Comfort Call Limited

Comfort Call Nottingham

Inspection report

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08 October 2019
01 November 2019

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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 is a domiciliary service providing personal care to vulnerable older people and younger adults in their own home. The service is run from an office located at Southglade Business Park on the outskirts of Nottingham.

Not everyone who used the service received personal care. 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.

At the start of the inspection 232 people were using the service. However, during the inspection period, the provider, after consultation with the local authority, reduced the numbers of people supported to 197. An alternative provider was found to support the remaining 35 people.

People's experience of using this service and what we found
People's support visits were not always on time and were sometimes cancelled with little notice. The provider did not always have enough care staff to support people safely; and that meant people were sometimes supported by care staff who did not understand their care needs. When people contacted the provider's office about missed, or late, calls they did not always receive a response.

People were supported by care staff who were not always up to date with the necessary training to protect them from the risk of harm or abuse.

People did not always receive support at the time they needed it. That happened more frequently when the person's regular carer was absent, because the provider's staff rostering arrangements did not accurately reflect when people needed support.

People's care was not well monitored by the provider, because the quality monitoring processes in place were not being carried out consistently. That meant the provider would not always be able to identify if people were receiving appropriate care.

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 requires improvement (published 8 January 2019).

Why we inspected
The inspection was prompted, in part, due to concerns received about increased risks; because of low staffing levels and an increase in missed, or late visits, to vulnerable people. A decision was made for us to inspect and examine those risks.

We received concerns in relation to the management of staffing. 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 new 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 not changed from requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report.

Since the inspection visit the provider has reduced the number of people it supports. This was following a discussion with the local authority who reallocated some people's support arrangements to an alternative provider.

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

Enforcement
At this inspection, we have identified a breach of regulations in relation to the provision of sufficient numbers of suitably qualified, competent, skilled and experienced staff. We also identified a breach of regulations in relation to the provider's systems and processes for ensuring the quality of the service provided to people. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Comfort Call Nottingham

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 one inspector and one inspection manager.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.
The service did not have a manager registered with the Care Quality Commission. When a manager is registered it 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. The regional manager told us they intended to apply CQC to become registered as the manager for this service.

Notice of inspection
The inspection visit took place on 8 October 2019 and was unannounced. After receiving details from the provider, we contacted people who used the service on 1 November 2019 to complete the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback from the local authority and professionals who work with the service. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service, and two relatives, about their experience of the care provided. We spoke with four members of staff including two regional managers, staff rota administrator and care co-ordinator.

We reviewed a range of records. We looked at staff rostering information, from the provider's computer software system, and details of the times care staff actually arrived and left people's properties. We reviewed 6 people's care records. We looked at 6 staff files in relation to recruitment and staff training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found, however, this was not always returned to us in a timely manner. We looked at training data and staff induction 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 requires improvement. At this inspection this key question has remained 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.

Staffing and recruitment

● Not enough care staff were available to meet people's needs. A staff member told us, "There are so few carers, so any slight problem in the field causes a major problem in the office because there are no spare people to help. We just have a lack of carers in the field." A person told us, "Now they are sending the office staff out, on the care calls, because they are so short staffed. It's getting ridiculous." This had a negative impact on people because it meant they were sometimes supported by staff who did not know them or understand their support needs.

● People did not always receive support when they needed it. Most people we spoke to told us staff visits were often late and sometimes missed altogether. A person told us, "I need my visits to be on time, it's critical for me." This had a significant negative impact on some people. For example, some people required their scheduled visits to be on time due to their complex personal care needs.

● Staff rosters did not accurately reflect the hours staffed worked or their timetable of visits to people. For example, some rosters indicated staff started work at 5am, which was never the case. Additionally, visit schedules did not always reflect people's visit times. This was because care staff often flexibly amended their visit times to fit in with people's needs. That informal arrangement worked well when a regular care staff member was visiting their regular clients. However, that meant people's visits occurred at the wrong times when a different care staff member was covering for the regular staff member's absence; because the roster was not accurate.

We found no evidence that people had been harmed, however, the provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet people's care needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had an appropriate recruitment policy and procedure in place. Staff pre-employment checks had been carried out. This helped to ensure care staff were safe to work with vulnerable people.

Using medicines safely; Preventing and controlling infection

● Arrangements for ensuring staff were trained in how to administer medicine to people, for whom it had been prescribed, were not effective. Approximately one third of staff had not received the necessary administration of medication refresher training; which the provider's own policies stated should be received at least annually. This meant some care staff were not up to date with medicine administration training.

