

Comfort Call Limited

Comfort Call - Cheltenham

Inspection report

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Date of inspection visit:
22 January 2018
23 January 2018
25 January 2018
01 February 2018

Date of publication:
07 March 2018

Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of our inspection it was providing a service to 100 older adults and younger disabled adults. This was the first inspection of the service.

Not everyone using Comfort Call - Cheltenham receives the regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Comfort Call – Cheltenham had a registered manager in post. 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.

Comfort Call – Cheltenham had significantly increased the number of people receiving personal care and the numbers of staff employed in the past six months in response to local commissioning arrangements. The provider told us changes to the way the service operated had to be made at short notice. We found the service had effectively managed the transition of people's care arrangements as well as the transfer of staff during this period of change.

The registered manager had plans in place to improve the timeliness of some people's calls and was aware that improvements were needed to how information was sent to people about times of visits and the staff allocated to them. However further improvement was needed to ensure people were always told when staff would be arriving late for a visit.

We made a recommendation about how information about visits was communicated to people.

People were protected from harm and abuse through the knowledge of staff and management. Risks to people's safety were identified, assessed and appropriate action was taken to keep people safe.

People were treated with respect and kindness. Their privacy and dignity was upheld and they were supported to maintain their independence.

People were supported by staff who had training and support to maintain their skills and knowledge to meet their needs. People were supported to have maximum choice and control of their lives and staff support the in the least restrictive way possible; the policies and systems in the service support this practice.

People received personalised care from staff who knew their needs and preferences. People were involved in the planning and review of their care and support. There were arrangements in place to respond to concerns or complaints from people using the service and their representatives. Care was provided for

people at the end of their life.

Quality assurance systems were in operation with the aim of improving the service in response to people's needs. A survey had been completed to gain the views of people about the service provided.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were safeguarded from the risk of abuse because staff understood how to protect them.

People's safety was monitored and managed.

People's medicines were managed safely.

Is the service effective?

Good ●

The service was effective.

People were supported by staff who had the knowledge and skills to carry out their roles.

People gave their consent to care and their rights were protected because the staff acted in accordance with the Mental Capacity Act. Improvements were being put in place to aspects of the recording of people's capacity to consent to care and support.

People benefitted from liaison with health care professionals where this was needed.

Is the service caring?

Good ●

The service was caring.

People were treated with respect and kindness.

People's privacy, dignity and independence was understood, promoted and respected by staff.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care and support and were involved in decisions about their care.

Care plans were regularly reviewed with people and their

relatives.

There were arrangements in place to respond to concerns and complaints.

Is the service well-led?

The service was not always well led.

Information about visits had not always been effectively communicated to people.

The service set out and followed its aims and values for providing care and support to people.

Quality checks were in operation to improve the service provided to people.

Requires Improvement 

Comfort Call - Cheltenham

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 22, 23, 25 January and 1 February 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the registered manager is often out of the office. We needed to be sure that they would be in. This was the first inspection of the service.

Inspection site visit activity started on 22 January 2018 and ended on 1 February 2018. It included talking to people using the service and their relatives, examination of records relating to their care and support. We visited the office location on 22, 23 January and 1 February 2018 to see the manager and office staff; and to review care records and policies and procedures. We visited two people who used the service and spoke with them and their relatives. In addition we spoke with three people and three relatives on the telephone.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

Is the service safe?

Our findings

No one that we spoke with had experienced any missed calls. People told us they felt assured that they would receive their care. The registered manager was aware that at times people might receive their call later than planned due to traffic congestion and staff sickness. We saw plans were in place to address this. People's safety was monitored and managed. Staff were aware of actions to take if there was no reply from a visit to ensure people were safe. This had been discussed at a staff meeting so that all staff understood their responsibilities. Support plans also included information of the action staff needed to take to ensure people were safe and secure when staff finished their visit.

People were protected from the risk of abuse because staff had the knowledge and understanding of safeguarding policies and procedures. People told us they felt safe with staff coming into their homes, one person said, "I trust them to go anywhere in the house." Staff were able to describe the arrangements for reporting any allegations of abuse relating to people using the service and were confident any issues would be dealt with correctly. Where people had been considered at risk through self-neglect the service had reported this to the local authority. Staff demonstrated a clear awareness and understanding of whistleblowing procedures within the provider's organisation and in certain situations where outside agencies should be contacted with concerns. Whistleblowing allows staff to raise concerns about their service without having to identify themselves.

