Care In Comfort Ltd

Care In Comfort

Inspection report

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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 caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an announced inspection of this service on 5 May 2017.

The service had two registered managers in post, who were also the provider. 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.

During this inspection we identified areas that required improvements to ensure people received care that was safe, effective, responsive and well-led. We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The service is registered to provide personal to people in their own homes. At the time of our inspection 22 people were using the service.

People's care records were not always updated to ensure that staff had enough guidance and instruction to provide for their current care needs. Although staff knew people they cared for, there was a risk to people's health, safety and well-being as their care was not being effectively reviewed and updated.

There was a lack of systems in place to ensure the safe administration of medicines.

People could not be assured they were receiving care from staff that had the training and supervision to carry out their roles. The provider did not adequately monitor staff training. There were no staff supervisions or appraisals and staff competency was not being checked to monitor the quality care being delivered.

The registered manager did not understand the requirements of the Mental Capacity Act 2005 (MCA) and staff did not always understand what was meant by mental capacity, despite some people using the service having conditions which may have affected their mental capacity. We have made a recommendation to the provider about the MCA.

People were not protected by safe recruitment practices; staff were not being safely recruited and some staff did not have the required recruitment checks in place.

There was a lack of effective quality monitoring in place at the service which meant that people's care was not being monitored on an on-going basis. There was a lack of oversight by the provider to ensure that people's care was being delivered safely and effectively by staff who were adequately trained to do so.

People received their care calls as scheduled and there were sufficient numbers of staff working at the

service.

People were treated with respect and staff were able to describe how they delivered care to meet people's individual needs. People's health and well-being was monitored and recorded by staff delivering care to people.

Staff were kind and caring towards people they supported and delivered care to ensure people's privacy and maintain their dignity.

Incidents and accidents were monitored and recorded at the service and had been reported to the relevant agencies as required by law.

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 not always safe.

Risk assessments did not always reflect people's current needs as they were not regularly reviewed or updated when people's needs changed.

Improvements were needed in relation to the management of medicines.

Safe recruitment practices were not in place.

Staff had not received training and guidance in their roles and responsibilities in relation to safeguarding people against the risk of abuse.

Staffing levels ensured that people received their care at the planned times.

People felt safe with the staff who looked after them and described having positive relationships with the care workers who delivered their care.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not receive care form staff that had the skills, knowledge and support to provide for their care needs.

Staff told us that they did not always feel supported and there was a lack of systems to ensure staff were supported and that their training and competence was monitored and up-dated as needed.

There were no mental capacity assessments carried out at the service and the provider lacked an understanding of the requirements in relation to the Mental Capacity Act (MCA).

Consent to care was obtained where people were able to give it.

People's well-being was monitored and referrals made to health

professional as and when needed.

Is the service caring?

Good

The service was caring.

People told us that the staff who cared for them were kind and compassionate and staff knew people's likes and dislikes in relation to the delivery of their care.

People's privacy and dignity was maintained at the service.

Care was not rushed and staff had time to spend with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not contain up-to-date guidance for staff to follow to ensure their current care needs were met.

People were involved in their care planning and their preferences respected.

People were able to express their views about how the service was delivered to them.

There was a policy in place to assist people to make a complaint and concerns and issued were addressed at the service.

Is the service well-led?

Requires Improvement

The service was not being well-led.

Some of the staff we spoke with did not feel supported by the provider and there were not effective systems in place to monitor staff competence and the quality of care being delivered by staff.

Staff training was not being monitored.

There were not effective systems in place to ensure people received their care safely.

Checks were carried out to obtain people's views about their care.

The relevant agencies were notified of incidents as required by law.	

