staff should have offered to stay or should have gone back to check on the person."

People had a timetable of care as part of their care package. This meant they had recorded dates and times of when they should expect staff to visit them. People told us staff were regularly late. One person told us, "Ninety percent of the time they [staff] are late. The calls are scheduled on the rota but care workers do not come when they are supposed to. I do not mind if they are five to ten minutes late but when coming up to an hour, they do not ring or see me to tell me they are late. This is not fair." Relatives also spoke to us about their dissatisfaction with staff turning up late for planned calls. One relative told us, "They [staff] let my relative down. They are late or do not even turn up and they do not even tell my relative. This is really upsetting for me to listen to my relative being so upset. I have to come and help my relative to have a bath because they have failed to do this."

People told us staffing pressures meant they could be left waiting for care and support. One person told us, "I can wait two hours for assistance going to bed." People told us staff turning up later than agreed for their planned calls impacted upon their dignity. One person told us, "When they [staff] are late they do not let me know. Sometimes they do not even turn up; they do not let me know. Before Christmas they [staff] said they were going to give me a shower on The Monday. They did not bother to turn up or tell me they were not coming. They do not even apologise. My relatives helped me to get a bath. They [staff] promised me the following Monday and the same thing happened again."

People told us their planned calls could be cut short when staff experienced delays. For example, one person told us they had a two hour shopping call which was delayed by 25 minutes and resulted in a call of one hour and 35 minutes. Another person told us they did not receive their full one hour planned domestic call because staff were running late. One relative confirmed that planned calls were cut short. They told us, "It's not good for my relative. It seems they [staff] clearly do not have the time, they are running to the next call. My relative has a 30 minute slots [planned calls]. The care workers only stay for ten minutes. Basically they come when they want and they do not follow the rotas set."

All of the people and relatives we spoke with during inspection told us they thought more staff were needed. One person told us, "They need more staff as they are rushed off their feet." Another person told us, "The time they [staff] spend with us is not good enough. The care workers make it clear that they are going the next [planned] call, everything is rushed. The company needs to sort out the rotas [for planned calls] to make sure care workers are not late." A relative told us, "My general concern is that staff are run ragged. They work very hard. I think more staff are required."

The registered manager told us they took action to ensure one person had their care package reviewed because they had felt rushed when they were supported with their health and well-being needs. We also found that the registered manager had increased the number of planned calls to the person when their family was on holiday. Another person had been allocated a shopping call following concerns made by a relative and staff became more proactive about recording nutrition and hydration. When another person had experienced deterioration in their health, extra planned calls had been put in place to monitor the person. The registered manager told us that they had made changes to staff rotas over the Christmas period to accommodate people's activities and visits to relatives.

We asked staff about the support available to them out of normal working hours. The registered manager told us an on-call system was in place for staff. One staff member told us, "We are left at night. Day staff have the management team. At night, when we need advice, I have rang the on-call and got no answer. We are left in limbo. Between us we figure it out and do what we think is right. Sometimes it's nice to have a second opinion." Staff lacked confidence in the on-call team outside of normal working hours. One staff member told us, "It takes ages for the phone to be answered. After midnight, it's not likely to be answered. If they don't answer, we have to deal with things as best as we can." One staff member told us, "[Registered manager] and [manager] don't do night shift. They don't know what it's like."

We spoke with the regional director, registered manager and manager about staffing levels at night and the comments made by staff. They told us they did not agree with these comments and there were three members of the management team whom staff could contact outside of normal working hours.

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

People told us there were too many staff involved in their care packages. People told us they struggled to

remember all of the staff who visited them and told us they would prefer for key staff to be involved in their care package. From speaking with people, we identified that this was particularly problematic where people experienced memory difficulties associated with their health condition. The registered manager and manager told us that they had recently made changes to one person's care package in light of this. They told us five carers with significant experience in dementia had been involved in one person's care and this has helped to improve this person's daily routine and had meant that the person started to access communal areas more frequently. From speaking with them, we could see they had already identified more people who they felt would benefit from this.