People had individual risk management plans in place. For example, for falls, mobilising, skin care and nutrition and use of bed rails. Staff were equipped with tape measures to enable them to perform upper arm measurements as a way of assessing if people were suffering from any nutritional issues. These identified the potential risks to each person and described the measures in place to manage and minimise these risks and these had been reviewed on a regular basis. The registered manager described how incidents were analysed and monitored for trends. This ensured lessons were learnt to improve the staff team's response when needed, and to review people's support plans and risk assessments.

People's medicines were managed safely. Where people were supported to take their medicines by staff, individual risk assessments were in place. Senior staff conducted weekly checks on the recording of people's medicines. Recently there had been a focus on checking the application of topical creams was being recorded. A monthly medicines audit was in operation with an action plan to address any findings. Medicines administration records (MAR charts) had been completed appropriately with no gaps in the records we examined. Staff received training and competency checks before they supported people with their medicines.

Procedures were in place to gather information about the suitability of applicants to posts providing care and support to people using the service. We examined the recruitment documents for four members of staff. We found identity checks and health checks were completed. In addition Disclosure and Barring service (DBS) checks were carried out before staff started work with people. If information appeared on a DBS check then this would be subject to a risk assessment to determine if the person was suitable for employment. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable people

from working with vulnerable groups. Checks were also made on the suitability of applicants from overseas to work in the United Kingdom.

References had been sought about conduct in previous employment. The registered manager was increasing their oversight of the staff recruitment procedures to ensure checks made in relation to previous staff employment would include all relevant employment.

Is the service effective?

Our findings

People's needs were assessed to ensure they could be met before they received a service. We saw examples of completed assessments in people's care plan folders. On-going assessments were in operation using recognised assessment tools relating to areas such as nutrition and skin care. Technology was used to monitor visit times in conjunction with people receiving care funded by the local authority.

People were cared for and supported by staff with appropriate knowledge and skills. Staff received training in subjects such as food hygiene, fire training and first aid. They also received training specific for the specific needs of people such as diabetes, dementia care and catheter care. This meant that a range of skills and experiences were available to support people's needs. Staff told us the training they received was adequate for their role and training was kept up to date. The registered manager described how some training topics such as medicines, choking and mental capacity used an approach called "Impact and Consequences" this emphasised to staff the possible effect of getting things wrong with people using the service.

Staff had regular meetings called supervision sessions with senior staff both on an individual and a one-to-one basis as well as annual performance appraisals. Supervision sessions could be themed to discuss staff members understanding of how to care for people with needs such as mental capacity, skin integrity and choking risk. In addition 'spot-checks' were carried out as a way of auditing staff practical skills and knowledge when providing care and support to people. Staff told us, "We get the support we need" and "The company is alright they do help us a lot". People told us staff were, "Very, very good" and "They do a good job".

We heard some mixed views about the meals staff prepared for people. Some people told us their preferences were not always met with their preferred items of food not served to them or out of date food. However others were satisfied with the meals prepared for them. We discussed this feedback with the registered manager who agreed to look into this. People's support plans included information on their preferences for food and drink. Staff had received training in food hygiene and nutrition and hydration.

Comfort Call – Cheltenham did not routinely support people to access healthcare appointments. However where the need arose staff would liaise with community healthcare professionals such as district nurses and occupational therapists. In addition we saw evidence of staff attending a multi-agency meeting to review the support provide to a person using the service.

The 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 helped 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's care plans described if they needed any support with decision making in relation to the care and support they received. Such as "I can make decisions but may take a while, my wife helps with this" and "I always ask staff for help". The registered manager was reviewing the paperwork used if additional decisions

needed to be made and was also planning to revisit the mental capacity assessment and best interest procedures with staff to ensure they followed a consistent approach.

Is the service caring?

