Comfort Call Limited

Comfort Call Bowmont House

Inspection report

Bowmont House
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Tyne And Wear
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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?	Good

Summary of findings

Overall summary

This was the first inspection of Comfort Call Bowmont House since it was registered in March 2016. The service provides an on-site domiciliary care team that delivers personal care to the tenants of Bowmont House, an extra care housing scheme. At the time of the inspection 28 people were receiving the service.

The service had a registered manager. 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.

We found there were appropriate arrangements in place to protect people using the service from abuse and respond to any safeguarding concerns. Risks were identified and actions were taken to ensure people's care was delivered safely. Enough staff were employed to provide safe, reliable and responsive care. The staff received training and support which equipped them to effectively meet the needs of the people they cared for.

People made decisions about and consented to their care and support. Care was tailored to the individual, well-planned and regularly reviewed to make sure it remained effective. Where needed, people were suitably supported in taking their prescribed medicines and assisted with their health and nutrition.

Staff had formed supportive relationships with people using the service. People told us the staff were caring, respectful and helped them to live as independently as possible.

People were informed about what they could expect from using the service and were given opportunities to express their views and rate their satisfaction. There was a clear procedure for making complaints and any concerns were taken seriously and investigated.

The management provided leadership, promoted an inclusive culture and worked in partnership with the scheme's housing provider. A continuous quality assurance process monitored the care provided to people and ensured standards at the service were being maintained.

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.

Appropriate systems were in place to safeguard people against the risks of harm and abuse.

Sufficient staff were employed to safely meet people's needs and provide continuity of care.

People were supported to receive their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff were trained and supervised to support their personal development and meet people's needs effectively.

The service worked within the principles of mental capacity law to uphold people's rights.

People were supported to stay healthy and helped with their dietary needs.

Is the service caring?

Good

The service was caring.

Staff were caring in their approach and had developed good relationships with the people who used the service.

People made choices and decisions about their care and were consulted about the running of the service.

The staff treated people respectfully and promoted their privacy, dignity and independence.

Is the service responsive?

Good

The service was responsive.

Care planning was personalised to the individual's needs and

preferences.

Provision of social activities did not form part of the service's remit and were arranged by the housing provider.

Any complaints about the service were suitably acted upon.

Is the service well-led?

Good

The service was well-led.

The management structure provided good governance of the service.

The service worked inclusively with people, their families, staff and other stakeholders.

People's care experiences and the quality and safety of the service were actively monitored.

Comfort Call Bowmont House

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 was 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.

The inspection took place on 20 June and was announced. We gave short notice that we would be visiting as we needed to make sure the registered manager and staff were available to assist the inspection. The inspection was carried out by an adult social care 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.

Before the inspection, the provider had 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 reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the local authority that commissions the service.

During the inspection we talked with eight people using the service, the registered manager, the regional manager, the scheme co-ordinator, a senior and two care workers. We examined four people's care plans, staff recruitment, training and supervision records, and reviewed other records related to the management and quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living within Bowmont House and knew how to summon help from the staff in between their scheduled visits, if this was needed. No-one we talked with had any concerns about their safety or the way they were treated by the staff.

People were provided with a guide to the service that gave them information about their rights to be safeguarded from harm and abuse. Safeguarding posters were also displayed in the scheme for reference. The provider's safeguarding and whistleblowing (exposing poor practice) procedures were accessible and all staff were trained in safeguarding at induction and then annually. Staff also received themed supervisions to continue to raise their awareness of how to recognise, prevent and report abuse. Three safeguarding allegations had been reported since the service was registered, each of which was notified to the relevant authorities and managed appropriately.

The service had a 'duty of candour' policy that had been disseminated to staff. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong. The scheme co-ordinator told us the duty was implemented in practice. They gave an example of working with a person's family and social worker when the person was at risk and their needs could no longer be safely met by the service.

Any financial transactions undertaken by staff were properly documented and regularly audited to ensure people's money was safely handled. One person commented, "She (staff member) gets the shopping and gives you your change and the receipt."

