Comfort Call Limited

Comfort Call (Liverpool - Meadow Court)

Inspection report

Meadow Court
Porchfield Close, Croxteth
Liverpool
L12 0LS

Tel: 01515450484
Website: www.comfortcall.co.uk

Date of inspection visit:
14 September 2016
10 October 2016

Date of publication:
10 March 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

An urgent responsive inspection was undertaken on 14 September and 10 October 2016 following concerns from a member of the public and the manager. There were breaches of regulations from the last inspection which had not been met. This meant that not enough improvements had been made which is a legal requirement.

The service is an Extra Care Living Scheme which means people were receiving care in their own homes in a complex which was staffed 24 hours per day. There were 47 people receiving a service at the time of our inspection. There was a scheme manager who was responsible for day to day management duties and a registered manager in post. The registered manager in post was also a registered manager at another location.

A registered manager is 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.

We found that the service were still in Breach of Regulation 12 2 (g) Medicines as gaps were still found on Medicine Administration Records (MARs) on our recent inspection. Therefore it wasn't clear if people had received their medicines as prescribed.

There was a breach of Regulation 19 on the last inspection. Out of the four staff files we looked at they included a reference from a family friend or neighbour and therefore, remained in breach of this regulation.

There was a breach of Regulation 17 on the last inspection due to audit systems not highlighting the issues found on inspection. We found the service remained in breach of this regulation as their quality control systems were still not effective and had not identified the concerns we found or appropriately addressed the concerns when they became apparent.

There were insufficient staffing levels to meet the needs of the people needing care. There was evidence of clashes on the rotas were staff were being required to visit different people at the same time.

Risks were not always identified with a risk assessment for staff to follow and risk assessments were not always being updated often enough.

The service was seeking consent at the point of the care package commencing but we could not see how the service was obtaining consent for times of calls. We were concerned the service was not always following Mental Capacity Act 2005 legislation and there was no record of a mental capacity assessment or best interest discussion having taken place for one person who did not have the ability to provide informed consent.

We were concerned people were not always receiving care calls at meal times due to a missed visit or a late visit. Therefore, we could not be sure people were having enough to eat or drink.

Staff were receiving an induction and training however we raised concern with the provider that we had not seen certificates to confirm staff had completed mental capacity training. We were provided with certificates following the inspection for two out of the four staff whos files we had checked. We could not see a system of competency checks being undertaken following training being completed.

Some staff were receiving supervision but not all staff. We did not see any appraisals being undertaken in the staff files we viewed. We were informed by the provider following the inspection that a small number of staff had appraisals due in August 2016 and November 2016 which had not yet been undertaken at the time of inspection. This was due to a new manager starting and there needed to be a period of familiarising themselves with the staff members before it was deemed appropriate for appraisals to be undertaken.

Staff were observed speaking with people in a caring way and were passionate about wanting to be able to deliver an improved caring service for people.

Staff morale was low due to low staffing numbers impacting on care delivery for people. Service users and staff were not always being listened to by the service.

Assessments were being completed and people's signatures were being obtained to agree to their plan of care but the care plans were lacking in detail such as the call times being agreed with the person.

All the care plans we viewed contained some person centred information but pertinent information such as the person's preferred times to receive their care was missing. We viewed one person's care plan who was living with dementia and found their plan of care was not detailed enough for staff to know how to provide them with person centred care.

We found a complaints system in place but not all concerns raised were being followed up. This was highlighted within an internal audit completed by the service.

There were ineffective governance and quality assurance systems in place to prevent a staffing crisis from impacting on service users and staff. Communication systems within the hierarchy of management had broken down.

The audits being undertaken were highlighting concerns such as the potential for some staff to be working over 60 hours per week but no checks were then in place to identify if this was occurring to ensure there was no negative impact on the quality of the care being delivered.

The rating of the last CQC inspection was not being displayed for members of the public to read it and to be aware of the overall rating of the service.

The overall rating for this service is 'Inadequate' and the service therefore is in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe

so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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.

There was insufficient staff to meet the needs of the people needing care.

Risks were not always identified with risk assessment for staff to follow or risk assessments were not being updated often enough.

