Comfort Call Limited

Comfort Call Hatfield

Inspection report

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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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out this inspection by visiting the registered office for Comfort Call Hatfield on 27 October 2015; Between this date and 12 November 2015, we spoke with care staff, visited and telephoned people who used the service and their relatives or friends to get feedback about the service. We gave the provider 24 hours' notice that we would be visiting the office to make sure that the appropriate people were there during the visit.

We decided to bring forward the inspection following the receipt of concerning information. This related to allegations of missed and late visits and people being left without care and support for many hours. Allegations included people's personal care needs not being met; people not receiving their medicines at the prescribed times, and in some cases people being unable to access food and drink because of the lack of support.

The Hatfield branch of Comfort Call was registered on 6 April 2015 with the Care Quality Commission. At the time of our visit Comfort Call Hatfield was supporting a total of 664 people. This included five flexi care schemes; These are sheltered housing complexes where people live in

Summary of findings

individual flats or accommodations. These were Chiltern Green, Swanfield Court and Woodside house (Welwyn Hatfield) and Emmanuel Lodge and Wormley Court in Broxbourne.

The service provides care and support to adults and a small number of children in their own homes. People supported by the service were living with a variety of needs including age related health conditions, physical fragility and people living with dementia.

The service did not have a registered manager in post. The previous registered manager had resigned from their post in June 2015. 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.

Although people told us they found the staff who delivered their care to be respectful and kind, many people found the behaviour and competency of the office staff, to be both unreliable and unhelpful.

Some staff were not fully aware of their role in relation to Mental Capacity Act (2005) (MCA) and not all staff had received training in this area

People's needs had not always been assessed prior to receiving a service from Comfort Call, care plans were incomplete and did not always ensure people's individual needs, preferences and choices were taken into account and implemented.

There were risk assessments in place that gave guidance to staff on how risks to people could be minimised. The systems in place to safeguard people from the risk of avoidable harm were inadequate as some were historic and had been completed by a previous care provider. Recent risk assessments were not done for many of the people and likewise reviews of the risks to people were not happening in a planned or timely way.

The provider failed to protect and support people safely due to ineffective and incomplete recruitment practices and insufficient staffing levels to ensure people's health and welfare was met. Staff did not always receive regular support and supervision from their managers. Staff were working long hours and many described feeling exhausted.

The provider failed to support and supervise people safely and effectively to take their medicines. Not all staff had received up to date training or supervision of their practice in relation to administering medicines or had their competency assessed.

People were not always provided with sufficient food and drinks due to a series of missed visits which placed them at risk of malnutrition and dehydration.

The provider had a procedure for handling complaints, comments and concerns but failed to ensure that complaints were handled effectively and in a timely manner.

The provider had ineffective management and quality monitoring systems in place that failed to identify serious errors and omissions in the monitoring of missed calls, which placed people at risk of serious harm.

At this inspection we found the service to be in breach of regulations 9, 10, 11, 12, 13,14, 16, 17, 18 and 19 of the Health and Social care Act 2008 (Regulated activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore 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. Where necessary, another inspection

Summary of findings

will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not supported to ensure their needs were met safely.

People's medicines were not managed safely.

There were insufficient numbers of staff employed at the service to meet the needs of people safely.

Inadequate

Is the service effective?
The service was not effective.

Staff did not receive training relevant to their roles and did not have their competency assessed.

People had not always been supported to eat and drink sufficient amounts to help them maintain a healthy balanced diet.

People were not supported appropriately with regard to their ability to make decisions. Staff were not clear of their responsibilities in relation to MCA.

Inadequate

Is the service caring?
The service was not always caring.

People were not always treated with kindness and compassion.

People were not consistently involved in their care planning and review of their care.

Peoples dignity and privacy was not always respected and upheld.

Requires improvement

Is the service responsive?
The service was not responsive.

People's care and support was not person centred and did not always meet their needs.

Staff did not always have access to information and guidance that enabled them to provide person centred care and support.

People were not always able to pursue their outside interests and social outings due to visits being late or missed.

There was a complaints policy in place. However complaints had not been managed in a timely or effective way.

Inadequate

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

The systems in place to monitor, identify and manage the quality of the service were inadequate and had not identified or resolved serious and life threatening issues found during our inspection.

People found the management of the service was both inconsistent and ineffective.

