Comfort Call Limited

Comfort Call - Beechfield

Inspection report

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12 September 2017
18 September 2017

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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

This focused inspection took place on 30 August 2017 and on 12 and 18 September 2017. This inspection was to follow up on warning notices issued at the last inspection in January and February 2017. The warning notices were due to insufficient staff being employed to meet the needs of people safely. Missed and delayed calls had impacted upon the dignity of people. We also found that people who needed support with their medicines had not been given the support and some people did not receive the medicines they needed. Safeguarding alerts had not always been made; a lack of communication meant that there was a delay in making some safeguarding alerts. We identified gaps in all records reviewed during inspection.

The inspection was announced. This meant the provider; staff and people using the service knew that we would be carrying out an inspection of the service. The provider was given 48 hours' notice prior to inspection because the service provided domiciliary care services. This meant we could be sure that the registered manager and people's care records would be available for inspection. This also gave the provider time to gain consent from people who used the service for us to speak to them by telephone. Due to some concerns found during the inspection around staff using hoists they were not trained for, a near miss fall from a hoist and not enough stock of medicines, we sent an urgent action letter to the provider requesting further information

Comfort Call Beechfield provides domiciliary care services for people living in Beechfield Court in Middlesbrough. Beechfield Court is made up of flats and bungalows. The communal areas of Beechfield Court include a café and hairdressing salon which are also open to the public The service caters for people who have physical and mental health conditions and those living with dementia. The building is managed by Group Thirteen (Landlord) and care was provided by Comfort Call Beechfield, both based at the service. At the time of our inspection there were 70 people using the service.

There was a registered manager at the service who had been registered since May 2015. However, a new manager had been employed to look after the day to day running of the service. 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 were told on the second day of inspection that the new manager was planning on becoming registered. Once this happened the existing manager would de register.

At this inspection we reviewed the action the registered provider had taken to address the issues we found at the previous inspection..

We found work was still needed to improved the safety of medicine administration. There were gaps in medicine records. Management had identified some issues in records relating to medicines during audit and had taken action, but not all issues were identified. Risk assessments were not in place for one person who administered their own medicines. Where care staff had, responsibility for obtaining medicines for

people this was not clearly documented and there was no procedures documenting how this would be undertaken. Some people were not administered medicines because they were not available.

We found audits were now taking place with an action plan to highlight concerns found and dates they would be rectified. However staff were still not following correct processes set out. For example, staff had not contacted the on call team during night duty when they were unable to attend planned calls because of a medical emergency. This meant people received calls much later than planned and had caused people to delay their medicines and go to bed much later than they normally would.

Risks to people arising from their health and support needs were not always assessed, and plans were not in place to minimise them. A serious incident took place in May 2017 which was reported to the management team however the incident was not recorded or investigated. We informed the management team at inspection on 30 August 2017, yet no action had been taken to address this when we returned on 12 September 2017.

There were enough staff to meet people's planned calls, however this became problematic when there were unplanned calls or when staff were off sick. The volume of unplanned calls was problematic for staff because people used the emergency buzzer when there was no emergency. No robust monitoring was in place to manage unplanned calls.

Limited feedback was sought from people, relatives, external professionals and staff to assist with the quality of the service.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not managed safely.

Not all identified risks to people were assessed and recorded. Staff did not follow correct procedures when incidents occurred.

There were enough staff on duty to meet people's planned calls. However, non urgent, unplanned calls, such as call bells ringing for a glass of water, caused staff to be late for planned calls.

Is the service well-led?

Requires Improvement

The service was not well-led.

Quality assurance checks had improved, however these had not identified all of concerns which we raised. There was no monitoring and action in place for unplanned calls.

People and staff told us that the service had improved since the new manager started. People told us they felt listened to and action had been taken when they raised a concern.

The manager understood their responsibilities in making notifications to the Care Quality Commission.

Comfort Call - Beechfield

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.

Before the inspection we reviewed all of the information we held about the service. This information included notifications that we had received from the service and information from people who had contacted us about the service since the last inspection. For example, people who wanted to compliment or had information that they thought would be useful about the service. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted Middlesbrough local authority commissioning team.

The provider was not asked to complete 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.