Prescribed medication systems of administration were not always safe.

Not all staff had adequate references as part of their recruitment prior to them starting to provide care for people.

Is the service effective?

Inadequate

The service was not always effective.

The service were not always following Mental Capacity Act 2005 legislation and there was no record of a mental capacity assessment or best interest discussion having taken place for people who did not have the ability to provide informed consent.

We were concerned people were not always receiving care calls at meal times due to a missed visit or a late visit. Therefore, we could not be sure people were having enough to eat or drink.

Staff were receiving an induction and training however, we did not see evidence of training in mental capacity. Some staff were receiving supervision but not all staff.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were observed speaking with people in a caring way and were passionate about wanting to be able to deliver an improved service for people.

Staff morale was low due to low staffing numbers impacting on care delivery for people.

We were told people were not always being spoken to by staff in a caring way when delivering care for people.

Service users and staff were not always being listened to by the service.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Assessments were being completed and people's signatures were being obtained to agree to their plan of care but the care plans were lacking in detail, such as there were no details of the call times being agreed with the person.

Care plans for people living with dementia were not detailed enough to show staff how to support them.

We found a complaints system in place but not all concerns raised were being followed up.

Is the service well-led?

Inadequate

The service was not well led.

There were ineffective governance and quality assurance systems in place to prevent a staffing crisis from impacting on service users and staff.

The audits being undertaken were highlighting concerns but checks were not always put in place to look into them further.

Communication systems within the hierarchy of management had broken down.

The CQC rating from the last inspection was not being displayed for members of the public to read it and to be aware of the overall rating of the service.

Comfort Call (Liverpool - Meadow Court)

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.

The inspection took place on 14 September 2016 and 10 October 2016 and was unannounced. We received concerning information which prompted us to inspect the service.

The inspection team consisted of one adult social care inspector. We gathered information before the inspection from the information we hold within CQC and from the local authority.

The methods used as part of the inspection were talking with people using the service, their relatives, interviewing staff, observation and reviews of records.

We viewed four staff files, four care plans and associated records such as daily records and Medicine Administration Records (MARs) for two people who were receiving assistance with their medication.

We spoke with eight members of staff, four people who use the service and two relatives. We contacted the Commissioners of the service.

The provider sent us with an action plan and details of staff deployed/recruited to alleviate the staffing problems impacting on people receiving care.

Inadequate

Is the service safe?

Our findings

We were concerned there were inadequate staffing levels at the service following a missed visit notification from the Scheme Manager and also a notification from the Scheme Manager that the service was unsafe due to low staffing levels.

We checked the staffing levels at the service by viewing the rotas and other documentation such as daily records, speaking to staff, speaking to people who use the service and their relatives.

All the staff we spoke with told us that there were not sufficient numbers of staff for them to meet people's care needs. One staff member told us that they had worked 70 hours over five days. It was not sustainable and it had been like this for a period of weeks. They told us that the only way to manage to support the amount of people who needed assistance at meal times was to visit one person, place a meal in their oven and leave them whilst the food was cooking to move onto the next person who needed assistance with cooking a meal. Another staff member told us, "No one gets the time on the rota, they are bringing in more and more complex people in here and a lot of people have dementia". They also told us they were 'call cramming' when assisting at tea time by leaving food cooking in one person's home to visit another person who needs support. A relative told us that a microwave meal had been placed in the oven and the plastic melted due to staff rushing and not spending the time specified as part of their care plan or on the rota to ensure food is being cooked in a safe way.

We received concerning information regarding a missed call. We visited the person and spoke to their relative. The person's relative told us that the person needing care had oxygen due to a condition affecting their breathing and they were concerned that their relative had been left in their nightclothes all night on one occasion due to a missed evening call to support them to bed. The relative also told us staff were rushing when they were providing care placing undue pressure on their relative which may exacerbate breathing difficulties. The relative told us that the person was visited by a friend some weeks ago who found the person's blinds were drawn and they were in their nightclothes in their armchair in the lounge, not having been supported to undress and retire to bed to sleep the previous night .The friend phoned the relative to inform them of this. We viewed the care plan in the person's home which was dated 3 January 2014. It did not specify the times of the day when the person could expect to receive their care. We asked the registered manager for details regarding the times of the day when the person needed care so we could check what the plan of care was. The registered manager provided us with a "Client Details" sheet which stated the person needed a morning call at 8.30am for one hour, a lunch time call at midday for 30 minutes, a tea time call at 5pm for 30 minutes and an evening call at 8pm for 30 minutes. The care plan stated - "I need the staff to assist me to undress and get prepared for bed. I need my oxygen machine taken into my bedroom. I sometimes need paracetamol before bed. I would like a cup of tea and to be offered some supper".