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 May 2017. The inspection was announced and was undertaken by one inspector. We gave 48 hours' notice of the inspection as we needed to be sure that the relevant people would be available.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with three people who used the service and three relatives of people who used the service. We also spoke with four care staff and the two registered managers, who were also the provider. We also looked at care records relating to four people who used the service at the time of this inspection. We looked at four records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

People received care from staff who were not always given enough information about risks associated with the delivery of people's care. People using the service had a plan of care in place and some people had risk assessments to outline any identified risks associated with the delivery of their care. We reviewed these documents to ensure that they contained enough current information to keep people safe. We found that several of the records we looked at had not been reviewed for some time and when we discussed the current picture of people's care with the provider, we found that some of the information was not up-to-date. For example, we looked at two people who were at a high risk of falls. However, there was no risk assessment in place to guide staff on how to minimise this risk in order to keep these people safe. When we raised this with the provider they told us that this had not been done and that they would implement these following our inspection.

One staff member we spoke with raised the issue of some of the documentation being out of date and in need of updating. When we asked about the care plan and risk assessments in place, they told us, "I think they could be updated more regularly." Two of the staff we spoke with felt that the way in which care was planned at the service could be improved upon. We also found this to be the case.

Staff had not received any training in the management of medicines from the provider. Although some staff relied on training they had received from previous employment, the provider had not taken any steps to provide the necessary training or check staff competencies in the safe management of medicines. However, when we checked whether people received their prescribed medicines they told us that they did. At the time of our inspection nobody raised concerns about not getting their prescribed medicines and the records we looked at indicated that people did receive their medicines as prescribed

People could not be assured that appropriate recruitment practices were in place; not all staff had all their checks made to establish they were of a suitable character to provide people with care and support. Records showed that one member of staff did not have any written references, documents confirming their identity or a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We brought this to the attention of the provider who told us they would take immediate action to obtain the relevant checks.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

People were not always supported by staff that knew how to recognise when people were at risk of harm. Although staff we spoke with knew what action they should take to keep people safe, not all staff had received safeguarding training to enable them to have the knowledge to recognise abuse and report to appropriate authorities. Allegations of abuse were reported and investigated appropriately by the provider. However, the provider had not taken adequate steps to protect people from the risk of abuse due to the lack of staff training in this area.

There were sufficient staff working at the service and nobody expressed concerns about calls being missed or late. Rotas were planned to ensure that people received their care at the planned times and for their time allocated. One person using the service told us, "She [care staff] never hurries me. She does all she can." People received care for staff that knew them as rotas had been planned to provide consistency of care. The relative of someone using the service told us, "They've been very reliable with timing."

People we spoke with told us that they felt safe with the care staff who delivered their care. Nobody raised any concerns about the conduct of the staff and everyone we spoke with described having positive relationships with the carers who looked after them. One person using the service told us, "They're very good." The relative of someone who used the service said, "They're a really lovely bunch of ladies." Nobody we spoke with expressed any concerns about people's safety and none of the people we spoke with had raised any concerns about the care being delivered.

The provider ensured that information required by emergency services was readily available for all people who used the service. We saw that people had "emergency grab sheets" in place to assist if they should be admitted to hospital in an emergency. These detailed what medicines people were on and any allergies and any medical conditions.

The provider recorded and reported incidents and accidents that had occurred and took the necessary action to rectify any issues.

Requires Improvement

Is the service effective?

Our findings

People could not be assured they received care from staff that had received training to meet their needs. Staff training was not being delivered or monitored to ensure that staff were adequately trained and skilled to deliver care to people. Some of the people using the service had complex care and medication needs and required staff to be trained and skilled in delivering the kind of care they needed. There was no training delivered to staff on the safe administration of medicines and some staff were giving people their medicines as part of their agreed plan of care.

The provider did not have a system in place to monitor staff training and so could not tell us which staff had received what training. When we spoke with staff, several of them told us they had received training in relation to catheter care, but told us they had not received any training in relation to safeguarding or the Mental Capacity Act 2005 (MCA). Some people using the service had conditions which may have affected their mental capacity and yet staff had not been trained in this area of care.

