Comfort Call Limited

Comfort Call (Liverpool- Latham Court)

Inspection report

Latham Court
Bridgemere Close
Liverpool
L7 0LS

Tel: 01512542161
Website: www.comfortcall.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This focused inspection took place on 2 December 2016 and was announced.

A previous inspection had taken place in October 2016, and breaches of the health and social care act 2008 were found which meant that some of the people living at Latham Court were at risk of harm. The service was rated as 'inadequate' and placed into special measures.

We asked the provider to take action following our inspection. The provider sent us an action plan following the inspection setting out what improvements needed to be made. Furthermore, we requested that the provider updated us weekly of any incidents or accidents at the service.

This inspection was to check that the provider's action plan had been implemented and to review their evidence. This inspection only looks at the serious concerns we found on our inspection in October 2016 and whether the provider had completed the actions required to ensure these breaches were met. This means we have only looked at four out of the five inspection domains, whether the service is 'safe' 'effective' 'responsive' and 'well-led.'

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Latham Court' on our website at www.cqc.org.uk.

The service was an Extra Care Living Scheme. A housing association held the tenancy agreements with the people who lived there, some of whom were being provided with care by Comfort Call Limited. At the time of our inspection there were 33 people receiving care packages from the service. There was one staff member present at night time and an alarm system in place for people to raise the alarm if they needed emergency assistance.

There was a registered manager in place at the time of the inspection. 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. Since the inspection we had been informed they have left their position.

During our inspection in October, we found concerns regarding the safeguarding of some of the vulnerable people who lived at the scheme. We found that some people were at risk of self-neglect and this was not always documented appropriately by the staff on shift. The provider was in breach of regulations associated to this. We asked the provider to send us an action plan detailing the action they were going to take The provider had detailed in their action plan what action they had taken to address these concerns, which we checked during this inspection. We saw during this inspection that new paperwork and risk assessments had been introduced for the people identified as being at risk, and the provider showed us how they had adopted this approach into their documentation for the future. We saw that adequate steps had been taken

to ensure staff complete records appropriately, and all incidents had been reported as requested. The provider had adhered to their action plan and were no longer in breach of regulation.

During our inspection in October we found that incidents and accidents were not always being recorded appropriately by staff and analysed by the registered manager, which meant that this information was not able to be analysed for any emerging patterns or trends. We asked the provider to send us an action plan detailing the action they were going to take The provider had detailed in their action plan the action they were going to take and we checked this as part of this inspection. We saw during this inspection that the provider had re-evaluated their approach to incident reporting. We had been updated regarding any recent incidents and accidents at the service, and saw the provider had taken the correct action. The provider had adhered to their action plan.

We found during our last inspection that risk assessments were not always being reviewed. We identified the provider was in breach of regulation associated to this. We asked the provider to take action this to ensure that all risk assessments were reviewed in a timely manner, and in accordance with any changing needs that the person had. We asked the provider to send us an action plan detailing the action they were going to take. The provider had detailed in their action plan the action they had taken and we checked this during this inspection and found that people's risk assessments had been reviewed and re-written to encompass any changing need. The provider had adhered to their action plan and were no longer in breach of this regulation.

We found during our inspection in October 2016 that the service was not always applying the principles of the Mental Capacity Act 2005, (MCA). We identified the service was in breach of regulation associated to this. We asked the provider to provide us with an action plan of how they were going to ensure the principles of the MCA were applied to people living at scheme who lacked capacity to make their own decisions. We saw during this inspection that the provider had addressed capacity and consent with everyone living at the scheme and had devised new paperwork in each person's care plan to determine what decisions people could make for themselves, and where best interests decisions would have to be applied, specifically with regards to medical conditions and potential safeguarding concerns. We found some inconsistencies in one of the care plans we viewed, which we highlighted to the registered manager, and they addressed this straight away. The provider had adhered to their action plan, and they were no longer in breach of this regulation.