Safeguarding alerts had been made since the last inspection and actions put in place to minimise the risk of reoccurrence. Staff training in safeguarding was up to date and all staff spoken to during inspection were able to tell us about the procedures which they needed to follow to raise safeguarding concerns. However we found that staff did not always raise their concerns when people missed their prescribed medicines. We deemed this to be a training issue. Information was on display in communal areas which provided people and staff with guidance about how to raise any concerns which they had about people they suspected could be at risk of harm.

People told us they felt safe living at the service. One person told us, "Yes, I do feel safe, very safe actually. The concept of the building is amazing. It's wheelchair accessible with easy access into the gardens and common rooms. This set out make me feel really safe and comfortable." Another person told us, "I feel safe, I fell over and staff were there in seconds. They [staff] are like family. They are good as gold." A third person told us, "I know I'm safe here. If they [staff] see me wandering out they say you don't want to be out there, I don't know I'm doing it. ." Relatives also confirmed people were safe. One relative told us, "My relative is very safe."

Accidents and incidents had been recorded and shared with the registered provider for analysis to look for patterns and trends. People told us staff responded quickly when they needed emergency assistance. One relative told us about an incident. They told us, "The staff responded straight away. If they've not been sure about something on other occasions, they've contacted 111 or 999."

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.

During the planning of this inspection, we became aware of a specific risk at the service which we discussed with the manager and registered manager during inspection. We could see that they had been unaware of this risk because the information had not been shared with them. This meant the service could not have foreseen the risk. However the registered manager acted quickly, they accessed the information needed, carried out a risk assessment and put measures in place to reduce the risk of harm. We also spoke with them after inspection and could see that regular reviews of this risk had taken place. This meant the registered manager had been responsive to our concerns and took the appropriate action to ensure everyone remained safe.

We looked at four staff recruitment files. We saw that each of these had a full record of the recruitment process. We saw potential staff had completed an application form where they were asked about their previous employment history and the reasons for any gaps in their employment. This meant the registered provider could see what experience applicants had before their interview. Records of interviews were in place and we could see that people were asked questions relevant to their specific role. This meant the registered provider ensured that staff had the right knowledge and skills. Two references had been sought

for all four staff, which included their last employment. We also saw the registered provider had obtained a Disclosure and Barring Services (DBS) check for each person before they took up their position at the service. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. This meant people who used services were protected by people of good character employed by the registered provider.

Requires Improvement

Is the service effective?

Our findings

We looked at the supervision and appraisal records of four staff. Supervision and appraisal are processes, usually a meeting, by which an organisation provides guidance and support to staff. Records showed that staff had not received supervisions in line with the registered provider's policy. All staff had received an annual appraisal. Of the four records looked at, one staff member had only received two supervision sessions during the last year and two members of staff four sessions. We noted there were gaps in supervision and appraisal records.

An internal audit carried out in December 2016, identified that supervision and appraisals were outstanding and an action plan was put in place. However we found that supervisions continued to be outstanding and the management team had been unaware that a staff member had only received two supervision sessions during the last year.

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

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. Where people may be deprived of their liberty in their own tenancy, an application needs to be made to the Court of Protection. At this service, each person using the service lived in their own homes and received domiciliary care support from staff.

In two of the 11 care records looked, we noted both care records made reference to best interest decision making. In one person's care records, the record stated that staff needed to ensure the person 'understood information given to them and any advice given was in the person's best interests.' In another person's care records, the record stated that the person's relative supported them with decisions because they experienced difficulties with this as a result of their health condition. The record stated that staff were required to contact the relative in regards of the person's best interests. Both people were deemed to have capacity. Although staff had received training in MCA, we found that they did not understand the principles of the Act or its legal framework, especially in relation to best interest decision making. These errors had not been identified during quality assurance checks.

We recommend the registered provider takes appropriate action to ensure the registered manager and staff understand the principles of the Mental Capacity Act 2008 and best interest decision making and care records are amended accordingly.