We found that staff competence was not being monitored to ensure the quality of care being delivered but also to ensure that staff were supported in their roles. It was not clear how training needs were identified in the absence of any staff spot checks or supervisions. Staff told us that they were experienced carers but there was no evidence of how the provider was assuring themselves of this. Some of the staff came to the service with training from former roles, however, the provider was not delivering training to meet the needs of people using the service on an on-going basis.

There were no processes in place to ensure that staff were supported on an on-going basis and no systems to monitor staff competence in order to assess whether care was being delivered effectively.

The above evidence indicates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We looked at the care records for people using the service to assess whether the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) as some people using the service had a diagnosis of dementia and may have lacked the capacity to make decisions in relation to their care. The MCA provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

We found the provider was unclear about the principles of the MCA and their obligations as care providers. Staff had not been trained in this area of care and were also unclear about the principles. The MCA has not been considered in people's care planning and delivering. Some of the people using the service may have lacked the capacity to make decisions in relation to their care and this had not been considered by the service. The provider told us that they would look into this following our inspection. We recommend that the provider familiarises themselves with the Mental Capacity Act 2005 Code of Practice.

People's consent to their plan of care was obtained and documented in their care records and we saw from daily care notes that people were offered choices and that their wishes were respected.

We found that referrals were made to health professionals when needed and that people's health was monitored by the service. Daily records made by staff detailed people's well-being and took action if there were any concerns.

Good

Is the service caring?

Our findings

People who used the service described being cared for by staff who were kind and compassionate. Everyone we spoke with described having positive relationships with the care staff who looked after them. One person told us, "They're lovely people. I'm quite happy."

Relatives we spoke with were equally positive about the care delivered to their relatives by staff working at the service. One relative said, "They are very kind. I don't think there are any concerns." Another relative told us "I can't fault them. They have been really good."

Staff and the provider were able to describe the people they cared for and knew them well. People's likes and dislikes were detailed in their care plans to some extent but staff took the time to get to know the people they were delivering care to. For example, the provider was able to tell us how staff had supported a family member during the time that the person using the service was approaching the end of their life. They were able to describe a compassionate and caring approach by the staff involved with this person's care and how they had been able to support them and their family member at a difficult time.

We saw evidence that people had been complimentary about the care they had received by reviewing some of the feedback provided by people who used the service and their families. This feedback indicated a kind and caring approach to the care they were delivering.

People's privacy and dignity was maintained; staff described how they ensured people were respected. For example, by considering people's domestic arrangements and ensuring that they were able to maintain their independence where possible.

The provider demonstrated a caring approach to people and respected their wishes. Calls were planned to ensure that people and staff had enough time and that care was not rushed. People had a consistency of care workers delivering their care and this enabled people to develop meaningful relationships with the care staff coming into their homes. People knew how to contact the office should they need to and any issues or concerns raised were addressed by the provider. People and their relatives were able to express their views about how the service was run.

Requires Improvement

Is the service responsive?

Our findings

People's care records did not reflect people's current care needs as people's care plans were not regularly reviewed or updated when people's needs changed. Staff did not have access to instructions on how to mitigate people's current risks. Although the staff we spoke with knew people's needs, likes and dislikes as they provided care to them regularly, there was a risk that staff were carrying out care that did not meet people's current needs. Staff that did not know people well did not have enough instruction or guidance to provide care to meet people's needs. For example, two people who were at high risk of falls did not have an up-to-date risk assessment in place to inform staff on how to mitigate this risk. We brought this to the attention of the provider; they told us there was further work needed in relation to updating the paperwork.

People were assessed before they received care to determine if the service could meet their needs. Care records when people began using the service clearly indicated that people's needs and preferences had been taken into account and care planning was individualised. However, changes to people's care needs and preferences were not reviewed on an on-going basis to ensure staff knew people's current needs and could respond accordingly.