Recruitment records showed all necessary pre-employment checks had been carried out to assess suitability before new staff were appointed. There was low staff turnover and the service had a full team of care workers. The scheme co-ordinator kept staffing under review and adjusted levels according to the numbers and needs of people using the service. The current levels were seven care workers during the day, three in the evenings and two waking staff at night. Rosters were forward planned and we observed staffing was well-organised. One person told us, "I've got regular girls (care workers) and they're great."

Existing staff provided cover for absence, giving people continuity of care, and if necessary, staff from the provider's other local care services could be called upon. An on-call system was operated outside of office hours for staff to obtain support and advice, or escalate any emergencies to the management.

Risks to people's safety and welfare, such as those associated with mobility, falls and skin care, had been assessed. Protective measures to reduce risks were built into care plans and kept under review, giving staff guidance on the ways to keep people safe when delivering their care. Accidents and incidents were reported, followed up and analysed to make sure any safety concerns were acted on.

The management worked alongside the housing provider's representatives, who were based in the same office and had responsibility for maintenance and safety checks. During our visit the fire alarm was activated

and a person told us this was a weekly test to make sure the system was working. A business continuity plan was in place that had been drawn up with the housing provider, to support people using the service in emergency circumstances.

People were supported, to varying degrees, with their prescribed medicines. This support was assessed and risk rated to make staff aware, for instance, of when the timing of a person's medicines was critical. The people we talked with said their medicines were provided at the times they needed them and this was confirmed in the administration records we viewed.

All medicines were delivered to the person's home by their supplying pharmacy. Staff who administered medicines had annual training, competency assessments and were supervised or re-trained if any issues in their practice were identified. The scheme co-ordinator and a senior carer had undertaken advanced training as 'medication leads'. We found they conducted regular audits, checking the accuracy of records and ensuring that medicines were managed safely.

Good

Is the service effective?

Our findings

People told us they felt their care and support needs were met by the service. Their comments included, "I'm happy with everything and everyone. I organise any hospital visits but I know I just need to ask if there's anything I need", "I find it excellent here. The staff are brilliant and they've given me a new lease of life" and "There's peace and quiet here, nothing is a bother to anyone – what more could you ask for?"

New staff were given a comprehensive induction that equipped them for their caring roles. The induction training was aligned to the Care Certificate, a standardised approach to training for new staff working in health and social care. Thereafter, staff were provided with refresher training in safe working practices and a variety of courses relevant to the needs of people using the service. Topics included caring for people with dementia, diabetes, continence, catheter and palliative care. Around 50% of the staff had gained nationally recognised care qualifications and a further eight staff were enrolled to study for these qualifications.

All care staff had individual and group supervisions on a three monthly basis, which were often themed to care-related issues, and an annual appraisal of their performance. Spot checks with observations of each staff member's care practice were also carried out every six months. We saw due dates for training and supervision were monitored through an electronic system and that all were up to date. The staff we talked with said they received a good level of training and support. One care worker commented, "I had a thorough probation with plenty of training."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are 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.

We found that staff were trained in the MCA to give them understanding of the implications for their practice. The scheme co-ordinator told us they had in the past worked with social workers when mental capacity assessments needed to be undertaken. No restrictions or 'best interest' decisions were in place for anyone currently using the service.

Care records showed people's communication abilities and capacity to make decisions about their care had been established. People had confirmed within their 'service user agreement' that they been involved in and agreed to their care plan. They had also given written consent to different areas of their care, for example for staff to administer their medicines. Where relatives were appointed power of attorney, care reviews were being more structured to ensure they were always consulted on their family member's behalf.

Staff had undertaken training in nutrition, healthy eating and food hygiene to help support people with their dietary needs. Details of people's food preferences were documented and nutritional risks had been assessed. Where applicable, people had care plans addressing the support they required, such as staff preparing meals, snacks and drinks.