Induction records were in place which showed the support staff had received when they started working at the service. This included shadowing experienced staff, becoming familiar with policies and procedures and

participating in training.

All staff participated in mandatory training. This is training identified by the registered provider which they deem is essential to the role staff are expected to carry out. At this service, this training included first aid, safeguarding, the Mental Capacity Act, food hygiene and health and safety. Staff also participated in other training which included diabetes, dementia care and dignity and respect. We review the training summary record for all staff and could see that training was up to date. Where gaps had been identified, planned dates were in place to participate in training.

People and relatives gave mixed reviews about whether staff had the right knowledge, skills and experience to provide care and support to people living in their own homes. One person told us, "The staff know what they are doing, I would be lost without them." However some relatives felt more training was needed. A relative told us, "Staff are competent, but they are in a hurry all the time. Another relative told us, "Staff needed more training, particularly in food hygiene." They also told us, "Staff needed to take on board training." People and relatives told us staff needed to be more assertive. Some examples of training people and their relatives thought staff needed included, signs and symptoms of infection, using hoisting equipment, customer care and leadership training.

Prior to inspection we became aware of an incident where a staff member had not carried out the duties expected of them during an incident despite being trained to do so. Other staff had been involved in the same incident and acted appropriately. Most of the people we spoke with during inspection told us about this incident and expressed their concerns to us in light of the staff member's capabilities and their anxieties should they require assistance in their own home during a similar incident. We discussed this with the manager and registered manager. We could see that an investigation had taken place and actions put in place. However, no discussions had taken place with people using the service. We asked the registered manager to take action to listen to and address people's concerns about this particular incident.

A small number of people required assistance with their nutrition and hydration. From speaking with people, we found staff assisted them with menu planning, shopping and with preparation and cooking of food. Risk assessments were in place for people at risk of dehydration or malnutrition. Staff also supported people to have meals in the on-site café.

People told us they regularly accessed appointments with health and social care professionals involved in their care. People told us staff helped them to make and attend appointments within their care packages. The registered manager told us that people's care packages were flexible and with people's consent, changes could be made to enable staff to attend appointments with people.

Requires Improvement

Is the service caring?

Our findings

At the last inspection, we found that people's dignity was not always maintained or respected because delays in answering planned calls had meant that some people had needed to wait for prolonged periods to use the toilet and had experienced incontinence during their wait. Although people lived in their own home, they told us they went to bed later than they had wanted to, because staff arrived later than the agreed call times within their care packages.

At this inspection, we found that people's dignity continued to be compromised. One person told us about an incident where they had pressed their emergency buzzer because they felt unwell and needed assistance. Details about this health condition were in the person's care plan which staff were aware of. The person told us that staff had stayed for ten minutes before they had told staff to leave to because they had felt pressured because staff repeatedly told them they needed to leave to carry out their planned calls. The person told us their dignity had been compromised because they had been left on the commode in a state of undress and they had not felt cared for. They told us they had been unable to get off the commode themselves and staff did not return to assist them until they had used their emergency buzzer again. We could see there had been insufficient staff to deal with emergency buzzers. We spoke with the registered manager about this during inspection and this was investigated by them. The manager confirmed that the person's dignity was compromised and staff had failed to act in a professional and caring manner.

People told us some staff spoke to them about the care and support they had carried out or had planned to carry out with other people during their care packages, such as assisting people with washing and dressing or going to the toilet. For example, one person told us, "Staff told me they were going to put someone on the toilet. I don't need to know that." Another person told us, "I don't want to know about other people. I want staff to concentrate on me. I felt insignificant. I object to being told, 'I've only got X minutes here with you.' Staff don't have time to do the job they are here to do." A third person told us, "Some staff who care for me are always in a hurry. They never have enough time for me."

The latest staff survey (73 distributed and 17 respondents) showed that 70% of people felt staff always upheld their dignity; 18% of people felt staff sometimes upheld their dignity and 12% felt staff usually upheld their dignity.