We received other information of concern stating that the service was severely understaffed and call times were being crammed. We viewed the rotas and found evidence of this as we could see the same staff member was on the rota to support different people who needed care at the same time of the day.

This is a breach of Regulation 18 staffing, due to there not being adequate staffing levels to meet the care needs of the people needing care.

We viewed four staff files to look into whether the service was following safe recruitment practices. All four staff we checked had undergone a Disclosure and Barring Service (DBS) check which ensured the service was aware if they had any previous convictions prior to them starting to provide care for people. However, we found all four staff files did not contain satisfactory references with all four files containing one reference from a family friend or neighbour. Three files contained a reference from a previous employer. This meant the appropriate checks had not been undertaken.

This is a breach of Regulation 19 Fit and Proper Persons Employed of the Health and Social Care Act Regulations 2014.

We checked if the service were identifying risks to keep people safe. We found it was inconsistent as they had completed some risk assessments including an environmental risk assessment but had not written other risk assessments. For example, there was a risk assessment for one person regarding their environment but they did not have a risk assessment for the oxygen in their home. The risk assessments which were in place for the person were dated 3 January 2014 with no evidence of them being reviewed despite the person having had a fall around a month previously. The falls risk assessment which was dated 3 January 2014 indicated a referral to a falls team was not needed. There was no evidence how the service were monitoring this or how they were determining a referral was not needed. This means we didn't place confidence in the risk assessment. Furthermore, due to the falls risk assessment not being updated not all that could be done was being done to mitigate risks for the person.

We looked into the systems for staff to obtain information and communicate important information and found the systems in place were not robust. We found that the rotas were left in the staff room for staff to refer to. There was a white board in the staff room for any important information to be highlighted on the board. We viewed the communication book in the staff room and found not all information written by staff was being communicated appropriately For example, we viewed an entry stating,"[Service user] had fall, phoned ambulance, they came at 8.40am. Happy to leave him at home but said if [Service user] gets pain later on to ring them back. [Service user] seems fine on leaving?. "We checked to see if this information had been recorded on an incident/accident form and found no record of it in the incident and accident book. This meant that the there was no contemporaneous record of the incident and no reporting of the incident for the manager to be aware this had occurred.

On 10 October 2016 during our second inspection site visit we were informed by the scheme manager there had been two incidents over the weekend but staff had not completed the incident form as yet. Therefore, this practice was continuing whereby records were not being completed in a timely manner with a contemporaneous record of what occurred.

There were some reported incidents seen in the accident/incidents book throughout the year of 2016 but no reported incidents recorded in the accident/incident book for the months of January, March, April, August, September or October 2016. The highest number of incidents were in June 2016 with 12 reported incidents/accidents. During April there had been three incidents/accidents, four during May and three during July 2016. There had not been an analysis of this to determine any trends or themes.

This is a breach of Regulation 12 Safe Care and Treatment as not all that could be done was being done to keep people safe.

We looked into if the service were following safe practices regards administration of prescribed medicines. We looked at one person's MARS records and found there were no gaps which meant staff had recorded the person had received support to take their prescribed medication. However, we found the person's medication was disorganised and not securely stored with For example, prescribed Pyridostigmine [used for the control of nerve impulses within the muscles] tablets container was left open with no lid to ensure they were stored securely. We asked the person about this and they told us they did not know what medication they were on and left it to the staff to assist them with their medication.

