Care Quality Commission

Comfort Call Limited

Comfort Call- Leeds

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Comfort Call - Leeds is a domiciliary care agency and provides care and support to people living in their own homes. Not everyone who used the service received personal care. The Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. Comfort Call had expanded in 2020 by taking over another domiciliary care agency. The service was supporting 320 people with the regulated activity 'personal care'.

People's experience of using this service and what we found
Risks to people's care were not always fully assessed, planned for or documented. Electronic care plans lacked detailed in relation to specific areas of people's care and needs. Records contained pre-populated information, which was not accurate or person-centred. This meant staff who did not know people well had limited information to guide them.

People told us there were areas of their support that needed to improve. These included shortened call times, not always knowing what time and who would be providing their care and some concerns about staff moving and handling practices. The quality assurance phone calls made by staff had not identified this which meant the provider was unaware of their concerns.

The provider had a good electronic system in place to enable remote monitoring of all aspects of the service provided. The most recent audit showed the service was working well and had achieved a high score in terms of quality. The interrogation of information was failing to identify the need to improve areas of care such as risk assessment and care planning.

People and their relatives shared positive feedback about their regular staff being person centred in their approach, as they had built up a relationship with them and knew them well.

People were protected from the risk of infection and plans were in place to mitigate the increased risks from the current Covid-19 pandemic. Staff followed best practice in terms of infection control procedures. Staff were provided with personal protective equipment (PPE) and people told us they wore this when providing care.

Staff were trained in the administration of medicines and had their competency assessed following training. The provider used an electronic medication administration record and monitored staff practice in relation to administering people's medicines.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was Good (published 10 July 2019)

Why we inspected
CQC had received concerns in relation to late and short calls. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. We found breaches in safe care and treatment although there was no evidence during this inspection that people had been harmed from this concern. Please see the safe and well-led sections of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Comfort Call- Leeds

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using a service or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. The inspection activity started on 3 November and ended on 3 December 2020. We visited the office location on 19 November 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We contacted Healthwatch to see if they had received feedback about the service and they shared the information they had received. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with 18 people who used the service and 14 relatives about their experience of the care provided. We spoke with 19 members of staff including the registered manager, regional manager, and support workers.

We reviewed a range of records. This included nine care records and multiple medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
● Risks to people had not always been assessed or planned to ensure they received care safely. Where risk assessments were in place, these did not always contain accurate or up to date information.
● We reviewed the risk assessment for people requiring equipment to move them safely as this had been a concern raised during our conversations with people. Their risk assessments and care plans did not specifically identify the risks involved and how to minimise them. All the equipment required to move safely was not in place, was often conflicting and did not clearly record the method staff should use to manoeuvre them safely.
● One relative explained their relative had variable mobility and often needed to use a hoist. They said staff were 'lifting their relative manually onto the commode and back'. We reviewed their care records and could see staff had not used the hoist that week. There was no guidance for staff to identify the triggers to look for which would indicate they should use the hoist.
● Where people had identified concerns around the management of pressure area care, the recording of the information needed to improve to give staff clear guidance. Staff needed to accurately record this had been completed.

Due to the lack of accurate records showing how risks were assessed and mitigated, there was a risk people would not receive the care required and they could be harmed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People and relatives told us visits were often late and shorter than the commissioned hours. Our review of records confirmed staff routinely did not stay the commissioned time and some calls were unacceptably short. The registered provider had an electronic system in place which alerted them to how long staff were at the person's home and whether they had logged in or out of the home. The registered manager took action when they identified a pattern amongst staff.
● Some staff had told us prior to the inspection the scheduling of calls was not efficient and did not allow for travel time between visits. The registered manager assured us this was not the case and travel time was allocated to each call.
● People and their relatives spoke highly of their regular, familiar staff. One said "I have three regular carers and it is very rare that they are late. I feel very safe with them and know I can rely on them to help me with anything I need. They are like friends to me now."
● Some relatives we contacted told us some staff did not have the necessary knowledge to care for people with dementia. Relatives told us they were not confident staff had been trained thoroughly to move people

safely, particularly new staff and they were concerned when two new staff provided care at the same call. The registered manager told us that during the pandemic, practical moving and handling training had not been provided in the office and staff were trained at the person's home.
● Staff were recruited safely. Pre-employment checks were carried out to protect people from the employment of unsuitable staff.

Systems and processes to safeguard people from the risk of abuse
● Most people we spoke with told us they were safe with their regular carers and trusted them in their homes. One person said, "I do feel safe with carers though, they take care of my property, I trust them." Another said, "The regular carers are all very good, they do what they are supposed to do."
● Staff had received safeguarding training and were clear about the processes they would follow if they needed to report any safeguarding concerns. The registered manager investigated concerns to ensure people were protected from the risk of abuse.
● Staff we spoke with took pride in their work. One said, "I hope all my clients are happy and all calls are done according with what clients want. We do extra if needed, like shopping, we try to do our best."

Using medicines safely
● Medicines were safely managed. The provider operated an electronic monitoring system to manage medication with real time monitoring by the office. We did note that one person's medicines should be given at a specific time before they ate but this information had not been transferred to the person's care plan to ensure staff gave this to them at the start of the call.
● Staff had completed medicines training and there was a plan in place to ensure their competency was regularly assessed. People told us they received their medicines when they should and did not highlight any concerns.