Comfort Call Hatfield

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This was the first inspection carried out since the service was registered with the Care Quality Commission on 6 April 2015.

This visit to the office took place on 27, October and between the 27 October and the 12 November 2015 people and staff were contacted to obtain feedback about their experience of receiving care or working for Comfort Call. The inspection was carried out by seven Inspectors and two experts by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service. Two inspectors visited the office and the other inspectors and experts by experience spoke with people using the service and staff. The visit was announced. We gave the provider 24 hours- notice of our intended inspection to ensure appropriate senior staff would be there to support us with the inspection. Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

As part of the inspection we spoke with 86 people who used the service, 6 relatives, 30 members of staff, one regional manager, one regional director, the head of quality and the managing director. We received feedback from health and social care professionals. We viewed people's support plans. We looked at staff recruitment records. We reviewed safeguarding records, comments and complaints records. We looked at quality monitoring records including staff support documents including individual training and supervision records. We also reviewed records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People did not always receive safe and appropriate care that met their individual needs. For example, in relation to personal care and supporting people's mobility, assistance with taking medicines, and continence care.

People provided us with a range of comments with regard to their welfare and we received 37 concerns from people about their safety. They told us that they often did not know who was coming to carry out their visits and that visits were frequently missed and late. People also told us how missed calls impacted on them and their wider family.

One person explained "There are never enough carers to cover the calls". Another person explained "I have had six missed visits in the past month and once it was over a whole weekend and no one called to say they were not coming. It was Friday right up to Sunday. When you phone the office they just say that they will call back or ''Oh they have just gone home". One Relative told us "At the weekend they called me to say no one will be coming and they were asking me to put my relative to bed."

Another person told us that on a recent occasion they received their usual morning call at 8.00 a.m. and were due a lunchtime visit at 12.30 a.m. However the staff member failed to turn up to carry out this visit and therefore this person did not receive a further visit until 6 p.m. This meant that this person was left without a care visit for almost 10 hours and had not had the personal care they needed provided. This caused this person unnecessary discomfort and pain and also caused their skin to breakdown and become infected. This placed the person at unnecessary risk of harm and neglect.

We found that the service had failed to provide a visit to one person from 2 p.m. until 9 a.m. on the following day. This person was assessed as requiring four visits per day and the care package was to assist with personal care needs and the preparation of meals and fluids. As a consequence of these missed visits this person went without meals and fluids for a substantial period of time. The management and staff were unaware that these visits had been missed and could provide no explanation on how this situation could have occurred.

We found that one person who required an afternoon and evening visit had these visits combined into one due to staff shortages. The staff then failed to turn up. This resulted in the person's catheter bag bursting and soaking their bed. This person was then left to sleep in a soiled bed for the remainder of the night, this had caused them discomfort and upset, along with the lack of dignity.

Staff also confirmed that visits were missed. For example one care worker informed us that "People don't always get their care on time and it can be up to four or five hours late. I turned up at one person's house at 19.40 p.m. and found their (incontinence) pad had not been changed since 10.30 a.m. I felt very upset by this and wanted to leave the company." Another member of staff told us "I am forced to miss calls because they add them to the rota without telling me". A third member of staff told us "Calls are normally 'back to back' with no account for travelling. People often don't get their visits; they are often missed or late".

We found that during the month of September 2015 there were a total of 31 missed visits to people according to information the senior management team at Comfort Call gave us. This was where nobody had turned up to provide care to the person. We have referred these concerns to the local safeguarding authority for further investigation.

The lack of care due to missed and late calls was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People raised concerns about personal care being provided by staff they had never met before.

We were told by one person's relative that "We are not sure who is calling at the door, and they just go in because they use a key safe. Sometimes my relative has not seen them before." Another person [Female] told us that at 11.45 p.m. they heard their front door open and a man's voice calling out saying that they had come to do their care. The person told us they were very upset about this especially as they were not expecting anyone at that time of night and had not agreed to a male care worker to provide their care. Another person said, "At the moment it can be a complete stranger that comes in to provide my intimate care…It makes me feel intimidated."

One person said that they feel safe with their regular care staff but when calls are missed and strangers come into their home to provide their personal care with no warning they do not feel safe.

Inadequate

Is the service safe?