We found during our inspection in October 2016 that there was not always detailed information in people's care files concerning their backgrounds, personal care needs and choices. We identified that the provider was in breach of regulation associated to this. We asked the provider to send us an action plan detailing the action they were going to take. The provider's action plan detailed the action they had taken to address this, and we checked it as part of this inspection. We saw that the provider had taken action the address the issues that we found, and care plans contained more person centred information, such as people's likes, dislikes and their backgrounds. We also saw that the provider had included in people's care plans whether they wished to be supported by a male or female carer. We found during our inspection in October people were not always given this choice. The provider had adhered to their action plan and they were no longer in breach.

We found during our last inspection in October 2016, staff did not always have the correct skills and knowledge to support to support people around their mental capacity, best interests and safeguarding. We identified a breach of regulation associated to this. We asked the provider to send us an action plan detailing what action they were going to take. The provider's action plan described the action they had taken between October 2016 and this inspection, and we checked this as part of this inspection. We found

that the provider had adhered to their action plan and staff had completed 'themed' training and supervision with particular emphasis on the Mental Capacity Act 2005 and safeguarding.

During our last inspection in October 2016 we raised some concerns regarding the management structure at Latham court as the registered manager was not always on site, and we were concerned that the scheme manager was not adequately supported and did not have a good enough oversight of the scheme. We identified a breach of regulation associated to this. We asked the provider to send us an action plan detailing the action they were going to take. The provider discussed a new management structure with us during this inspection, which included a new management post created specifically to support the scheme manager.

The service was managed day to day by a scheme manager and a registered manager who was responsible for undertaking supervisions with staff, overseeing the care delivery and reporting to an Area Manager. The provider had adhered to their action plan and were no longer in breach of this regulation.

The rating for the service was no longer inadequate. This was because the provider adhered to the action plan in respect of the serious concerns identified at the last inspection. We will review the rating for the service in full at the next comprehensive inspection.

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

The service was safer than what we found at the last inspection.

The rating for this domain was no longer inadequate. This was because the provider adhered to the action plan in respect of the serious concerns identified at the last inspection. We will review this domain in full at the next comprehensive inspection.

Staff were able to explain the action they would take if they felt someone was being harmed or abused in any way.

Risk assessments were in place and had been updated to include relevant and up to date information about the people who lived at Latham Court.

Incidents and accidents were being appropriately documented and analysed for any patterns or trends.

Is the service effective?

Requires Improvement

The service was more effective than what we found at the last inspection.

The rating for this domain was no longer inadequate. This was because the provider adhered to the action plan in respect of the serious concerns identified at the last inspection. We will review this domain in full at the next comprehensive inspection

The principles of the Mental Capacity Act had been referenced in people's care plans when appropriate, including any decisions requiring a best interest process to be followed.

Staff had been re-trained in topics such as safeguarding and the MCA.

Supervisions were taking place and were themed to include additional learning the staff had recently undertaken.

Is the service responsive?

Requires Improvement

The service was more responsive than what we found at the last inspection.

The rating for this domain was no longer inadequate. This was because the provider adhered to the action plan in respect of the serious concerns identified at the last inspection. We will review this domain in full at the next comprehensive inspection.

There was information recorded in each person's care plan which included their backgrounds, likes, dislikes, preferred gender of staff member and call times.

Is the service well-led?

Requires Improvement

The service was more well-led than what we found at our last inspection.

The rating for this domain was no longer inadequate. This was because the provider adhered to the action plan in respect of the serious concerns identified at the last inspection. We will review this domain in full at the next comprehensive inspection.

The provider had a registered manager in post at the time of inspection that was responsible for the day to day running of the home and was at the service for two and half days each week. There was other management cover between Monday to Friday, and on all arrangements in place at the weekend. Since the inspection we have been made aware that the registered manager had left their post.

Comfort Call (Liverpool- Latham 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.'

This inspection took place on 2 December 2016 and was announced.

The provider was given 48 hours' notice because the location provides a domiciliary care service we needed to be sure that someone would be in.