Our findings

People had developed positive relationships with the staff that supported them. The Provider Information Return (PIR) stated, "Staff are encouraged to build positive relationships and are trained to maintain professional boundaries in a caring and appropriate way that is person centred outcome focussed." We heard positive comments from people and their relatives such as "Very respectful", "Very friendly", "Very pleasant" and "Very nice." One person told us, "The care is excellent". A relative told us the person "had a good relationship with most of them (staff)".

Compliments the service had received included, "Care Worker gives lovely care", "Kind and caring." Staff were also thanked by a person's relative for "their kindness to my husband and for putting a smile on his face when he was feeling low." Comments received from a survey of people's views included, "thoughtful and helpful" and "lovely and caring". When we visited people we witnessed staff using a warm and friendly approach when interacting with people.

Minutes from a team meeting reminded staff of the importance of the relationships people had with them particularly people who had no family or friends visiting at Christmas. Staff were told, "Your friendly face can make all the difference." Staff were also reminded that where people would receive visitors they would be "reliant on staff to help them look their best for their special day." With the onset of winter weather, staff were reminded to ensure people were kept warm by checking people had their heating on, had suitable clothing, had at least one hot meal a day and were warm when left in bed in the evening.

People were supported to express their views about the care and support they received. The PIR stated, "We agree care services with the individual, this takes into account their goals and aspirations and the choices they make in their own lives. This includes personal life stories and important relationships, we seek consent to involve family and friends and ensure that we gain this before we share information." Reviews of people's care was carried out through consultation with them and their relatives.

People's privacy and dignity was respected. The PIR stated, "We promote and train staff about privacy, dignity and respect and encourage that they become dignity champions." Staff were able to describe the actions they would take to maintain people's privacy and dignity and this was reflected in people's care and support plans. Staff had received training in promoting dignity and respect. Spot checks by senior staff on staff visits to people included an assessment of whether people had their privacy and dignity respected and appropriate professional boundaries were observed. The importance of the confidentiality of information about people had been discussed in depth at a recent team meeting.

People were supported to maintain their independence. One person's care plan described how staff should approach this, "I know what I can do, I don't want care staff asking to try to do something I can't do. Just let me do what I can myself." Another person's care plan goal was "To maintain my level of independence by supporting choice with personal care." On a visit we saw how staff verbally encouraged a person to mobilise independently. Staff had received training in reablement to support people who needed to regain their independence after an illness or injury.

Is the service responsive?

Our findings

People received care and support in response to their individual needs. People's support plans contained information for staff to follow to provide individualised care and support. For example, one person who used a wheelchair had a description recorded for staff reference of how they would answer the door. Staff we spoke with knew people's needs and their individual preferences, likes and dislikes. People's care was usually provided by staff familiar with them although at times other staff had to be used. There had been no use of agency staff since September 2017. Information was also included about people's life stories and the preferences, likes and dislikes for staff to get to know the person they were supporting. They were written in the first person emphasising choice and involvement.

One person we spoke with was unhappy with some of their visit times and told us these did not meet their needs. We discussed this with the registered manager who was aware of the situation and had been in discussion with the local authority funding the person's care. Currently there was no capacity in the current staff team to provide some different visit times. A review of the person's care needs was planned to address some of the issues they had raised.

People were consulted about the care and support they received. A system was in place to review care plans through visits and discussion with people and their relatives. People and their relatives told us they had been involved in the assessment and review of their care needs.

There were systems in place to record what care had been provided during each visit. This included information on when personal care had been provided, when support had been provided with medicines and any food preparation. The Provider Information Return (PIR) stated, "staff are instructed to check and record on every visit that the service has met the desired outcome as described by the service user." Electronic call monitoring was used in conjunction with the contract the service held with the local authority.

There were arrangements to listen to and respond to any concerns or complaints. There had been 14 complaints from representatives of people using the service since June 2017. Some of these related to the use of agency staff, a practice which has now ceased. Records of investigations had been kept and appropriate responses given to complainants. Information was available for people using the service to guide them in how to make a complaint. A record of previous complaints received and the responses to them had been kept. We spoke with one person who had made a complaint and they were satisfied the issues they raised had improved. They commented, "They seem to have got it right now." Part of the follow up to the complaint had involved staff 'shadowing' another member of staff to observe how the person was supported to meet their needs. Complaints were followed up through the quality assurance system. The PIR stated, "We audit the management of complaints to ensure that these have been responded to with feedback given to the complainant."