Fifteen people out of 86 people we spoke with told us that there had been an improvement and there had been less missed calls in the past month. One person said "It used to happen very often but recently, there has been a reduction in the number of occurrences. Ten people we spoke with told us they felt safe with the care staff who supported them. One person told us, "I am safe and comfortable with the carers that come." Another person said that, "I have been looked after at home for several years and have generally felt safe in my own home with the carers that they send me. This lot seem ok too."

We looked at 10 recruitment files as part of this inspection and found that none of these files contained all the required information to demonstrate that the process for recruitment was safe and effective. We found that four staff files only contained one reference, one file contained no references at all, and references had not been validated to check their authenticity. Disclosure and barring checks [DBS] were not evident in people's files. We discussed this with senior managers and they told us that most of the staff had transferred from other providers. They intended to review all recruitment files in the future to ensure a consistent standard in relation to recruitment practices. However at the current time this meant that we could not be assured that people who were employed had had sufficiently robust checks carried out and may not have been suitable to be working with vulnerable people.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us that when they arrived at their relative's house they discovered that they had the incorrect medicine box and had been given another person's medicines. The staff had failed to check that the name on the medicine box. This was reported to the regional manager for their immediate attention. A safeguarding alert was raised with the local authority safeguarding team immediately following this inspection, for further investigation.

We found that there were 22 care staff who had not received up to date training in the management of medicines. The provider was unable to confirm that all staff had been through a competency assessment process prior to them supporting people with their medicines. This meant that people were placed at risk of safety from staff that may not be trained or assessed as competent to support people with their medicines.

People had not always received their medicines at the prescribed times due to late or missed visits.

Medicines were not being managed safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Inadequate

Is the service effective?

Our findings

We received mixed feedback from people about whether they thought staff had the skills and abilities to support them effectively. We found that a quarter of people had concerns about the ability of staff to support them, half did not express an opinion when asked and a further quarter told us that they felt that staff were competent and caring.

One person told us that "What is not so good is that I get people coming in and they don't know where they are or what they're doing. They just don't seem to grasp my care needs". Another person told us that "I emphasise that areas in need of improvement are training and qualifications, some staff just do not know what they are doing." Another person stated "Have they had the correct training and gained the qualification, that's the question, and I don't think some of them have." Feedback regarding the skills and experience of staff varied and some people had better experiences than others. Training and skills were inconsistent. People told us they often had to talk people through their care plan and they found this tiring.

We saw from the records we reviewed that staff did not always have the up to date training, skills and knowledge to carry out their role effectively. We found the year in which the training was provided missing from each person's file therefore it was impossible to know if the training provided was current or historic. Feedback from staff also proved to be inconsistent and varied from person to person. For example one member of staff told us "One carer gives catheter care but has not been trained". Some staff told us they had received training from a previous company they had worked for but had not had their competency checked by their current employer. The managers told us they would be reviewing training and streamlining it to make sure all staff had consistent training and their competency had been checked.

We saw from the records provided that out of the 10 staff files looked at only four people had received the required training in safeguarding people from abuse, risk management, MCA, food hygiene, medicines and moving and handling. Staff confirmed this to be the case and staff we spoke to had varying degrees of knowledge about safeguarding people from abuse and other key areas relating to obtaining consent and the safe administration of medicines. This meant that people did not always have the skills required to care for people safely and there was an increased risk of harm to people who used the service.

We found that there were inconsistencies regarding the evidence of supervision meetings which had not always been dated so it was impossible to determine if these were current or historic records. We asked the managers about this and they were unable to clarify the position and told us this would be reviewed as part of the overall review of staff records. Records that related to the induction of staff were also incomplete; We spoke with 30 staff the majority told us they did not feel supported by the management team. Many staff members we spoke with told us they had considered leaving the company because they found the poor practices unacceptable, one person said "I only stay because I feel sorry for the people we are supporting".

One person told us that "I have not had supervision in the last nine months; I don't even know who my line manager is." We asked five staff about their induction into Comfort Call. One staff member told us that "I did my induction and three days shadowing. I found it daunting after just three days to do care on my own but I am fine now." We were told by managers that the new induction programme that was currently being implemented was linked to the 'Skills' for Care' induction programme. This programme was being delivered over a 12 week period.

The lack of appropriate training and support for staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where 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. We checked whether the service was working in line with the principles of the MCA.