The inspection team consisted of two adult social care inspectors.

During the inspection, we spoke with the registered manager, the area manager, the quality manager, three support staff, and two people who lived at Latham court.

We looked at four people's care plans and associated documentation, staff training records, supervision records, the incident and accident log and the management structure of the service.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in October 2016, we were concerned because the provider did not have robust procedures in place to ensure people were appropriately safeguarded from harm and abuse. This was because staff were not always taking action when concerns were raised and reporting them appropriately. We identified a breach of regulation. Following our inspection the provider sent us an action plan at our request detailing the action they were going to take to address our concerns. We checked this as part of this inspection.

We saw that staff had undergone a training session around safeguarding which included a learning work book and case study. We asked staff about this training and if they felt it had helped their knowledge of this subject. One staff member said, "Yes, I feel like I know what to look out for now."

We saw that one person who lived at Latham Court was at risk of self-neglect. We were concerned at our last inspection in September as there was no specific strategy for the staff to follow if this person refused to engage in personal care, and they were being left without any intervention for a length of time. We saw during this inspection that the same person had an agreed strategy in place which included the number of days the staff would be able to leave the person before contacting other services for support.

We saw another example of where the provider had updated one person's strategy plans to ensure they were protected against the risk of abuse. This included a strategy of when to call the police and how the staff should record and report the incident. This meant that the provider had taken steps to ensure vulnerable people were safeguarded from abuse. The provider was doing what was stated in their action plan and the breach had been met.

During our inspection in October 2016 we found that the service did not have appropriate records relating to incidents and accidents some documentation was either incomplete or missing. This meant that accidents could not be effectively analysed for any emerging patterns or trends. We told the provider to take action and they sent us an action plan at our request which we checked as part of this inspection.

We saw that the provider had a process in place which analysed the accident, which now included 'Action taken,' this was then checked and signed and entered on to electronic database for analysis. The examples we saw were incidents which had occurred in November 2016. This shows the provider has taken a more robust approach in incident reporting and was doing what they stated in their action plan.

During our last inspection in October 2016. We were concerned because risks assessments were not always updated and did not always contain enough detailed information to keep people safe. We identified a breach of regulation. We told the provider to take action and they sent us an action plan at our request detailing what they had taken to address this, and we checked this during this inspection.

We saw that risk assessments had recently been reviewed and important information such as people's mental health and emotional well-being were documented along with risk plans informing the staff of the

action they should take if people became unwell. We saw that monthly reviews of people's risk assessments were taking place and this was checked as part of the service's quality assurance procedures. We saw that one person had recently been admitted to hospital however they were due to return to Latham court. We saw that their risk assessment had been updated in include this information. The provider had adhered to their action plan and the breach had been met.

The rating for this domain was no longer inadequate. This was because the provider adhered to the action plan in respect of the serious concerns identified at the last inspection. We will review this domain in full at the next comprehensive inspection.

Requires Improvement

Is the service effective?

Our findings

During our inspection in October 2016, we were concerned because did not have the knowledge and skills surrounding subjects such as the MCA and safeguarding. This was because staff were not always taking appropriate action in people's best interests or identifying when people might be at risk of harm. Following our inspection the provider sent us an action plan at our request detailing the action they were going to take to address our concerns and when the actions would be implemented in the service.

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 supported 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw during this inspection care plans had been reviewed and the principles of the MCA were being incorporated into people's plan of care. People had signed consent agreements consenting for their records to be shared only after their individual capacity to understand this decision had been assessed. We saw where people lacked capacity or had 'fluctuating' capacity additional protocols were out in place. For example, one person who was assessed as having fluctuating capacity had two separate care plans for staff to follow, which had been completed following a best interest process to keep that person safe from harm.

Another person who was at risk of self-neglect had a best interest decision in place which they had agreed to. The decision instructed the staff what action to take in their 'best interests' if the person continued to self-neglect over a specified time period. The provider had adhered to their action plan and the breach had been met.