A service charge for meals taken at the independently run onsite café was built into people's rent payments to the housing provider. The service ensured that café staff were informed about people's dietary requirements so they could cater accordingly. We observed care staff supported people to access the café, if this was needed.

The service made sure information was gathered about people's medical history, current health needs and the health care services they accessed. Assessments took account of how medical conditions might impact on the person's care and care plans often included goals of maintaining good health. People we talked with mostly made their own health care arrangements and were aware that podiatry and optician services were available through home visits to the scheme.

We were told staff would contact GP's and other health care professionals if asked, and instigate this when necessary if a person was ill or injured. Given sufficient notice, the service could arrange for people to be accompanied to appointments. This was confirmed by a person who told us, "I organise to be taken for hospital appointments and they (staff) pick me up from my apartment and bring me back." Staff routinely checked on people's welfare and there was capacity to provide extra support during times of acute illness. The staff had also received reablement training to help them support people's independent skills following illness or discharge from hospital.

Good

Is the service caring?

Our findings

People using the service spoke positively about their relationships with staff and the care they received. They told us, "Staff are very caring. Nothing is too much trouble", "Everything is just great" and "The girls (staff) are generally very good."

We noted people's relatives had praised the care provided to their family members in the form of letters and 'thank you' cards. For example, a relative had written '[Name] has been at Bowmont House for a whole year now and in this time her health and well-being have improved beyond all expectations – even her doctors are amazed. We believe that is entirely due to the care and attention [name] receives from all the Bowmont House staff members'.

An informative guide to the service was given to people and a range of useful information was displayed within the scheme to refer to. This included details of local facilities, events and activities within the scheme, and a charter setting out the service's commitment to providing dignified care.

The scheme co-ordinator told us each person's preference for male or female care workers was accommodated and new staff were introduced to people before they started providing their care. All personal care was carried out in privacy and documented in the records kept in people's homes. We observed that staff worked in an unhurried way and engaged with people in a respectful manner. People looked well cared for in their appearance, appropriately dressed and well groomed. Some people told us they made use of the in-house services offered, such as hairdressing and the laundry system which they said worked well.

The people we talked with confirmed they decided how they wished to be supported and that this was facilitated by the staff. One person told us, "I have a set routine and an agreed care plan, but if I need an adjustment I just talk to the manager and we agree it." Another person commented, "They (staff) give me my breakfast in bed then I generally have lunch in the café because it's nice to socialise. I might have tea in the café or in my apartment."

Staff were trained in the importance of person-centred care and treating people with dignity and respect. The management ensured they adhered to these principles by observing their practice and asking people about their care experiences.

People were encouraged to express their views about their care and the service in general. They were involved in their care planning and in care reviews, which were combined with getting direct feedback about the quality of their service. Meetings were held jointly with the housing provider and people rated their satisfaction of the service in surveys. If necessary, people could be signposted to advocacy services to represent their views and information about this was included in the guide to the service.

People told us the model of care provided at Bowmont House supported them to live as independently as possible, secure in the knowledge that help was on hand if needed. Their comments included, "They're all

very good here. They look after you as much or as little as you want" and "I find it excellent, as opposed to being at home with carers or being in a care home."

Good

Is the service responsive?

Our findings

People told us the staff were responsive to their requests and attended promptly if they called upon them for assistance in between their planned visits. A person who used a wheelchair described how staff had facilitated their move to a larger apartment which had been adapted to better support their needs. They said, "The staff are brilliant. I can have a bath downstairs or I can have a shower here. I've got a hoist and they manage that really well."

We found people's needs and any risks involved in providing their care had been fully assessed by the service. Information was also captured that gave staff a real sense of the person as an individual including their life history, communication and interests. Care plans were in place for all assessed needs which detailed the extent of support the person required and what they could do independently. The care plans were personalised to the person's preferences and routines and set out the care and support to be given at each visit. Flexibility, in terms of the additional support that might be needed from staff at other times, was also identified. All of the people we talked with confirmed that they received individualised care, as agreed within their care plans.