We asked the regional director for a list of people who had capacity to consent to their care. From the list provided we saw that 174 people had been identified as being able to consent. This meant the remaining 490 people were considered unable to give consent to their support and

care. However, mental capacity assessments were not included in people's files and there were no records of best interest decisions being made to ensure any care or support provided was in the person's best interest.

We asked staff if they were aware of the MCA and how it related to the people in their own homes. We found that 10 staff were unable to tell us any information that related to the MCA. Four staff told us that it meant they had to ask people before assisting them. However six staff we spoke with were unaware that providing care to a person without consent could be unlawful.

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

The majority of people we spoke with who had not experienced too many missed or late told us that staff were helpful and always ensured that they had access to drinks and snacks before they left. Some people commented on the standard of meals care staff provided. Four people told us that care staff were always happy to help prepare their meals and snacks. However two people told us that staff did not always have the skills required to support people with their food choices. One person told us "The actual suppers are a bit of a headache. I find 50% of the staff don't know how to cook. For example I asked for poached eggs and they couldn't do it so I had to choose a sandwich. This is an area they lack experience."

We found people who had been the subject of a series of missed or late visits were at risk of receiving inadequate amounts of food and fluids. We found that one person had been left for a substantial period of time without access to food or drinks due to two missed calls. A further four people, who all lived on their own and required the support of staff to provide food and drink, had a number of missed calls during September 2015 which meant that people were placed at high risk of dehydration and malnutrition. One person, who required support and encouragement to eat, had four missed visits in September. The person was unable to provide food for themselves and on one occasion had not eaten any food for a period of up to 24 hours. A safeguarding referral was raised with the local authority immediately following this inspection.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they would ask staff to arrange for them to see a GP or in some cases their relatives would make the arrangements. They were also supported to attend other appointments such as hospital, opticians or chiropodist when they needed to, subject to the availability of staff. Staff told us that if someone was not feeling well, they would contact their GP and then informed the office staff. The care notes we looked confirmed that people were supported to maintain their health.

Requires improvement

Is the service caring?

Our findings

People's preferences were not always taken into account and there was no effective process in place to ensure when there were changes to times or staff people were informed in advance to reduce their anxiety. People complained to us that they often did not know who was coming to provide their care until they arrived at the door. This had been a particular concern for females who had specifically asked the office not to send male carers but this continued to happen. One person [Female] told us, "One evening I had a male carer turn up on my doorstep that I had never seen before and it was dark outside. This made me scared and anxious. The office should have warned me that a man was coming as I don't like being cared for my man." We were told by five people that they had asked not to be cared for by a male worker but all five had been sent male staff in the past two months. One person told us" here I am still sitting in my dressing gown……hopefully tomorrow a lady will come and shower me." Another person explained how a male carer had been sent to support them with personal care. They said "I didn't think it was appropriate that he should see me in the nude really." The impact of this regular uncertainty impacted on people's quality of life.

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

The majority of people we spoke with told us they were happy with the care they received when it was provided by their regular care staff. One person told us that "The individual carers are wonderful." Several other positive comments were received from people, for example "I have the same carer during the week and they are really very good." One person explained "Carer [X] is my favourite; I wish I could have them all the time, not only are they funny and brighten up my day, and they are really kind and gentle. I really look forward to the days when they come." Another person commented "They are really good at helping me to be independent, they are very encouraging, and if I'm down they really do help me to feel better." Another person told us that "I've known some of them for so long, they are like an extended family." I am very happy about the care, I can't complain about the carers."

However people were less happy with the way the office staff responded to them and on occasions felt that they were spoken to in an abrupt and rude manner. One person told us that they contacted the office to request a rota in order to know who would be providing their care and the response was "I haven't got the time to read them to you." Another person explained how when they called the office to enquire if anyone was coming to provide their morning visit they were told "No one is coming to see to you but we can assure you that tomorrow morning you will be our first priority." Four people told us that when they telephone the office they either could not get through to speak to anyone or they were promised a call back which never happened. One person told us that, "They never ring back when they say they will."

35 people that we asked about dignity and respect told us that they felt care staff respected their dignity and privacy. One person said, "I like the way the care staff respect me as a person. When they help me with personal care they shut the curtains and make sure I am covered with a towel." The staff demonstrated that they were aware of the importance of respecting people's dignity, privacy and independence." A member of staff told us, "We always call out the person's name before we enter their home; after all we are the visitors."