We saw during this inspection that staff training had been completed around the principles of the Mental Capacity Act and safeguarding adults which included reading a case study and responding to the case study with action they would take, we also saw that staff completed a competency assessment as part of this training. When we spoke to staff they were able to tell us what the principles of the MCA were, one staff member said, "I would never just assume someone did not have capacity." Someone else said, "It's okay for people to make an unwise decision." Staff explained their training in safeguarding and said this had helped them to understand their role better.

Staff confirmed they undertook 'themed' supervisions, which focused on specific topics, for example safeguarding and the MCA. We asked the staff if they felt these supervisions helped in their everyday roles. One staff member said, "I think so, because it's easy to forget bits, but the supervisions are a way of refreshing us." We did not look at the content of anyone's supervision, however, we saw a supervision matrix which confirmed all staff had completed a themed supervision in the last four weeks, and we saw the topics

discussed as part of staff supervisions. This information confirmed the provider had adhered to their action plan and the breach had been met.

The rating for this domain was no longer inadequate. This was because the provider adhered to the action plan in respect of the serious concerns identified at the last inspection. We will review this domain in full at the next comprehensive inspection.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection in October 2016 we were concerned because information contained in people's care plans was not personalised and did not provide relevant information about people and their preferences for receiving care such as call times and gender of care worker. We identified a breach of regulation in respect of person centred care. Following this inspection the provider sent us an action plan at our request detailing how they were going to respond to our concerns. We checked this as part of this inspection.

We saw that information in people's care plans had been reviewed and updated to reflect people's personal preferences concerning gender of care worker, and preferred call times. Due to the setup of Latham Court some people did not have time-specific calls, however they had preferences for when they wanted staff to support them and this was documented in their care plans. For example, we saw information recorded in one person's care plan that they opened their curtains when they wanted to staff to support them as this meant they were awake. We saw other person centred information documented in people's care plans regarding how the person liked to spoken to and what their preferred name was, and who they liked supporting them. One person we spoke with said, "The call times are not an issues, the staff come, I know them, its fine." This information confirmed the provider had adhered to their action plan.

The rating for this domain was no longer inadequate. This was because the provider adhered to the action plan in respect of the serious concerns identified at the last inspection. We will review this domain in full at the next comprehensive inspection.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection in October 2016 we were concerned about the overall day to day management of the service. This was because the registered manager of Latham court at time of this inspection was based in another service for some of their time, and the scheme manager who had day to day oversight had not been in post for very long. They relied upon staff working at the service for information and oversight which meant that they could not provide the oversight required themselves. We identified a breach of regulation in respect of good governance. We asked the provider to take action and following our inspection they sent us an action plan at our request detailing what action they were going to take to ensure that the management model of the service was effective. Following our last inspection in October 2016, we had requested that the Care Quality Commission was to be updated weekly of any incidents or accidents that had taken place at the service as we were concerned following the inspection in October inspection that there was not enough management oversight and risks were not being effectively reported and monitored. We had received all weekly updates as required.

During this inspection we met with the registered manager, area manager, scheme manager and quality manager who showed us what plans they had in place to ensure management systems were robust. We saw that since our last inspection another senior manager had been recruited to be at Latham Court five days per week to provide support and oversight to the registered manager and the scheme manager. We also saw that the regional manager had been spending one day per week at the service for additional support, and this was going to continue. There was also a team leader would was contracted to spend five days per week at the service. There was an on call system in place at the weekend which was coordinated by a senior manager.

Staff we spoke with were complementary about the registered manager and people who lived at the scheme knew who the registered manager was. One staff member said "They [registered manager] are approachable, nothing is too much trouble." The provider had adhered to their action plan and the breach had been met.

Since the inspection the registered manager for the service had left their position.

The rating for this domain was no longer inadequate. This was because the provider adhered to the action plan in respect of the serious concerns identified at the last inspection. We will review this domain in full at the next comprehensive inspection.