We were concerned that people were not always receiving their medicines when they needed them due to the system in place of ensuring they were always had a repeat stock of medication. We read in the staff communication book dated 7 August 2016, "[service user] still has no medication". We viewed the daily records which stated on 4 August 2016, "[Service user] has no medication for tonight. Phoned chemist who said delivery would be tomorrow morning". There was an entry on 6 August 2016 stating, "[Service user] should have gone in a taxi to collect medication". Another entry on 7 August 2016 described how the person was becoming delusional. Staff did not action contacting the chemist again until 8 August 2016 when the chemist then delivered the medication that day. This meant staff did not take action for three days despite the person needing their medication to control seizures and psychotic behaviour.

We checked further MARs records for the person and found gaps where the person had not been supported to have their antipsychotic medication on 4 and 5 August 2016. The person had also not received their seizure medication on 1 and 2 August 2016. We spoke to the manager about this who told us the chemist had attempted to deliver the medication on 5 August 2016 but the person did not answer the door. We were concerned that the service had not taken action when they became aware this had happened to ensure there were effective systems in place for people to receive their medication.

This is a breach of Regulation 12 (g) Safe Care and Treatment Management of Medicines of the Health and Social Care Act Regulations 2014

Staff were able to tell us about whistleblowing and were aware what to do if they had concerns about the people they were providing care for.

During the inspection the service had deployed staff from other areas and sent us an action plan to reassure us what action they were taking. They had completed an analysis of the dependency levels of the people receiving a service to inform them of the staffing levels required to meet the needs of the people they were caring for.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked into whether the service were seeking consent from people and found consent was not always being sought or reviewed. We checked one person's care plan which had first been written and signed by the person on 3 January 2014. Although the person had signed to agree they had been involved in the care planning, the care plan did not evidence the person's call times when they wished to receive care. We also found consent was not being sought in line with the specific instructions in the care plan asking staff to use a key safe to enter the person's home. We found the care plan had been reviewed on 12 February 2015. We did not find consent to hold a key or to times of calls was sought. However, we did find consent for medication to be administered had been sought on both 3 January 2016 and 12 February 2016.

We viewed another person's care plan and care records and found they were living with dementia. We met the person and observed they were disorientated in place and time. The service user agreement stated the person was unable to sign the agreement. The care plan also stated the person was able to answer the door but they would prefer staff to use the key safe. The care plan also stated – "[service user] can become confused with the simplest of tasks, my family make all my big decisions". There were no mental capacity decision specific assessments for the person or evidence of best interest's decisions for the person in line with the Mental Capacity Act 2005 legislation. Therefore, we were concerned the service may be acting unlawfully.

This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked into the induction, training and support for staff working within the service and found the service provided staff with a workbook evidencing their induction. Training seen in four staff files we looked at included Safeguarding training, First Aid, Restraint, Medication, Health and Safety, Privacy and Dignity, Nutrition. We did not see evidence of training in the Mental Capacity Act 2005 legislation. Following the inspection the provider sent us further information which confirmed two out of the four staff whos files we checked had received update training in dementia and mental capacity. There was a system in place of highlighting when staff were required to complete refresher training and also a shadowing pack which contained details of shadow shifts. There was a system of supervision for staff but not all staff had received regular supervision. Two out of the four staff files we looked in contained evidence of supervision but no evidence of annual appraisals. We did not see a system of checking competencies upon completion of training to ensure staff had understood and consolidated their learning. We were informed by the care

provider following the inspection that a small number of staff had appraisals due in August 2016 and November 2016 which had not yet been undertaken at the time of inspection. This was due to a new manager starting and there needed to be a period of familiarising themselves with the staff members before it was deemed appropriate for appraisals to be undertaken.

One relative we spoke with told us they were concerned their relative was not always having food due to a missed visit resulting in them not having supper or breakfast. The relative told us that on another occasion they had discovered staff placed a microwave meal in the oven which resulted in the plastic container the food was in melting onto the surface of the oven. Staff we spoke with told us the tea time run was the busiest time of the day and as a consequence the only way they were able to prepare food for people was by placing food in the oven and then leaving the food to cook to visit another person. We also read in the communication book staff were not always providing food at a time convenient for the person. For example one staff member wrote in the communication book, "[service user] made their own breakfast and took their own medication because I didn't get to them until 10.40am". We could not be sure people were receiving care at meal times for the duration of the call time or be sure staff were preparing food appropriately for people.