● The provider's audits of medicine records were not carried out consistently. We found examples of medicine administration records which had not been checked by the provider, and which contained errors

made by care staff. This meant the provider was not monitoring whether prescribed medicine was being administered in the required way; and increased the potential for medicine errors to go unnoticed.

● Care staff had not all received refresher training in the prevention and control of infection. That training ensures staff understand how to prevent and control the spread of infections. That meant the provider could not be sure that staff understood how to work in a safe way.

Systems and processes to safeguard people from the risk of abuse

● Arrangements for ensuring staff were trained in how to protect people from the risk of abuse were not effective. Approximately one third of staff had not received the necessary prevention of abuse refresher training; which the provider's own policies stated should be provided at least annually. However, staff we spoke with knew how to raise safeguarding issues, and the provider had raised safeguarding concerns appropriately with the local authority.

● Checking of care records was not carried out consistently. For example, monthly care records were not always reviewed by senior staff before being archived. This meant the provider was not always monitoring whether care was being provided in the required way; and increased the potential for neglect or abuse to go unnoticed.

Learning lessons when things go wrong

● Lessons were not always learned when things went wrong. People told us they had contacted the provider's office when their visits had been missed or delayed. A person told us, "I have complained, but you can't usually get hold of the manager. My [relative] has to have ago at them to make sure they are going to turn up on time. But we shouldn't have to be ringing up every day. This is the way I have to live now. Never knowing if the carer is going to turn up on time or not."

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 requires improvement. At this inspection this key question has remained 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.

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

- The management team did not always support staff to provide person centred support which achieved good outcomes for people. For example, people told us their scheduled visits were often late and sometimes cancelled because of staff shortages. That had a negative impact on people's required outcomes.
- Care staff were not empowered to meet people's needs by the provider's rostering system. People told us care staff tried to work flexibly to meet their needs, despite the roster they were given. That often meant they were not working in the way the roster management system directed. As a result, the management team did not always fully understand the times people needed their support to be provided.
- People did not always have good outcomes because of the care they received. A person told us, "They cancelled my sitting session yesterday. The office didn't tell me. The carer in the morning noticed that she had been given seven more jobs to complete that day, and she was upset about that. She was really sorry, but there was nothing she could do. That meant I couldn't go out, so I had to cancel my appointment."

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

- Arrangements for monitoring the quality of the service were not always effective. Quality audits were not consistently carried out. For example, medicine administration and care records were not always reviewed before being archived. That meant the manager was not always aware of the quality of the service being provided to people.

The provider failed to ensure the systems and processes in place to assess, monitor and improve the quality and safety of the services provided were fully and consistently effective. This was a breach of regulation 17 Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The providing of information to CQC, during the inspection, was not always timely. That delayed the process of gathering feedback from people who used the service. There were also delays in responses to questions raised by CQC about some of the information that had been provided as part of the inspection.
- The provider had made the necessary notifications of incidents to CQC. The manager understood their responsibility for reporting deaths, incidents, injuries and other matters that affected people using the service. Notifying CQC of these events is important so that we are kept informed and can check that

appropriate action had been taken.
● Care staff and managers were aware of their different roles and responsibilities when caring for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, and staff, were not always engaged and involved by the provider. A person told us, "I have rung the office about things before, but they usually just tell me that the person I want to speak to is in a meeting, and they don't usually ring me back." That meant people were not being involved in shaping the care they received from the provider.
● Staff morale was low. A staff member told us, "It's terrible at the moment. I just think it is because lots of carers have left. We don't have a recruitment officer, so we are not gaining new staff quickly enough, and that puts lots of pressure on the existing staff. Then when we get new staff we put a lot of pressure on them." That meant staff did not always feel engaged and supported by the provider.

Continuous learning and improving care; Working in partnership with others
● The manager told us they had started taking action to fix the problems that had been identified to them by external agencies. The manager told us the agreement, with the local authority, to reduce the size of the provider's service meant they could concentrate on stabilising the support they continued to provide in the areas where they were still operating.
● The manager had engaged with the local authority to identify ways in which the service could be stabilised and improved.

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 manager understood, and acted on, their duty of candour responsibility by contacting relatives after incidents involving family members occurred. This ensured that relatives were notified of the incident and made aware of the causes and outcome.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the systems and processes in place to assess, monitor and improve the quality and safety of the services provided were fully and consistently effective. This was a breach of regulation 17 Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet people's care needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.