

Comfort Call Limited

Comfort Call - Monica Court

Inspection report

Monica Court
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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

Comfort Call Monica Court is an extra care scheme located in Salford, Greater Manchester. Two other extra care schemes form part of the registration called Mount Carmel and Moores House. Extra care schemes operate in purpose-built properties, which provide accessible and safe housing for older people to live independently. Not everyone who used the service received personal care. 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.

People's experience of using this service and what we found

People did not receive their medication safely. Staffing levels had been increased during the night at Monica Court since our last inspection, however some of the feedback we received was that there were not enough night staff at Moores House. The registered manager informed us talks were underway with the local authority to recruit an additional staff member at night.

Auditing and governance systems were in place, however further improvements were required to ensure regulatory breaches identified at the previous inspection were rectified so the service could improve, particularly regarding medication.

People living Monica Court and Moores House and their relatives, told us they felt Monica Court was a safe place to live. Safeguarding allegations were reported to the local authority for further investigation and staff knew how to recognise potential safeguarding concerns. Safe infection control practices were followed and we observed staff wearing correct PPE throughout the day.

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

Rating at last inspection (and update)

The last rating for this service was requires improvement (published February 2021) and the provider was in breach of regulations relating to good governance and staffing. At this inspection, not enough improvement had been made and the provider was still in breach of some regulations.

Why we inspected

We carried out an announced comprehensive inspection of this service in November 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when improve.

The inspection was also prompted in part due to concerns received about medication, people not receiving personal care and management/leadership. The concerns raised were specifically relating to the Moores House scheme. A decision was made for us to inspect and examine those risks.

We undertook this focused inspection to check they had followed their action plan and to confirm they now

met legal requirements. This report only covers our findings in relation to the key questions safe and well-led which contain those requirements.

Prior to this inspection we reviewed the information we held about the service. No areas of concern were identified in the other key questions (Effective, Caring and Responsive). 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.

We looked at infection prevention and control (IPC) measures under the Safe key question. We look at this at all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively. We only looked at certain aspects of infection control practices however, due to the building being managed by a housing provider who is not registered with CQC.

The overall rating for the service remains Requires Improvement. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Comfort Call Monica Court on our website at www.cqc.org.uk. You can see what action we have asked the service to take at the end of this report.

Follow up

We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Enforcement

We have identified breaches in relation to good safe care and treatment and good governance. Please see the action we have told the provider to take at the end of this report.

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 - Monica Court

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services. We only looked at certain aspects of infection control practices however, due to the building being managed by a housing provider who is not registered with CQC.

Inspection team

This inspection was carried out by two inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

This service provides care to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought, or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing and this inspection looked at the personal care people received.

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

The inspection was unannounced. This was because we had received information of concern about the quality of care being provided.

Inspection activity was carried out between 13 July and 6 August 2021. We visited both Monica Court and Moores House on 13 and 14 July 2021 as part of our site visit to the service. Further inspection activity was completed via telephone and by email, including speaking with people living at the home, relatives and reviewing additional evidence and information sent to us by the service.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from professionals who worked with the service, including Salford local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We visited both Moores House and Monica Court as part of the inspection. We spoke with four people who used the service and four relatives about their experience of the care provided across both schemes. We also spoke with eight members of staff including the registered manager, care coordinator, regional manager and five care staff.

We reviewed a range of records. This included eight people's care records and a selection of medication administration records (MAR). We also looked at two staff files to check staff were recruited safely. A variety of other records relating to the management of the service were also taken into account as part of the inspection.

After the inspection

We continued to seek clarification from the service to validate evidence found following our site visit.

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 requires improvement. At this inspection this key question remains the same. 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.

At our last inspection the provider had failed to ensure there were enough staff to care for people safely. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

Staffing and recruitment

- During our last inspection of Monica Court, people raised concerns with us that there were not enough staff available to care for people safely, particularly at night. The contracted care hours had been increased since the last inspection, following discussion with the local authority. This resulted in an increase to staffing levels at night. Additional staff support was also in place for the registered manager.
- Staff told us they felt there were enough staff on duty at Monica Court. One staff member said, "I think we have enough staff and most staff work as a team and try and chip in to help each other." A second staff member told us, "We do okay unless someone is off on sick and then we have to try and get others and split the shift. Normally I feel there are enough staff when we're all in."
- However, people raised similar concerns with us at Moores House about night time staffing levels, although we had not visited this scheme at our last inspection. At night, there was only one member of staff in the building and people felt this could impact their safety. One person said, "I don't think so, especially at night." Another relative added, "I don't think they are particularly safe at night because there is only one staff member on at night with 40 people."
- We raised this concern with the registered manager, however they assured us that there wasn't currently anybody living at Moores House who required assistance from more than one member of staff night. We were also informed talks were underway with the local authority, for additional staff at night.
- Staff were recruited safely. Recruitment records showed pre-employment checks, such as criminal record checks and identity checks had been done. References for staff had been received and recorded. These checks helped to ensure staff were suitable to provide safe care to people.

Using medicines safely

At our last inspection the provider had failed to ensure accurate and contemporaneous records were maintained, particularly regarding people's medication. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17. However, additional concerns were identified regarding people's medication which could impact on their safety. We have reported on this as a separate issue under regulation 12.