This is a breach of Regulation 14 Nutrition and Hydration of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found staff had contacted a person's General Practitioner to request specific advice regarding the person's health but we also found staff had not contacted a Pharmacist at such time when they became aware a delivery of prescribed medication had not been successful. Therefore, we could not be certain staff were always taking action and contacting other professionals in a timely way when needed.

Requires Improvement

Is the service caring?

Our findings

We received concerning information prior to the inspection informing us a person needing care had been seen crying because their care call was rushed.

Staff were observed speaking with people in a caring way and cared about the impact of not having enough staff on the people they were caring for. Staff were passionate about wanting to be able to deliver an improved service for people but due to the impact of the high number of hours being worked morale was extremely low. One staff member described how they were contacted on their day off to work and because the staff member was worried about people who may not receive their care calls. They cancelled their holiday to work. This demonstrated compassion and empathy for people needing care. In view of the limited time staff had available to provide care for people they were only able to provide task based care.

We spoke with people who use the service and their relatives to find out how they felt about the way staff cared for them.

One person told us - "They're abrupt (the staff)". The person gave us examples of how the person was being spoken to by staff. One example was "What are you doing sitting there." Another example was - "Hurry up and get dressed". The person told us -"If I'm nice to them they're nice to me". Another person we spoke with told us - "You can't fault them here, staff ring you every morning to see if you're ok".

Staff we spoke with told us they were concerned they were unable to provide the care people needed due to them not have enough staff and as a result of this the care being provided was task led. One staff member told us the service had accepted people into the extra care living scheme who were complex and this was one of the reasons why the staffing levels had become insufficient. They told us - "No one gets their care for the times of the rota".

We found evidence people were sometimes signing to say they were involved in their care planning when they first began to receive a service. We were concerned people were not being consulted when changes occurred and were not being kept informed of changes to their plan of care. We could not see any system in place of agreeing times of care calls with people so we could not be sure people were being listened to.

People were being encouraged to be as independent as possible by staff at times such as one person who was encouraged to take a prescribed medication independently. However, the staff had limited time to spend with people such as when preparing food. Staff told us they were rushing from one person's flat to another to prepare food and not remaining in the person's flat for the duration of the care call.

We observed two staff members interacting with people receiving care during the inspection and found staff spoke with people in a respectful and dignified way. We were informed advocacy services would be arranged for people if they needed them.

Requires Improvement

Is the service responsive?

Our findings

We viewed four care plans which contained some person centred information but they did not provide detailed information including the person's background or preferences so staff could provide person centred care. Three out of the four care plans contained a service agreement document which had been signed by the service user. At the time of signing the agreement people were agreeing they had been involved in their care planning. The care plans provided some information which was person centred such as whether the person had any food allergies or dislikes and religious beliefs but there was crucial information missing such as the times when the person agreed for staff to visit their home to provide care.

People were not always receiving care at the time they needed it. One person we spoke with and their relative told us they were not provided with support at the time they needed it and remained in their armchair all night and didn't retire to bed. The impact of this can be tiredness the next day, dehydration and pressure areas from sitting in the same position for hours at a time.

We found people were being asked at the point of their care package commencing with the service if they would prefer a male or female carer. However, we were informed by staff there was often one staff member who works the night shift due to staff shortages and therefore, there was no choice for people from 8pm to 8am.

One person who we visited, who was living with dementia, did not have a detailed care plan to provide staff with enough information to support them. For example, the care plan says that the person gets confused when attempting to do simple tasks but it did not provide any further detail for staff to know which tasks. For preferences of food is stated in the care plan - "I like all types of food". This minimal information did not provide staff with enough information to know how best to encourage the person to eat. People living with dementia require person centred care plans which provide staff with detailed information for them to support them correctly as they may be unable to tell the staff. Knowing things such as favourite things to eat and drink, favourite films to watch, favourite types of music can provide the person living with dementia with comfort and helps staff build a rapport with the person. We spoke with a person's son who told us the staff were not staying for long enough and there was no consistency of staff. Consistency of staff is important for people with dementia for staff to become familiar with their likes/dislikes and preferences so staff know how to in the best way to provide reassurance and comfort if the person became anxious due to memory problems.

