Comfort Call Limited

Comfort Call Gateshead

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Comfort Call Gateshead is a large domiciliary care agency providing personal and nursing care to in excess of 1000 people at the time of the inspection.

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.

People's experience of using this service and what we found
A significant number of people and relatives were unhappy with the current rota system. Care workers were regularly late, not always consistent and calls were often cut short. Although most people and relatives felt staff were caring, the inconsistencies they experienced had a negative impact on the care they received. Most staff gave similar feedback describing their rotas as unmanageable and constantly changing. Rotas we viewed mirrored this feedback.

People and relatives told us they had raised concerns about inconsistent care many times without improvement. During the last consultation with people using the service between September and December 2019 a significant number of people rated the service very poor or poor for time keeping, communication and dealing with complaints quickly.

The provider lacked a robust system to investigate and address incidents. Investigation reports did not evidence thorough investigations took place to ensure risks to people's safety were managed safely. Although the provider monitored incidents, action plans lacked detail and lessons learnt were not identified and shared.

Staff knew how to raise concerns and most felt confident to do so. Safeguarding referrals were made to the local authority when required.

Although the provider had a structured approach to quality assurance, these systems had not been successful in improving people's experience.

Staff gave mixed feedback about the culture of the organisation. A significant number of staff told us management were not approachable and felt their views were not listened to.

The provider has developed an immediate action plan to address the issues identified with the South Tyneside branch.

The provider followed safe recruitment processes to recruit new staff and managed medicines safely.

Staff had access to the personal protective equipment (PPE) they needed. The provider took timely action to ensure staff consistently followed PPE guidance.

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

Rating at last inspection
The last rating for this service was good (published 8 November 2018).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the quality of people's care, treating people with dignity and the robustness of investigations to address concerns raised.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Following feedback from people using the service and staff gathered during the inspection, a decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with timings and duration of care calls, poor communication and the effectiveness of investigations to address these concerns, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective and well-led.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement.

You can see what action we have asked the provider to take at the end of this full report.

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

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 caring?

Requires Improvement

The service was not always caring.

Details are in our caring 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 Gateshead

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
One inspector carried out this inspection and three Experts by Experience carried out this inspection. 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 is a domiciliary care agency. It provides personal care to people living in their own houses and flats. The registration for this service incorporates separate branches covering three local authority areas.

The service had three managers 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
We gave a short period notice of the inspection because we needed to arrange telephone calls with people using the service and to contact staff prior to visiting the office. Inspection activity started on 17 September 2020 and ended on 22 October 2020. We visited the office location on 16 October 2020.

What we did before inspection
We reviewed information we had received about the service since the last inspection and sought feedback from the local authority. We used this information to plan our inspection.

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 spoke with 55 people who used the service and relatives about their experience of the care provided. We received feedback from 40 care workers either by phone or email. We also spoke with senior managers and the registered managers. We reviewed a range of records. This included 15 people's care records and multiple medication records. We looked at 10 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
The provider sent additional information which we considered when making judgments.

Requires Improvement

Is the service safe?

Our findings

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

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

Staffing and recruitment

- People did not always receive care from a reliable and consistent team of care workers.
- 24 out of 55 people and relatives told us care workers changed frequently, were often late and did not always stay for the full length of the call. They described how this negatively impacted on their care and wellbeing.
- People and relatives said, "During the week fine, at weekends the care is terrible. You get all different ones and they come at all times. [Family member] only has one call a day in the morning to [provide specific personal care tasks] and if late causes [family member] discomfort" and "You haven't a clue who is coming. The carers are themselves trying to work out their rotas. I have two carers on each visit, and they tend to travel and arrive together but they are not sticking to the times and can be late or even early."
- One relative described how care staff rushed when providing their family member's care. We viewed daily records for this person. These showed, on some occasions, staff had stayed for between six and eight minutes instead of 30 minutes. They recorded they had provided full personal care during this time.
- 26 out of 40 staff raised concerns about rotas. They described rotas as unmanageable and constantly changing without notice. This was often at the last minute and impacted negatively on their ability to fulfil their rota and meet people's needs. One staff member commented, "Most of the time my rota was badly organised and unrealistic. I would have calls from 5.45 am, but not be able to enter a house till 7am. So I would already be late before I had started. It left me late to service users or not enough time to do my job correctly and very stressed. Let alone how it would make the service user feel."

The provider had failed to ensure rotas were efficiently organised so that people received care when they needed it. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

- The provider followed safe recruitment practices when recruiting new staff.

Learning lessons when things go wrong

- Managers investigated individual incidents and accidents when these occurred.
- The provider did not always thoroughly investigate incidents and accidents to ensure people remained safe and lessons learnt.
- Investigations were concluded without having fully considered all the relevant evidence. People and relatives were not always consulted or involved during investigations to make sure decisions reached were appropriate.

● Investigation reports were not always fully completed. Some were brief and others lacked information about the outcome from the investigation or lessons learnt.

The provider had failed to robustly investigate incidents so that risks to people's safety were minimised. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Assessing risk, safety monitoring and management
● The service did not always manage risks effectively. People described how care staff were often late which impacted on them receiving their care on time. One person described how on one occasion a care worker hadn't turned up. This meant they had to put them self to bed without assistance.
● Risk assessments were carried out when people started receiving care. This included assessing the person's living environment and other areas, such as managing medicines safely.
● Additional risk assessments were carried out, depending on people's individual needs. This included where people had particular health conditions.
● The provider had procedures to ensure people continued to receive care in emergency situations.