One adult social care inspector, carried out this focused inspection on 30 August 2017 and one pharmacist inspector attended on 31 August 2017. Two adult social care inspectors and a pharmacist inspector visited on the 12 September 2017. One expert by experience spoke with people and their relatives face to face during the inspection on 30 August 2017. In addition another expert by experience spoke with people and their relatives by telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience involved in this inspection had experience of working with adults and older people. One adult social care inspector returned on 18 September 2017 to follow up on our letter of serious concerns.

We reviewed 11 care records, six staff recruitment records, the training summary records for all staff and four staff supervision and appraisal records as well as records relating to the management of the service. We looked around the service and went into some people's flats and bungalows (with their permission) and visited the communal areas. We spoke with the registered manager, the manager, a manager from another service, the area manager, seven care staff and nine people who used the service. We visited five people in

their homes to make sure appropriate arrangements were in place to manage medicines safely.

Requires Improvement

Is the service safe?

Our findings

At the last inspection, we found the service did not have appropriate arrangements in place for the safe management of medicines. We issued a warning notice and asked the service to make improvements.

At this inspection, we found staff supported some people with their prescribed medicines. We found that the arrangements for managing these medicines did not always keep people safe. We looked at eight medicines administration records (MARs) in detail, spoke with the members of the management team and five care staff about medicines, and reviewed the provider's medicines policies.

Staff had recorded the level of support that individual people needed in their care plan, however, one person we visited was administering their own inhaler and there was no risk assessments completed in accordance with the provider's medicines policy. This meant we could not be sure that staff were supporting people to look after their own medicines safely. Care staff had responsibility for obtaining medicines for some people but this was not clearly noted in the care plan and there was no procedures documenting how this would be undertaken.

We reviewed MARs and found gaps in six out of eight records where staff had failed to sign or enter a code to explain why a medicine had not been given. This meant MARs did not accurately reflect the treatment people had received. We also found that the medicines recorded on the MAR did not match the medicines that staff administered. For one person a medicine had been discontinued in the pharmacy supplied medicine compliance aid (blister pack) but care staff continued to sign on the MAR for administration. For another person the strength of two medicines were not correctly listed. Where the non-administration code 'o' was used on the MAR, care staff had not always recorded the reason why this medicine was not given. Checks of the medicines administration records were completed weekly and these had identified some of the issues and action was taken however; these had not picked up all of the issues we identified at our visit.

Several people were prescribed creams and ointments that were applied by care staff. There should be guidance for care staff in the care plan that described how these preparations should be applied. However, in the care plans we looked at this information was missing, or the guidance referred to several creams on the same chart. This meant there was a risk that staff did not have enough information about which creams were prescribed and how to apply them.

The process for ordering and obtaining people's prescribed medicines was failing, which increases the risk of harm. Three people had not received pain relief medication. One person for six days, one for nine days and another person for two days. Staff had documented that the stock of these medicines was absent on the MAR but had failed to ensure that an adequate supply was obtained from the pharmacy. We raised a safeguarding alert about this.

For medicines that staff administered as a patch, a system was in place for recording the site of application for pain relief patches; however, they were not all fully completed. This is necessary because the application site needs to be rotated to prevent side effects.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), were monitored on the controlled drug record sheet as stated in the provider's policy.

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

We looked at the current MAR for one person prescribed a medicine with a variable dose, depending on regular blood tests. Written confirmation of the current dose was kept with the person's MAR. Care staff were able to check the correct dose to give. Staff had recorded that this medicine had been given correctly. Arrangements were in place for the safe administration of this medicine.

We saw records showing staff had received medicines training and supervision to ensure they were competent to administer medicines.

We saw risks to people's skin integrity, falls and mobility were assessed and plans put in place to minimise the risk. However, one person needed two staff to hoist them from the bed to the chair and vice versa. When we spoke with this person, they told us they had experienced a slight fall when staff were trying to assist them up from the chair using the hoist. We spoke with the management team following this discussion and we found they were not aware of this incident. We reviewed the person's care records and found this person had a new ceiling hoist fitted in November 2016 along with other new equipment. A letter was in the care records to show that an occupational therapist had provided instructions on how to use the hoist and sling. However, staff were not aware of this letter and had not received the training identified within this letter. This meant staff were using equipment they had not been trained on which was an unsafe practice.