This was a continued breach of regulation 10 (Maintaining dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about the care and support they received from staff. People described staff as 'kind' and 'brilliant. One person told us, "[Staff member] is very assertive, quick thinking, kind and thoughtful." Another person told us, "They [staff] do a brilliant job and should be paid extra." They're lovely, I can't fault them." A third person told us, "Some [staff] are very good and caring, they talk to you and do the job exactly how it should be."

People told us staff went 'above and beyond' what they expected. One person told us, "[Staff member] came

in one hour before her shift started to wash my hair to avoid any interruption to her rota."

Staff told us they spent time talking to people when they could and were aware of the impact of this upon people' health and well-being. Staff told us they supported people to go shopping in their local community, helped to style people's hair and apply make-up when they had planned events.

People gave mixed responses about the extent to which they were involved in making decisions about the care and support which they received whilst living in their own homes. However, records were in place to show that people had been asked for their views about their care. In the survey (carried out May 2016), results showed 53% of people felt totally involved; 41% of people felt somewhat involved and 6% of people did not feel involved in planning their care.

One relative confirmed they had been involved in planning and reviewing care. Another relative told us, 'I'm trying to sort it out, just reviewing the care plan now. Some [staff] don't update the care plan properly. I'm waiting for them to get back. It's not affecting [person using the services] care'. A third relative also confirmed they had been involved in reviewing care and told us, "If I ask for something to be altered they have done it."

Staff were aware that people could be signposted to local advocacy service and there was information on display in communal areas at the service. This is a means of accessing independent advice and support.

Requires Improvement

Is the service responsive?

Our findings

We looked at care records and spoke with people about the care and support which they received in their own homes. Three care records looked at contained inaccurate information because they contained contradictory information or because staff had completed records before they supported people.

For example, staff had made an entry into one person's records which specified the care and support they had given, which was completed before they had gone to support the person. Staff had then left the person's home without carrying out the specified activities. This meant the record was inaccurate. We spoke with the registered manager and manager about this during inspection. This was investigated and responsible staff were involved in disciplinary procedures.

In another person's care records, we noted discrepancies in the information available. This meant it was difficult to determine the person's needs. One person's care record stated that they had 'no impairment; however staff may need to rephrase words at times.' However, the records also stated the person was living with a learning disability and required support from staff with their medicines because they didn't understand them. We discussed this with the manager and they told us the person was able to make day to day decisions but not complex ones. We noted that the person had capacity to make their own decisions. They accessed a support plan given to the person by the local authority which stated the person had an undiagnosed learning disability. We asked the manager to take immediate action to update this person's care records to ensure they remained accurate.

In another person's care records, the record stated the person had 'no impairment,' but also stated that their 'understanding and conversation may be impaired because they were living with dementia.' We noted that coping mechanisms for areas of difficulties were not always appropriate, for example, staff were required to reassure the person when they became forgetful because of their dementia. There was no information about using prompts, repeating information or rewording information in a meaningful way to increase understanding.

A third person's care records stated that their 'understanding and conversation may be impaired because 'I have no impairment.'' The record also stated the person could make their own decisions and also stated that the person's family supported them with any major decisions.

We noted there was a lack of information about how to provide person-centred care in people's care records. One person's records stated they experienced 'memory difficulties due to health condition.' There was no information in the care record about these memory difficulties and how this could impact upon the person's care or what support they needed from staff. We also noted this person had been diagnosed with diabetes and Lymphoedema, however there was no information in the person's records about these, such as information about how to support the person, signs of deterioration or action staff needed to take.

Care records were not always updated following reviews of care or changes in people's health and well-being. One person had participated in a review of their care with their social worker; we noted there were

two actions identified in the review however they had not been updated in the person's care records. We could see these were actions staff were required to complete when they visited this person in their home. This meant we did not know if staff were aware of these changes. People also told us they had requested changes to their care packages, but these had not always been carried out. For example, one person told us, "I have told [staff member] that I would like to have my bath day changed and the timing. I am still waiting for this to be done."