Preventing and controlling infection
● Systems were in place to prevent and control the spread of infection. Additional measures had been taken to protect staff and people who used the service from the risk of COVID-19.
● Staff had received training in infection prevention, hand hygiene and COVID-19 and were provided with regular updates by the registered manager and provider on their handheld devices. The registered manager provided us with copies of emails sent to care workers throughout the pandemic which covered step by step guidance on what PPE to wear and when and how to wear and dispose of PPE. Staff were provided with links to the government website to ensure they had the most up to date COVID related guidance.
● Staff were provided with personal protective equipment, including face masks, gloves, aprons, and hand sanitiser. Staff collected PPE from the office which operated a one-way system to ensure staff were protected from the risk of transmission. Where it had been identified that there had been breaches in PPE wear, the registered manager had acted swiftly to retrain and where necessary discipline staff to ensure people were kept safe.

Learning lessons when things go wrong
● Accidents, incidents and complaints which had been brought to the attention of the registered manager were investigated thoroughly. These were reviewed electronically by the quality managers within the organisation and we could see they were not closed down until they were satisfied with the actions taken. Analysis of these events was used as a learning opportunity to improve the service.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- This inspection was in part triggered by a number of complaints from staff and people using the service. This included knowing the time staff would arrive, shortness and timing of some calls and inconsistency of staff at each call. Where issues were raised with the registered manager, they acted very promptly to resolve these. A snapshot review of people's care records did confirm these issues were still happening during the week of our onsite inspection. In contrast, a number of people told us they were very happy with the quality of care and particularly care staff who regularly provided their care.
- We checked the call logs for these people who told us their calls were shorter than the commissioned time and they were not happy about this and found their calls were shorter than expected. When we asked the registered manager how they assured themselves in relation to the length of the call they said, "We check the punctuality and call duration also within the quality assurance process. If care workers spend less or more time allocated in a visit, then they are expected to fill out a 'visit variation' feedback and follow up form to the office. This is to explain why the call was shorter or longer than expected." This shows there was a mechanism in place to monitor this, but further action was required to resolve the concerns.
- Some people had raised concerns in relation to staff training and understanding around caring for people with dementia. Some people raised concerns about staff competency in moving them safely. Staff training records showed this training had been included in their induction and was refreshed. Moving and handing risk assessments and care plans were not of good quality to provide a detailed guide for staff to follow.
- Our review of records showed improvements were required in the recording of decision specific mental capacity assessments and how people's best interests were determined. Some people were unaware they had a care plan in place.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager with the support of the provider was managing a service which had been through a takeover, during a pandemic which had presented the service with additional challenges. This inspection confirmed there were areas that needed to improve, but the registered manager was open to promoting a culture that was inclusive and empowering and achieved good outcomes for people. They had numerous staffing issues which required a formal approach and the registered manager was keen to tackle issues to ensure people were supported by staff with the right skills and values.
- The registered manager told us they were well supported by the regional manager and the provider had

good support mechanisms. They said, "It's a very supportive company. They send out a lot of help and guidance."
● The majority of staff spoke highly of the registered manager. One said, "I think they are a good manager. If you have any issues they are dealt with. Very professional." They told us they were approachable and available should they need to raise any concerns. Other staff spoke positively about the support provided by the care coordinators based in the office.
● The provider had systems in place which enabled them to monitor the quality of the service without having a presence at the service. There was a regional manager in post who attended the office each week and was in daily contact with the registered manager
● The electronic record system monitored all aspects of the service they delivered, and this information was captured in a whole service internal quality audit. The service measured 83.5 % in June and 94% in July 2020. This showed the service provided was meeting the provider's targets. As part of this inspection we contacted a random selection of people using the service and their relatives. Some people told us staff did not stay at the service for the allocated time and some people told us they did not receive care from a consistent staff team.
● The electronic record system enabled the office-based staff to monitor which service users were not getting continuity of staff. This currently stood at 84.2 %. The registered manager advised if continuity was not met this was addressed with the coordinator. One person we spoke with had 10 different staff for 14 calls, which they said affected their overall quality of care. One person said, "I do like to have continuity because I think you get better care that way."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their regulatory requirements and had submitted statutory notifications to the CQC, to inform us of important events such as accidents, incidents, and safeguarding concerns.
● Throughout the inspection the registered manager was honest and open with us and any concerns we raised were dealt with extremely promptly. They wanted to ensure all their processes kept people safe and protected them from harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
The provider fully considered the equality characteristic of staff and regularly sent out newsletters and memorandums advising them of services provided such as employee benefits and assistance programme.
● Due to the pandemic, staff meetings and staff supervisions had not taken place face to face. Staff told us communication was good, and most staff told us they had received a recent supervision session.
● An annual survey had been carried out by the provider's head office in 2019. This had not yet been undertaken in 2020. Coordinators contacted people or their relatives every three months to check they were satisfied with the service. The responses showed people were happy with the service. Yet, when we spoke with the same people, they told us about the issues they had with the service. This showed us the way the information was gathered was failing to identify issues to enable the service to improve.

Working in partnership with others
●There was evidence which demonstrated the service worked in partnership with health and local authority partners to ensure people's needs were met in a timely way.

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 12 HSCA RA Regulations 2014 Safe care and treatment 12(2)(a) and (b) Risk assessments relating to the health, safety and welfare of people using services must be completed and reviewed regularly by people with the skills, competence and experience to do so. The lack of accurate records showing how risks were assessed and mitigated, meant there was a risk people would not receive the care required.