We asked the management team to take immediate action to carry out an investigation, complete an incident record, update the person's care records and contact the occupational therapist for clarification on training. We also asked that competency assessments be carried out for the two staff members involved in this incident. On the second day of inspection, we found that no action had been taken.

The manager told us that staff had received moving and handling training. Records were in place to show staff had completed e-learning but no records were in place to show they had undertaken practical training for manual and ceiling hoists. We sent the provider an urgent action letter on 14 September 2017, asking for assurances that this person would be safe and that staff would receive the appropriate training immediately. The provider told us that all staff would receive the training by 29 September 2017. We visited the service again on 18 September 2017 and could see that staff had already started to undertake training in moving and handling and evidence was provided to show all staff had received the training by 21 September 2017.

The provider had not taken appropriate action to ensure the safety of this person until we sent our urgent action letter. This meant that the provider had not done all that was reasonably practicable to mitigate the risk and support the health, safety and welfare of people who were using the service

These findings evidenced a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

There were eight staff on duty during the morning and five staff on duty on an afternoon. Staff told us there was sufficient staff on duty for all planned calls, however they became under pressure when staff were off sick because replacement staff were not always put in place.

On the first day of inspection staff rota's were in place which showed the days each staff member was working but there were no start and finish times. This had led to confusion and there had been occasions where staff had not turned in for work because they hadn't been made aware that they should have been in earlier than planned. As a result there had been some missed calls.

Following the last inspection, a procedure had been put in place where staff were required to contact the on-call during night duty if incidents occurred that would impact on calls for people. For example if there would be a delay in responding to calls for longer than one hour.

One person had a planned call in place for 9 pm. They contacted staff using the emergency buzzer at 10pm. Staff told this person they were involved in a medical emergency and could not carry out the person's call. The person told us they did not take their medication at 10pm because one of the medicines was to assist with sleep and they required support from staff to get ready for and in bed and with personal care. Staff did not turn up until 11:45pm. This meant the person experienced a delay with their medicines and going to bed. We found that staff had not followed correct procedure and had not contacted the on-call manager for assistance to prevent this call being so late.

There was no robust monitoring in place for unplanned calls. We noted that some staff recorded these; however staff told us they did not reflect the actual volume of unplanned calls. Although staff took some action to record unplanned calls, no analysis was carried out.

There was a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) regulations 2014

We asked people who used the service if they felt safe whilst receiving care from Comfort Call. People said, "Yes I feel safe." Another person said, "Oh yes I always feel safe, they never miss a call." And another person said, "Oh yes I feel safe, I know they are there if I need them." However one person said, "No I don't always feel safe, they [staff] are always in a rush."

Staff we spoke to had a good understanding about safeguarding and how to raise a concern if needed.

Staff we spoke with said they thought there was enough staff on duty and they had time to get to one appointment from another. We saw from looking at rotas that people received calls from the same staff each week. There was no evidence of missed or unallocated calls. People who used the service said, "Yes there are enough staff for me." Another person said, "I see them four times a day, they are sometimes late but never miss a call."

Staff we spoke with said, "We had eight staff on today and things ran smoothly. It's awful if there are only seven of us." Another staff member said, "Sometimes staffing is manageable, it depends what is going on as there is not spare person to pick up extra calls and emergencies. Five staff on an evening is sufficient."

There were enough staff on duty to manage the calls people planned in and for emergencies. Due to the office and staff being on site permanently people were using their buzzers to ask for non urgent support outside their allocated time slots. This then had an impact on other people's calls as it made staff late. The manager and regional director were putting a system in place to address this issue.

Requires Improvement

Is the service well-led?

Our findings

At inspections in January and February 2017, we told the provider to make improvements to the service because we identified breaches of the Health and Social Care Act 2008.

We found care records were not updated to reflect current needs and there was a significant gap in internal audits.

We issued warning notices in relation to regulation 17 of the Health and Social Care Act 2008 telling the provider that by the 31 May 2017 they must improve in Regulation 17 Good governance. Records were not updated and there were significant gaps in internal audits.