During inspection, we found people expressed their concerns to us We found that the registered manager and manager were aware of some of these concerns, but not all. In some cases, people had not spoken with the management team and discussed their concerns with us during inspection. Prior to inspection people had also contacted the Commission to express their concerns and dissatisfaction with the service they were receiving. Where the management team was already aware of concerns, we found action had already been taken. We noted there wasn't always a clear audit trail in place which meant there was a delay in obtaining information and people had not always been made aware of the outcomes when they had been involved in situations which had caused them to express their concerns. Where the management team had been unaware of concerns, they acted quickly to investigate and resolve these concerns.

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

In other care records looked at, we found the records provided information about the care and support which staff needed to support people living in their own homes with. In three of the care records looked at there was sufficient detail about the care and support people needed, what they could do for themselves and how to encourage people to make their own choices. There were also details about personal care routines including what staff needed to do and what products the person liked to use. This meant staff could provide care and support in line with people's personal preferences, wishes and needs.

Staff carried out reviews of care with people in their own homes to make sure people were satisfied with the care and support they had received. This included a discussion with people and a review of their care records.

We could see that outcomes from these reviews had been included into people's personal goals and their care records updated. For example, one person had wanted to avoid social isolation and wanted support from staff to attend healthcare appointments. We could see these had been included into the person's care records.

People, staff and Group Thirteen worked together to provide activities at the service. This was not part of people's care packages, but was designed to increase people's social contact within the community which they lived. People spoke positively about these and told us they were happy with the quality and quantity of activities. Most recently, these had included a Christmas fare, Halloween buffet and music, bonfire display, karaoke and Pantomime. During inspection, we observed a weekly craft session and observed people regularly spending time with one another in communal areas.

The service had good links with the local community. People, their relatives and members of the local community were invited to attend events at the service and the communal areas of the service, including the hair salon and café were accessible to members of the community. People could have their relatives and friends to visit them at any time.

Since the last inspection, the service had received 14 complaints. Records were in place to show the nature

of the complaint, the action taken to resolve complaints and the outcomes of all complaints. The registered provider and registered manager had acted appropriately when dealing with these complaints. We could see that actions had arisen from some of these complaints and themed supervisions had been carried out with staff. A review of the complaints had taken place and no patterns and trends had been identified. One person told us, "The management always listen to me if I raise any concerns. I am very happy with the service I receive."

We looked at two compliments which the service had received prior to inspection. One of which stated, "A very special thank you for your kindness."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, we identified five breaches of the Health and Social Care Act 2008 in respect of maintaining people's dignity; safe management of medicines, safeguarding people from abuse, quality assurance procedures and staffing levels. We asked the registered provider to take immediate action to make improvements.

At this inspection, we found four breaches of the Health and Social Care Act 2008 regulated activities (regulations) but noted some improvements had been made to safeguarding people from abuse. We were concerned at the number of continued breaches and wrote to the registered provider about our concerns. We asked them to tell us about the action they were going to take to make improvements. In addition to continued breaches, we were also concerned because staff champions for medicines and maintaining dignity had been introduced since the last inspection; however we received many concerns from people during inspection in each of these areas.

The registered provider responded to our concerns. They told us they took our concerns seriously. They sent an action plan which detailed actions already taken and those in place yet to be completed. All actions had dates in place by which the registered provided expected them to be completed.

People and staff gave mixed reviews about the management team in place at the service. We were told that the management team needed to be stronger and communication between staff and the management team needed to be improved. One person told us, "The management should know what is going on; it looks like management are not told of issues. There has been a breakdown in communication between staff and management." Many people expressed comments about their requests not being actioned by the management team. Another person told us, "The [registered manager] comes and goes, however the managers are smashing." A third person told us "Communication with the managers has been fine so far. I'd say something if I needed to." The regional director told us that the management team were being supported to become a more robust team and this included specific training and supervision. They told us there were happy with the management team in place and felt they were capable to carry out the roles they had been employed to do.