People who used the service and their relatives were involved in planning their care. During assessments discussions took place about how people wanted to receive their care, for example their meal preferences, how they spent their time and how independent they wanted to be. People described being asked how they were through telephone contact with them and we saw that reviews of care were undertaken which involved asking people how they were finding their support.

People received care in line with their personal preferences. Staff described how they supported one person who liked being taken out on walks, which staff told us they did whenever they could. The person's relative told us their relative was regularly taken out into the community by staff working at the service. They told us, "They seem to know the area and take her to the park." People were able to specify how their care was delivered to them and this was taken into consideration by the provider.

People felt confident that they could raise their concerns or make complaints to any member of staff. People and their relatives were given information about how to make a complaint and there was a complaints policy and procedure in place. The provider told us that they had not received any complaints in the last 12 months. One relative told us they had raised an issue informally with the provider about their relative's care and that this had been addressed in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

There were a number of areas of concern identified during our inspection that the provider told us they had been aware of and that other agencies had identified as areas for improvement when they had looked at how the service was being run. These improvements had not been made at the time of our inspection and the provider attributed this lack of action to them not having the time to make the changes needed. For example, some of the care records and risk assessments did not contain current information and although the service was in regular contact with people using it, they had not updated people's care records to ensure people were kept safe.

There was a lack of staffing training and competency checks for staff administering medication to people. The provider had not always monitored people's medicines records to ensure they had been provided with their medicines as prescribed; we saw that one person who started using the service in March 2017 had not had their medicines records checked since they commenced. People were at risk of not receiving their medicines safely as the provider failed to oversee the management of medicines or ensure that staff had the knowledge, skills and competencies to administer the medicines.

Some of the staff we spoke with described, at times, feeling unsupported by the provider and stated that they felt that they could not contact the office. One staff member said, "A lot of the good carers have left because they haven't felt supported. You don't feel you can ring up." Another staff member told us, "They could be a bit more supportive." These staff described the providers, who were also the registered managers, being unavailable at times.

Staff described receiving an induction when they started at the service and undertook a period of shadowing prior to starting work with an experienced member of care staff. However, there were no supervision records for us to review as we were told by the provider that these were not carried out.

Staff felt that the care being delivered to people was good, however, three of the four staff we spoke with commented on the lack of robust quality monitoring systems in place at the service. One staff member told us, "I've felt a little bit let down by them to be honest." They went on to say, "I think they like to do everything themselves but they don't do it." Another staff member said, "I do think there are things that could be tidied up."

The provider was unable to show us how they monitored staff recruitment and training records and there was no system in place to ensure that staff had the required training to deliver safe care. We found gaps in staff training in relation to safeguarding and the Mental Capacity Act 2005 (MCA). As people using the service may have been vulnerable to the risk of abuse and some of the people may have lacked the mental capacity to consent to the plan of care, these were key areas of staff training. We also found a lack of staff competency checks in relation to how they delivered care to people in their own homes. There was no system in place to monitor staff performance and this was a gap in the quality monitoring systems at the service.

There were no systems in place to support staff and obtain staff feedback. Two of the staff we spoke with told us that they sometimes felt as though they could not approach the office due to the provider being too busy. There were not adequate systems in place to enable staff to be supported and to feel part of the organisation. One staff member said, "I've always felt like I can't ring up." Other staff members expressed concerns about the availability of the management of the service, who were also the provider.

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

People who used the service were contacted regularly by the provider to establish whether they were happy with the care they were receiving and checks were carried out on the daily care notes made by staff.

There were two registered managers in post, who were also the provider, who understood their responsibilities which included notifying the commission of incidents or changes to the service which are required to be notified by law.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate systems and processes in place to assess, monitor and improve the quality of the service. (17 2a)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not follow effective recruitment procedures that would ensure that persons employed were of good character. (19 1a and b and 2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that staff received the training and supervision they required to carry out their roles (18 1a)