This is a breach of Regulation 9 Person Centred Care of the Health and Social Care Act Regulations 2014.

We looked into how the service was obtaining the views of the people receiving care and their relatives. We found quality assurance telephone check forms in people's care files. We found actions had not been completed according to the information being obtained. For example, we found one person's relative had been contacted by telephone on 17 September 2016. One of the questions on the sheet of questions asked was -"Do your care workers stay for the full time required?" The answer given by the relative was - "no". Other questions included whether the person receiving care were informed if carers were running late or if

the person was informed if there was a change of carer. The relative asked these questions stated "No" in response to both questions. The relative also stated on the call -"Had missed call last week explanation given short staffed. Feel like carers rush in and out". There was nothing documented on the form to explain what actions were going to be taken by the service.

This is a breach of Regulation 17 Governance of the Health and Social Care Act Regulations 2014.

We viewed the complaints system and the 'Service Quality Survey' to look into whether there were any concerns about the service. We found 100 percent of people who responded said they would know how to complain if they were not happy with the service. We viewed the complaints file and found evidence of one complaint in the last 12 months regarding staff not spending enough time on the person's morning call. Although there were no other formal complaints seen, we saw concerns had been raised through the service's quality control systems, but they had not been looked into further by the service. An audit we viewed dated 8 September 2016 stated, "There was incomplete or missing information regarding the handling of complaints and safeguardings. Training needs to be arranged for the manager to ensure all complaints are handled properly and where this is complete the manager needs to review all complaints and follow procedures for complaint handling ensuring that each complaint has evidence of the investigations, actions and outcomes."

This is a breach of Regulation 16 Complaints of the Health and Social Care Act Regulations 2014.

We found there was a 'reminiscence room' but it was locked. Staff told us there had not been time to complete activities with people who lived there. There was a lounge/dining room where people could meet but staff explained there was limited time to support people to access them.

Inadequate

Is the service well-led?

Our findings

We looked into how the service was being managed and what quality assurance checks were in place.

Prior to the inspection we received a Statutory Notification from the scheme manager dated 8 September 2016 stating, "Due to high levels of staff absence and staff vacancies this service will be unsafe for the weekend of 10-09-2016. All steps have been taken to try and get staff to cover the calls but to no avail. We are trying to recruit, we have approached nearby branches for staff."

Although the scheme manager had raised concern regarding an imminent crisis of staffing levels to their managers they informed us they were not being listened to. We were informed by the Nominated Individual there had been a break down in the process of escalating the concerns up the management chain and if it had not been for CQC contacting the Nominated Individual they would not of been aware of the crisis.

We looked into how the crisis in staffing levels had come about. We asked the manager for examples of any audits which had been undertaken and we were provided with a copy of an internal audit completed on 8 September 2016. It stated - "No evidence of Certificate of Registration with CQC displayed or details were incorrect"; it stated immediate action needed by the manager.

The internal audit report also stated there were numerous pieces of information not on display including health and safety at work for staff, Whistleblowing and information for staff regarding safeguarding. The auditor requested these be actioned by the manager. We found the report evidenced other concerns which were not being addressed. The audit report stated that some staff may be working over 60 hours per week and advised the manager to ensure this was not impacting on the time spent with service users. Although this had been identified as part of the audit we found staff were working a high number of hours. One staff member had worked 70 hours over a five day period with no checks in place to identify if the number of hours worked was impacting on the staff's ability to deliver care. Therefore, we were concerned not enough was being done by the service to have oversight of this for staff and service users.

Clashes of care calls were documented as an issue in the audit report dated 8 September 2016. We found evidence from the rotas we viewed that care calls were still being entered for staff for them to visit more than one service user at the same time, resulting in clashes still occurring on our inspection. The report stated - "There are care worker visit clashes for the previous working two weeks – all rotas need to be reviewed to ensure there are no clashes at any time. If possible the system should be reconfigured not to allow clashes". We were concerned that the action being taken by the service was to add further runs to the rota. There was no analysis being undertaken of the dependency levels of the people receiving care and staff numbers required to ensure people were receiving care when they needed it and for the duration of time allocated on the rota.