Quality assurance procedures were in place. As part of this, the service was required to complete 'monthly branch returns' which is a system of reporting information about the number of care hours provided, recruitment, risk, supervision and appraisal, complaints and safeguarding alerts. The quality manager told us the quality team visited the service three to four times each year to carry out an audit of the service. Available records showed they had visited in January, April and November 2016. We were concerned that there had been a significant gap, especially when we had identified numerous breaches during our inspection in 2016 and we received regular concerns from people throughout 2016. We also noted that the results of the audit carried out in April 2016 rated the service at 81.8% and this had dropped to 70% in December 2016. Our findings from inspection in January and February 2016 had not supported the registered provider's audit result which gave the service a score of 91.5% in January 2016. During that inspection we found the service needed to make improvements to most aspects of the service.

From the audit information provided during inspection, we could see that gaps in records and medicines errors had been continually highlighted. We could see the registered provider had taken action to make improvements, however we identified continued breaches in these areas during inspection. We also found that audits of planned and unplanned calls had been carried out. The audit showed that all calls had been carried out within 45 minutes of the planned call time. This meant we could see why some people had told us staff were often late for their calls. From speaking with people, we could see they expected staff at the time recorded on their timetable of agreed care. Although the audit had highlighted this, late calls continued and people remained unhappy with call waiting times.

A mock CQC inspection had been carried out by the registered provider since our last inspection. From speaking with the regional director, quality manager and registered manager we could see that the inspection had identified some areas for improvement and action plans had been put in place. This included training and staff competency checks and record keeping. Changes had been planned to complaints, quality assurance procedures. This mock inspection report was not available to us during this inspection which meant we could not look at the results in detail to determine whether the findings had been similar to this inspection. From our discussions, we could see that the mock inspection had highlighted areas for improvement and these had not all been addressed prior to this inspection.

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

We asked staff for their views about working at the service. One staff member told us, "I love it." Another staff member told us, "I love my job. The service users are lovely and the manager is lovely." A third staff member told us, "I just love my job, there's never a dull moment. I like it here."

The registered manager told us that all information relating to the service, such as safeguarding alerts, accidents and incidents, staffing, and complaints were shared with the registered provider. We queried whether this could be the case given staff had not always raised their concerns when people had missed their prescribed medicines. The results of this information were discussed at senior management meetings. The quality manager told us that action plans, supervisions, serious case reviews and training were put in place where appropriate.

Audits of daily records had been completed in during our inspection, where errors in recording had been identified. Actions, such as themed supervisions and updates in staff meetings had been put in place to reduce the risk of reoccurrence.

The manager and registered manager told us that three members of staff had been shortlisted for national care awards in respect of dementia care and dignity.

The registered provider distributed a regular newsletter to all staff which included key themes, updates and planned changes. Most recently, this had included safety at work, responding to medical emergencies and outcomes of inspections for other services within their portfolio. Regular staff meetings had been carried out and minutes available for staff. Regular memos had been distributed to update staff about changes or where improvements were needed. These included staff champions, medicines, hot weather and staff conduct.

Group Thirteen facilitated meetings for people which staff from Comfort Call Beechfield Court attended. This meant people were kept up to date about any changes to their care or accommodation. We could see that discussions had taken place about emergency call bells, catering and upcoming events.

The registered manager was aware of their roles and responsibilities. They worked closely with the local authority contracts and commissioning team and safeguarding team. Both of whom had not expressed any concerns to us prior to inspection. The registered manager had submitted notifications to the Commission when required to do so.

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 Regulation 10 (1) Service users must be treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 1.Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. 2.Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) Care and treatment must be provided in a safe way for service users which includes he proper and safe management of medicines.

The enforcement action we took:

A warning noticed was issued.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 1.Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2.Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; d. maintain securely such other records as are necessary to be kept in relation to I. persons employed in the carrying on of the

regulated activity, and
ii. the management of the regulated activity;
e. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;
f. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

The enforcement action we took:

A warning notice was issued.