Systems and processes to safeguard people from the risk of abuse
● The provider had effective systems to help keep people safe from the risk of abuse. Some people and relatives said they felt safe with the care staff. One person said, "Very safe, have four calls a day. I have a manual hoist they need to use to lift me from bed and they do this safely and well."
● The provider dealt with safeguarding concerns appropriately; previous concerns had been referred to the local authority and investigated.
● Staff knew about the safeguarding and whistle blowing procedures. They told us would raise concerns if needed.

Using medicines safely
● People received their medicines when they were due. One person said, "Most importantly when they come they remind me about taking my meds, which I take myself but can forget to do. Very happy they do that for me."
● Staff maintained accurate records to confirm the medicines people were given.
● Senior staff checked care staff followed the correct medicines management procedures.

Preventing and controlling infection
● Staff followed safe infection prevention and control (IPC) procedures. The provider had updated policies and procedures to deal with the Covid-19 pandemic.
● The provider had systems to check staff followed the IPC guidance.
● Staff told us they had access to the personal protective equipment they needed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Due to difficulties with rotas, people were not always treated with dignity and respect. This often impacted negatively on the care people received.
- People described how care staff were often late or did not stay for the full length of the call. One person said, "On Monday no carer came at all. I had to go and try and put myself to bed. This has happened before."

Ensuring people are well treated and supported; respecting equality and diversity

- Although some people and relatives raised concerns about rotas, most people consistently said they received good care.
- People described the care staff as kind and considerate. People commented, "I am very happy with them. All carers are nice and treat me with full respect and dignity when helping me get washed and dressed."
- Where people had a consistent staff team, positive relationships had developed. One person said, "I think they are great. They are great, chatty. I love them so much. Yes has the same carers, now and then there is a new one. They are usually on-time. They are smashing, I wouldn't like any other. Everything is great."

Supporting people to express their views and be involved in making decisions about their care

- People were supported to make decisions about their care. One person told us, "My carers are very good indeed, I really appreciate all they do. They cook for me. They ask me 'what do you want?'"
- Relatives were involved in people's care and advocated on behalf of some people, depending on their needs.

Requires Improvement

Is the service well-led?

Our findings

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

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

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

- The culture of the organisation required further development to ensure it was fully open and inclusive.
- Many staff described how they felt unable to approach management and felt their views were not always listened to when they did. They said this impacted on their ability to provide good care to people.
- Staff told us, "Staff morale is when the company is supporting staff and making them feel positive which in the end makes a huge difference in work performance. I don't believe any of this exists in the company and you will find this as you ask further carers during your investigation" and "I don't feel supported at all. A lot of staff morale is very low, carers feeling run down, stressed and anxious. Not a very good place to work."

The provider had failed to promote a culture where people and staff views were encouraged and acted on. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider needed to improve how feedback was encouraged and valued to ensure people and staff were listened to and their concerns addressed.
- Some people and relatives told us they had raised concerns about rotas several times. They felt they were not listened to and had seen no improvement. They commented, "They are not responsive at all to my issues when I speak to them" and "I have complained a lot but it is a waste of time. I complained about the call times for [family member] and training of some carers. They do not do anything about it."
- People and relatives gave similar feedback during the last formal consultation carried out September and December 2019. A significant number of people rated the service either very poor or poor for time keeping, communication and dealing with complaints quickly. The provider had not taken robust action to ensure sustained improvements were made.
- Staff felt their views were not always welcomed or listened to. They told us, "I least like how we get spoken to and how when you ask the office or need support it doesn't really get listened to" and "I did not feel like I could make a suggestion unless it would benefit them in some way."

The provider had failed to learn lessons from previous feedback and improve people's care. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 Good governance

Continuous learning and improving care
● The provider needed to develop effective systems to ensure lessons were learnt and used to deliver sustained improvement in people's care.
● Feedback gathered during this inspection mirrored the findings from the last formal consultation. This showed the provider had not addressed people's concerns and improved their care.
● Although the provider reviewed incidents and accidents every three to four months, the analysis did not evidence lessons were learnt and sustained improvements made. Action plans lacked detail and included little evidence of lessons being learnt to promote continuous improvement.
● Investigation reports lacked enough information to offer reassurance incidents had been fully investigated. Some reports did not document how investigations were conducted, how decisions were made and appropriate action taken.
● The provider developed an immediate action plan to address the issues identified with the South Tyneside branch.
● A governance review for the South Tyneside branch showed improvements had been made in areas people and staff raised, including consistency and timekeeping. These remained well below 100%. A similar analysis was not available for the Sunderland and Gateshead branches.

The provider had failed to robustly investigate incidents so that risks to people's safety were minimised. This placed people at risk of harm. The above is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance

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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The provider was proactive in submitting statutory notifications to the CQC following significant events at the service.

Working in partnership with others
● The provider was working with local commissioners to improve the care people received.

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 had failed to robustly investigate incidents so that risks to people's safety were minimised. The provider also not learnt lessons following feedback to ensure people received good care.