People were supported at the end of their life where this was required. The PIR stated, "We link with palliative care teams and have access to advice, equipment and support additionally from internal sources

including nurses to support end of life care and support." Staff received appropriate training to care for people at the end of their life.

Is the service well-led?

Our findings

The vision and values of the service were included in their mission statement, prominently displayed in the provider's branch office. This focused on providing a service that promoted people's independence, dignity and choice.

It was evident through our conversations with the registered manager and branch manager they were motivated to continually improve the service and were keen to take action to ensure good care was provided to people. Staff were positive about the management of the service. They sought the views of people using the service and their representatives through a quality survey carried out in July 2017. We saw action had been taken to address the survey feedback which included ensuring people knew how to raise a complaint and further dementia training for staff.

The survey results and feedback we received from people showed that people were satisfied with the care they received however there were times that their care calls had run late. The registered manager and the branch manager were aware of these challenges which included, recruiting staff from the local area and dealing with the issue of travel times at busy periods of the day when there could be traffic congestion. An action plan had been drawn up to ensure ongoing monitoring of call times as well as improving communication between the service and people so that they would always be informed when staff were running late. People told us further improvements were needed before the communication would always be effective.

People told us they did not always know which staff were visiting them and at what time. Important information about times of visits, allocated staff and any lateness of visits had not always been effectively communicated to people using the service and their relatives. People told us they had not always received rotas which gave them information about visit times and the staff allocated. Comments included, "I don't seem to get a rota", "I do like to know who is coming", "I haven't had a rota for about three weeks", "Not had a rota this week", "The rota is very important." We were also told it was important to know which staff were visiting so important information about people's needs could be shared with non-regular staff. We discussed this issue with the registered manager and the branch manager. They told us there had been a change in the system for informing people of their care visits and staff were supposed to take rotas to people and they were aware this was not proving timely or effective. The registered manager told us this system was being reviewed.

When staff were late people told us they did not always receive a phone call to tell them about this. People commented, "If late I would like a phone call" "Sometimes I am not told when they are going to be late.", "I am not told about late calls". One person commented they did receive a call about lateness but only from regularly allocated staff. When we visited a person we saw how staff were just over half an hour late, the person did not receive a telephone call to tell them about this and staff did not apologise for the late call when they arrived. The person also told us, "The other day they were half an hour late and I didn't get a phone call."

We recommend the service reviews their communication systems to improve further the consistency of information for people about times of visits and staff allocated to them.

Developments for the service included more dementia training for staff and training for dementia link workers with the aim of creating a staff team with the appropriate skills and knowledge to provide support to people living with dementia. There were also plans to create a 'hospital to home' team in conjunction with the local authority. This was to support people returning home from hospital and so facilitate an earlier hospital discharge. The service also planned to further develop the service provided to people who paid privately for their care. In addition more training was to be provided for staff in nationally recognised qualifications and the training facilities at the office were to be improved. Managers kept up to date with relevant developments in the adult social care sector through regular meetings and updates.

Comfort Call – Cheltenham had a registered manager in post who had been registered since 19 January 2018. 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. The registered manager was aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred.

Regular meetings ensured staff were informed about developments with the service and the expectations of the management and provider. Staff also received regular newsletters. Staff working at weekends and out of office hours were supported by an 'on-call' system provided by managers and senior staff.

People benefitted from provider quality checks to ensure a consistently good service was being provided. A range of audits were carried out using the provider's electronic system to monitor the quality and risks with the service. Checks were made on the quality of the service provided to each person. The results of these checks recorded people's level of satisfaction with the service provided. Regular checks were also made on people's risk assessments and care plans to make sure they were accurate and up to date. A report was produced on a monthly basis and sent to the provider. The Provider Information Return (PIR) stated, "We have implemented a new audit tool that is easily modified to continuously measure and drive quality improvements in the branch and that is adaptable to changing review practices and service delivery. The results and actions are reviewed and a league table of performance is maintained. The results of this are shared and discussed at team meetings, including the lessons learned from other branches, feedback and complaints." A comprehensive Improvement Action Plan was in operation detailing all areas where improvements were needed following quality checks and audits.