- Prior to our inspection, we received information of concern about people's medication not being administered safely. The concerns raised included poor record keeping, missed medication and in some cases, too much medication being given.
- Medicines were not managed in line with current NICE (National Institute for Health and Care Excellence) guidelines and the service did not follow their own medicines policy.
- People had their medicines left for them to take later despite being assessed as needing full support with all their medicines. Other people had access to their medicines but there was no information recorded they could manage their own medicines. There were no checks in place to ensure they were managing their medicines safely.
- Medicines which were dispensed by some of the supplying pharmacies in a 'monitored dose system/blister pack' were not always properly labelled. The missing information meant it was not possible for staff to identify tablet/capsules before administering them.
- The information on the medicines administration records was not always accurately transcribed and did not always have all the information required to safely administer people's prescribed medicines. Staff did not always complete records about medicines administration, and it was not always possible to tell if people had been given their prescribed medicines.
- There was no information recorded when families were involved in helping their relatives with their medicines or where medicines should be stored in the property.
- The system for managing time sensitive medicines (medicines which need to be given at a certain time to make sure they are safe or work effectively) was not effective, and 'before food medicines' were not being given correctly.
- Information about medicines and creams were prescribed to be given 'as required' staff did not have any written guidance to ensure medicines prescribed in this way were given safely and consistently.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management;

- People had a range of risk assessments in place regarding their care. These covered the living environment, skin integrity, falls, moving and handling and nutrition. Where any risks were identified, information was detailed about how to keep people safe.
- People at risk of choking and aspiration were provided with food and drink of the correct consistency. The service also had good links with the local speech and language therapy team (SALT) where there were concerns about people's swallowing abilities. People had access to necessary equipment to help keep them safe. For example, hoists and stand aids which were used when assisting people to move to ensure this was done safely.
- Prior to our inspection we received information of concern about people not receiving the personal care they required. We spoke with people who used the service about this and asked if they had any concerns and they informed us personal care tasks such as baths and showers were always provided. People's daily records also contained details about the personal care people had received.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Staff had received safeguarding training and when spoken with, displayed an understanding about safeguarding procedures and how to report concerns. One member of staff said, "If I had to report an issue, I

would write out a statement of truth and report to the registered manager, and the safeguarding alert would then go to the Local Authority."

- Allegations of abuse were reported to the local authority for further investigation. Notifications were also sent to CQC where any safeguarding concerns had been reported.
- Both people living at the home and relatives told us they felt the service was safe. One person said, "Yes, no one can come into my flat." A relative also said, "Oh yes, that's one of the reasons (family member) went there. I feel secure because its gated."
- Accidents and incidents were recorded, with information detailed about actions taken to prevent re-occurrence.

Preventing and controlling infection

- People were protected from the risk of infection. The provider had ensured there was sufficient stock of personal protective equipment (PPE) in place. The provider worked in partnership with the housing provider to ensure communal areas were safe to use. We saw staff wearing PPE appropriately in the office and when supporting people.
- Staff followed appropriate infection control measures, such as hand washing and wearing protective equipment when supporting people with personal care. A practical exercise had been done in the donning and doffing of PPE and government updates had been communicated to staff.
- The service had an up to date COVID-19 management plan and COVID -19 risk assessments were in place for people and staff.

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 our last inspection this key question was rated as requires improvement. At this inspection this key question remains the same. 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.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- At our last inspection, we identified concerns regarding the effectiveness of the provider's governance systems and regulatory breaches were identified regarding staffing arrangements, record keeping and governance systems. Whilst some of the concerns had been addressed, some remained outstanding, particularly regarding medication.
- Following our last inspection, the service sent us an action plan which detailed how they would become compliant with the regulations. This included carrying out regular audits to ensure areas such as record keeping could be monitored effectively.
- We looked at a selection of people's care records including food/fluid intake and re-positioning charts. These had been areas of concern at the last inspection. Although some gaps in recording were still evident, this had been identified as part of the providers internal audits that were in place. The audits however, had not identified the concerns regarding medication which were found at this inspection.

This meant there had been a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regarding Good Governance.

- Systems were in place to involve people using the service, relatives and staff in how the home was run. This included the use of satisfaction surveys to obtain feedback. Staff meetings were also held so that feedback could be sought and used to make improvements.

Managers and staff being clear about their roles and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Prior to our inspection, we received information of concern about management and leadership and the fact that the registered manager was rarely onsite, particularly at Moores House. This was in part, due to the fact that they were also the registered manager for several other extra care housing schemes under the same provider and predominantly based at Monica Court.
- We asked the registered manager to provide us with an overview about how they managed their time across the various schemes and were given assurances this was being done effectively.
- We asked people using the service for their views of management, leadership and if they had any concerns about the availability of the registered manager. One member of staff said, "The manager is good and she is always on the end of the phone if we need her. We have a care coordinator based here too and is available if

we need her." Another member of staff said, "The manager is supportive and approachable and we have her number if we need her."

- Staff told us they enjoyed their work and that there was a positive culture at the service, with good team work throughout. One member of staff said, "I love my job and I love the residents. We work well with the managers and all know each other well." Another member of staff said, "I like working here and the way staff work together is amazing."
- Both people living at Moores House and Monica Court and relatives were complimentary about the care provided which ensured good outcomes were achieved. One person said, "I'm very satisfied. They are very kind and caring." A relative added, "The staff are fantastic. Mum is very happy. Her mental capacity is spot on and she tells me the carers actually care."

Working in partnership with others; 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 service worked in partnership with various local authority's and health teams. The registered manager also worked in partnership with one of the housing providers, who told us, "There is a weekly housing report from the care coordinator which is sent to the housing company. I feel we work very well together with the Comfort Call staff and there is a good rapport and good partnership working."
- The provider and registered manager understood the requirements and their responsibilities under the duty of candour.
- The provider and manager understood the regulatory requirements. They pro-actively provided information to CQC following significant events at the service and their rating from the last inspection was displayed at the location, which is a legal requirement.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate systems were not in place to ensure people received their medication safely.

The enforcement action we took:

We issued a warning notice regarding this regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not always in place to monitor the quality of service effectively.

The enforcement action we took:

We issued a warning notice regarding this regulation.