People told us that generally, when they had regular staff they felt they understood their needs and knew how to support them. However much of the feedback we received from people was about the lack of continuity of staff and continuous changes of staff. Staff also confirmed that they had a good knowledge of the people they supported regularly, and had developed good working relationships. However staff told us that they were regularly moved around and could never tell if they would actually cover the visits on their rota because office staff constantly contacted them to ask them to cover missed or late calls. Clearly this impacted of people being able to develop relationships with their care staff. We found staff to be caring for example when speaking with care staff they demonstrated a fondness for the people they supported and spoke in a kind and caring way about their duties. One person told us their care worker was a "sweet and loving carer" but they were worried that they would leave if things did not improve within the organisation.

Inadequate

Is the service responsive?

Our findings

We saw that although some care plans had an assessment of need in place there was confusion about how current and up to date these assessments were. This was because they contained paperwork from previous domiciliary care agencies which made it difficult to determine the accuracy of these records. Staff told us they found this confusing. We asked the managers how they ensured that people's 'current' needs were being met as people had not had assessments or had their care needs reviewed since transferring their care to Comfort Call in April 2015. Managers told us that they were planning to review all care plans and risk assessments.

Although there was clear evidence that people had been involved in the planning of their care this again had been when their care was delivered by other providers. We found only one care plan out of ten had been reviewed since April 2015. We found daily records noted the care each person had received on the days our visits took place but care plans had not been reviewed or updated to reflect any changes to people's requirements.

Although there was evidence that people's preferred visit times had been recorded, there was little evidence that confirmed these times were adhered to. For example we saw one care plan where the preferred call times were between 8 p.m. and 8.30pm, but several visits were carried out as late as 10:00 p.m. For another person, we saw call times were requested to be between 7.30 and 7.45pm, but times were all generally much earlier, for example between 5.15 p.m. and 6.15 p.m. We asked this person about the call times and they said, "I'd prefer them to come at 8pm and not before, I don't like them too early because at night I want to watch the telly. I have to eat at different times, because I never know when they are coming and don't want to be eating when they arrive." Another relative told us "they are supposed to come in time to get (relative) ready to be collected by the transport by 8.30am, they have been late so many times in the last few weeks that (relative) has missed the transport and then their mood changes and we all suffer, if only they realised how it affects the rest of the family".

Many of the people we spoke with said the weekends were the most difficult time in terms of staff consistency. One person explained that the cover staff rush them. " They will come if there isn't anyone to cover but they have to be quick to get to the next person. I find this hard when someone wants to rush me. It makes me feel very uncomfortable and I wish they would just let me know beforehand."

15 people said they found the constant changes in care staff, particularly at weekends difficult. They said they found it frustrating because the office didn't inform them of the change, so they expected someone else only to find a completely new staff member had been sent. Although people told us they were happy with the hands on care given, they said they had to instruct new staff how to provide the care, and in one person's experience this could be "Demeaning having to explain to someone how I like to be washed." A second person said, "I have some carers I haven't seen before, I'm not happy with that, some of them need telling and it can be embarrassing". A relative told us "I get so fed up reiterating the same instructions repeatedly, and they are so often fitting the visit in so never have a chance to look at the care plan".

The lack of person centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people had a copy of the complaints procedure within their care plans which contained details of who to contact if they were unhappy about the care provided. We found the experiences of people who had made a complaint were varied." A relative told us that they had complained on numerous occasions about the level of missed calls but they had "given up because nothing ever changed or improved." Whereas another person told us that they had made a complaint which they felt had been appropriately responded to.

A total of 20 people told us that the office was a source of consternation. People cited a lack of communication, rudeness, lack of planning and aggressiveness as negative experiences they had received from the office staff. For example, one person was quite clear that they would never contact the office staff to complain after raising a complaint two months ago. They told us that when they spoke to the office staff the response was, "Off hand, aggressive and unprofessional to say the least, I will never call them again." Another person told us that, "The office make you feel like a burden."

Inadequate

Is the service responsive?

Care staff confirmed that there were issues with the office and management of the service." One person said ". All of my clients moan about the company the office staff never listened and don't care".