We questioned the contingency policy and plan in emergency situations when staffing levels were low. We were informed by the manager and the Nominated Individual that the service's policy is to deploy staff from other Comfort Call Limited locations to assist. The consequence of this was some staff were staying in a

hotel locally to reduce travel time to provide care for people at Meadow Court.

We viewed the staff meeting minutes and found evidence of staffing issues as far back as October 2015. The minutes we viewed stated - "Rotas – it is vital we have appropriate staffing levels across the whole week. This also includes the weekend were we are in a position where we are often struggling or the same individuals are covering the majority of the shifts".

In view of the concerns regarding low staffing levels we asked the manager how they would know if there had been a missed call and what system was in place to identify if this had happened. We were informed by the manager that they weren't aware how this would be identified or how missed visits would be recorded. We were told the system was staff would contact the manager if they were aware of a missed visit; however, there was no system in place for the manager to identify how many missed visits there had been to identify trends and patterns. We were also concerned the quality control systems in place had not identified the concerns we identified regarding the lack of detailed information in the care plans, the issues we found regards management of medicines and the absence of decision specific mental capacity assessments in line with the best interest's process.

We viewed an internal audit which identified care plans were not being stored in a locked cabinet and there was no system in place to destroy confidential documents. We were therefore, concerned people's confidentiality was not always being maintained. The service's quality control systems were still not effective and had not identified the concerns we found such as incidents not being recorded in a timely manner or appropriately addressed concerns when they became apparent.

This is a breach of Regulation 17 Governance of the Health and Social Care Act Regulations 2014.

The provider produced an action plan following the inspection to provide assurances they were working on the issues identified as part of the inspection.
On our first day of our inspection on 14 September 2016 we found that the rating from the previous inspection was displayed behind the office door were members of the public would not have access to. This was brought to the attention of the manager who agreed to display the rating in the reception area of the building so members of the public could see it clearly.

This is a breach of 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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 9 HSCA RA Regulations 2014 Person-centred care The care plans we viewed did not contain enough detailed information for staff to be able to provide person centred care. Times if calls, the person's background and preferences were not being detailed within the care plan.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Staff and people who received care informed us they were not always receiving care when they needed it to enable them to eat and drink when they needed to. One person we spoke with had not had enough to eat/drink due to a missed care call. Other people's food was being warmed by staff who then left the food heating to visit another person who's food needing preparing. Therefore, we could not be sure people were receiving the support and care they needed to ensure they were receiving enough to eat and drink at the times specified on the rota.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We found the system of handling complaints was not effective. This had been identified by the care provider who found there was incomplete or missing information regarding the handling of complaints and safeguarding's.

They identified that training was needed for the manager to ensure all complaints were handled appropriately.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The remained in breach of Regulation 19 since the previous inspection as we found out of the four staff files we viewed we found a family friend or neighbour had provided a reference for the staff member.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The service had not displayed their rating in a public area to enable people receiving care and members of the public to view it.

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 11 HSCA RA Regulations 2014 Need for consent We were concerned people's consent was not always being sought including for specific times when care calls were planned. Mental capacity assessments and best interests processes were not always being followed when appropriate.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had inadequate staffing levels leading to people not receiving care when they needed it or for the duration of the time allocated to them on the rota. The service were not demonstrating they were recording all incidents/accidents or identifying trends to reduce risks reoccurring. Risk assessments were either not being updated often enough, absent or were not detailed enough. Medicine records were not completed accurately or consistently for us to be sure people were receiving their prescribed medication.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider had identified through their own audit in September 2016 that there were staffing problems however, not enough had been actioned by the care provider to prevent a staffing crisis which was reported to us by their scheme manager. The care provider had been aware some

staff were working 60 hours per week and staff morale was low. There had been a breakdown in communication within the care providers own management systems which we considered was attributable to poor leadership and governance systems.

The enforcement action we took:

Warning notice