During this inspection we found the previous manager had left the service and a new manager started in June 2017. The new manager had implemented new systems and audits and we found audits were now taking place in areas such as missed/late calls, training, supervision, complaints, staff hours, care files and medicines. We found the audits were picking up on some of the concerns we raised. However, quality assurance procedures had not highlighted all of the concerns during this inspection, such as our concerns with medicines and the incident with the hoist sling. Staff were not following correct processes. For example, if staff were busy on a call for an hour or more they were supposed to ring the 'on call' number for support. We found staff were not doing this and were then late for other calls.

The area manager and manager told us that issues were arising due to the service acting and providing support as if they were a care home not a domiciliary care agency (DCA)

It was clear that action taken regarding the procedures for monitoring the quality of the service had improved since the last inspection. Audits had highlighted where action was needed and action plans were in place. However further work was needed.

There was no robust monitoring in place for unplanned calls. We noted that some staff recorded these; however staff told us they did not reflect the actual volume of unplanned calls. Although staff took some action to record unplanned calls, no analysis was carried out.

This is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulations) 2014.

People told us the quality of the service had significantly improved since the last inspection. People told us they felt listened to and the manager kept in contact with them when they raised a concern. This meant that people knew what action was being taken to resolve their concern and what the outcome of this was. People told us they felt able to approach the manager and had confidence in them. People we spoke with said, "The new one [manager] is lovely." Another person said, "[Manager] has only been in the job a couple of months. [Manager] is doing a sterling job." During inspection, we could see the positive measures that the manager had put in place and this had assisted in overall improvements at the service

We heard mixed reviews about the manager from staff. We were told by the area manager and staff that this was because the manager was making a lot of changes and new procedures were being put in place.

We asked staff what they thought of the management. Staff said, "I think the staff team have improved, I like [manager's name] I feel I can go to them." Another staff member said, "It is a good service and we can raise concerns with the manager. The team need to be united and support the manager. Changes are being made which will improve the service." And another staff member said, "The changes [manager's name] has made are positive and for the better, sometimes changes are needed."

All the staff we spoke with said they were really happy working at the service. One staff member said, "I really enjoy it, I like helping people." Another staff member said, "It is my first job in care and I love it. I always liked looking after people, I treat people with respect and I get respect back."

Relatives we spoke with said, "I have been very happy with the service [person's name] loves the staff coming in." Another relative said, [Person's name] loves it and has fitted in well."

The provider had carried out a survey in July 2017. The manager had only been in post a few weeks when the survey went out, 73 surveys were issued and 14 had been returned so far. The manager was waiting for further responses then planned to put an action plan in place to address any issues. Looking at the responses received the main concern seemed to be lack of communication around late calls, listening to what is important to the person and consistency of care workers. However, a high percentage of people thought care workers were well matched to their needs, people were supported to achieve their goals and people knew how to make a complaint.

Staff meetings took place quarterly. Topics discussed were group (Comfort Call) news, information governance, time critical calls, lone working, values and news relating to Comfort Call Beechfield. During staff meetings different training topics were also discussed such as safeguarding, record keeping and health and safety. In addition to these meetings small group sessions were undertaken. At these meetings any relevant topics at that time were discussed such as a change to staff rotas.

Regular meetings for people took place and these were carried out by Group Thirteen which the provider/manager? also attended. This meant that people were given the information they needed and if any concerns were raised and the most appropriate team could pick this up. For example, for care concerns the provider/manager would address this, building and maintenance concerns would be addressed by Group Thirteen.

We saw evidence of regular spot checks on staff. During these checks the manager would make sure staff were completed tasks correctly, using the equipment correctly and wearing appropriate personal protective equipment (PPE)

We asked for a variety of records and documents during our inspection. We found these were stored securely. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The new manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring that medicines were available in the necessary quantities and was not working in line with current legislation and guidance to address the supply and ordering, storage, dispensing and preparation, administration, and recording of medicines. The provider had not taken appropriate action to ensure the safety of people.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not follow systems and processes to enable them to identify and assess the risks to the health, safety and welfare of people using the service. There was no robust monitoring in place for unplanned calls.