The lack of an appropriate response to complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People told us repeatedly that communication was poor with Comfort Call. They told us that they were not encouraged to provide feedback, and were not listened to. One person told us, "The organisation is terrible, the care staff are really good but the care organisation is very bad." We found during the course of our inspection that the provider's management and monitoring systems had not ensured that people received the care they needed when they needed it.

Another person described the organisation as "Organised chaos" and another told us "I wouldn't recommend them for all the tea in china". We found that the general consensus from people we spoke to and their relatives was that it was difficult and problematic to get information from the office when staff were late or did not arrive. They told us that they often had trouble getting through to anyone on the phone and on occasions staff were rude and abrupt with them which deterred them from having any further contact.

One person told us "I can never get through to the office, we are left on hold for ages and then the phone goes dead." Staff reiterated these concerns, one staff member explained "People often don't get their visits, or they are often missed or late. The office staff are very inefficient, nothing ever gets sorted, they never get back to you". Another staff member told us "The office simply can't cope, it's chaotic…We don't get rotas until very late, which causes missed and late calls. ". This feedback we received during the inspection demonstrated a disconnection between office staff, the management of the service and how expectations of staff were not being managed effectively. The results of this were people who were being supported by the service not getting a good standard of care which met their needs.

Staff told us morale was low. One staff member told us they were frightened to ask any questions, as staff in the office did not have time for them, because they were too busy. The person told us they did not feel important or valued, and never got any thanks or praise.

Prior to our inspection we requested information about people experiencing missed or late calls. This was because we had received information that suggested people did not receive their calls when required. However we experienced significant delays in receiving this information. For example on the 15 September we requested a record of all missed visits for September. However we did not receive this information until the 3 November 2015. Senior staff were unable to explain why there was such a delay in providing this information as they had told us that the 'monitoring system' provided detailed reports.

There were further discrepancies regarding how many missed visits were recorded in October. We were informed on the 3 November by the regional director that the total number of missed visits was four. However information received from other sources including Hertfordshire County Council and directly from people using the service stated that the total number of missed visits was higher than this. This demonstrated that the true total of missed visits were not known and that the provider's system for monitoring and responding to missed or late calls was not effective. Without appropriate systems to identify missed calls the provider was unable to take the necessary action to make sure people received their care. We found that information and updates requested from the provider contained retrospective information and were not assured that the provider was aware of what was happening until the window of opportunity to address the issues had passed.

During our inspection the regional manager told us they had staffing shortfalls and how these were exacerbated by the recent transfer of another service without any additional staff. The provider had taken action to mitigate some of this shortfall, however some rotas were not planned or produced in advance so people did not know who was providing their care.

This was demonstrated by the difference in the data from the provider and the feedback we received from people using the service. This lack of effective monitoring placed people at serious risk of harm.

There was limited information on how the organisation obtained the views of the people who used the service. None of the people we spoke with were able to confirm if they had been consulted or sent a satisfaction questionnaire about the service they received. This showed a lack of commitment by management to obtain feedback to enable them to put actions in place to improve the standards of care and improvements across all aspects of the service.

Inadequate

Is the service well-led?

We were informed that the provider transferred 157 care workers from 2 previous employers in April 2015, 64 staff in August 2015, and a further 63 staff in September 2015. We found that there were gaps in the recruitment records of people employed by Comfort Call which placed people at risk of harm from staff who had not been recruited in line with the providers recruitment and selection policy. This included a lack of disclosure and barring checks for people, inadequate references in place for care staff and staff files that contained the paperwork from three separate domiciliary care agencies and previous employers.

We looked at 4 files of staff recruited directly by Comfort Call, all of these staff files contained the required pre-employment recruitment checks.

During our inspection we requested a comprehensive training record for all staff on the 27 October 2015. This information was not sent to us until 9 November 2015 and showed staff as not having training in key areas relating the support they were providing.

We found that evidence of training was missing from these files, as information had not been provided by their former employers. However there was not a comprehensive training record/plan in place at the time of the inspection that confirmed which staff had received the necessary training.

Medication training had not been provided to all staff who supervised people taking their medicines, first aid and moving and handling.

We saw limited information within the care plans to show seniors or field care supervisors had completed regular 'checks to ensure that people were being cared for in line with their plan of care.

This lack of robust monitoring meant that issues of missed and late visits were not picked up and addressed in a timely way, and the poor practice continued.

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