A service agreement was completed with each person that evidenced their involvement in the assessment and care planning process. The agreement was signed to acknowledge they had received the guide to the service, been informed about how to make changes to their care plan, cancel a visit and what to do if their care worker did not arrive.

Staff made entries in the person's log book at each visit to keep an on-going account of the care they had provided. Handovers took place between shifts to ensure staff were kept updated about any events or changes in people's well-being. Reviews of people's care were carried out every three months, which included checking any changes in needs and the progress of their care plan outcomes. A full re-assessment of each person's needs was also completed annually.

The registered manager told us the service aimed to continue to care for people if they became more physically or mentally frailer, in conjunction with input from health care services. At times this had not been possible and following re-assessments by professionals, some people had moved onto alternative care settings where their needs could be met.

Provision of social activities was the responsibility of the housing provider and was not built into the contract for the care service.

People were given the complaints procedure and this was discussed with them to make sure they understood how to raise any concerns. None of the people we talked with had any complaints about the care service. The service had received five complaints to date which had been appropriately responded to and investigated.

Good

Is the service well-led?

Our findings

The service had a registered manager who understood their regulatory responsibilities and had ensured the Care Quality Commission was notified of any events that occurred within the service.

A defined management and staffing structure was in place that supported the running of the service. The registered manager was registered in respect of three personal care services and divided her working hours between them. They received support in their role from the regional manager, the scheme co-ordinator, the provider's quality team and managers of the provider's other care services. The scheme co-ordinator was accountable for the day to day operation of the service and had regular contact and support from the registered manager. They worked in addition to the care staffing levels, enabling them to effectively co-ordinate the service, and there were experienced senior care workers who led shifts.

The people and staff we talked with felt the service was well-managed and that the management were approachable. We observed the service worked inclusively with people, regularly reviewing their individual care and providing them with opportunities to give feedback. As a minimum, each person had a quarterly quality assurance visit during which they were asked about their care workers, the way their service was managed and their overall satisfaction. People signed the visit record to confirm they were fully involved in the quality process and that their opinions had been accurately reflected.

Annual surveys were in the process of being carried out with people using the service. We saw last year's findings had indicated everyone was either 'satisfied' or 'very satisfied' with the service. Less favourable responses to survey questions had been acted on, demonstrating that people's comments were able to influence the service. For example, action had been taken to keep people informed about changes to their care workers and any times when they might be late in visiting them. Tenants meetings were held and the management told us they worked collaboratively with the housing provider in supporting people who used the service.

Meetings took place every three months with staff where they could air their views and debate employment and care-related matters. Reviews of serious incidents within the care sector, themes arising from within the provider's services, and lessons learned, were cascaded to the staff team. Training sessions had also commenced to help staff understand the consequences of poor or unsatisfactory standards of practice. These had included, for instance, staff completing a case study audit to identify and discuss the impact of deficiencies in care and medicines records.

Staff received the provider's newsletters which reported on current care issues and celebrated events and achievements throughout the company. A weekly 'round up' memo was being introduced to give staff an overview of updates from the company and invite their suggestions for improvements. Social media was also used to engage with staff and champion their work.

The senior management were kept appraised of, and monitored the service's performance through an electronic branch reporting system. This included oversight of staff training, supervision and ensuring

appropriate action was taken in response to accidents, incidents, complaints and safeguarding alerts.

Internal audits were conducted to validate the quality of care people received and the regional manager visited each month and prepared detailed reports on the quality of the service. The registered manager told us the provider's quality team were a good source of advice and had last inspected the service in May 2017. The regional manager said this visit had highlighted mainly procedural and recording issues, most of which had since been addressed. An action plan was in place that was subject to close monitoring to check the improvements had been progressed.

The management informed us about their plans for further developing the service. This included increased input from the registered manager and regional manager and training more staff to have lead roles for medicines. A pool of staff was also being consolidated to work across the provider's community based services, improving cover for absence and, when needed, enhancing the skills mix.