Comfort Call Limited

Comfort Call-Whinndale

Inspection report

Cecily Close
Normanton
West Yorkshire
WF6 1PU

Tel: 01924245070
Website: www.comfortcall.co.uk

Date of inspection visit:
15 April 2019

Date of publication:
31 May 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Whinndale is an extra care housing scheme for people who live independently within their own self-contained homes. The housing scheme is managed by South Yorkshire Housing Association. Comfort Call-Whinndale provides domiciliary care services for people living there. There were 29 people being supported at the time of the inspection. The registered manager confirmed people are able to choose other providers of domiciliary care if they wished.

People's experience of using this service:

The measures put in place to protect people from harm were not always robust. Information about risks associated with care and support needs was not always documented, call management lacked oversight and control, and there were persistent errors in the recording of medicines that people had been given. People's complaints were not well managed. We made a recommendation about improving staff knowledge about reporting concerns about people's safety.

People said they got on well with staff, and said they felt staff were mindful of their dignity and privacy. Staff were recruited safely and used appropriate protective equipment such as gloves and aprons. Staff had formal and informal support and there was a programme of training in place. We made a recommendation about improving the content of one piece of training.

People said they were offered choice and asked for consent, however we found some issues with documentation about decision making.

Care plans were brief and lacked evidence people were involved in writing them. Information about how people were supported to remain independent was lacking. There was no information about the kind of additional support people may need at the end of their lives.

We identified two breaches of regulation relating to person-centred care and safe care and treatment.

The processes to monitor and measure quality in the service were weak. When issues were found the action taken as a result did not always resolve them. There was a lack of drive to involve people and staff in the running of the service.
Rating at last inspection: This was our first inspection of the service since the change of provider in 2018.

Why we inspected: This was a planned inspection based on the date of registration.

Enforcement: Please see the 'action we have told the provider to take' section towards the end of the report.

Follow up: We have asked the provider to send us an action plan to show how the required improvements will be made. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

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

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 effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive 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-Whinndale

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two inspectors and an assistant inspector.

Service and service type:

The service is a domiciliary care agency. It provides personal care to people living in specialist housing.

The service had a manager 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:
Our inspection was unannounced.

Inspection site visit activity started and ended on 15 April 2019. We visited the office location on to see the manager and office staff; and to review care records and policies and procedures, and spoke with people living at the housing scheme on the same day.

What we did:
Before our inspection we reviewed all the information we held about the service, including notifications sent to us about key events and incidents which the provider is required to send to us. We gathered information from other sources including commissioners of services, safeguarding teams and Healthwatch. We did not receive any information of concern.

During the inspection we looked at records including two staff recruitment files, three care plans, medicines

administration records and other information relating to the running of the service. We spoke with three people who used the service and two members of staff.

Requires Improvement

Is the service safe?

Our findings

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

Requires Improvement: 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. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse

- Staff understood how to identify signs of potential abuse, although we found a low awareness that they could make referrals to the local safeguarding team and CQC themselves. This is an important part of making sure people are safe. We recommended the provider refresh staff training and knowledge in this area.
- We saw notifications had been made to the local authority and CQC as required when concerns were identified. However, we needed to ask the registered manager to make a safeguarding referral about one person as we identified concerns about self-neglect which thorough review and documentation of the person's care needs should have identified. We received confirmation this referral had been made after our inspection.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- Information about complex care and support needs was not always transferred into people's care plans from the assessments carried out by the local authority. This meant staff did not always have access to information about these needs or how best to support people safely.
- A falls and mobilising risk assessment for a person who used a wheelchair and a hoist for transfers stated they were independently mobile, however information in the care plan stated they were unable to stand or walk. A risk assessment for another person who was living with a condition which meant they were at risk did not mention either the condition or the associated risks.
- Audit and review of care plans focused on identifying staff errors and did not assess the quality or content of documentation.
- People did not raise concerns about how staff supported them with their medicines, and the registered manager's reviews of medicines practice concluded people always received their medicines.
- There was a persistent issue with staff not always completing medicines administration records (MARs) fully, which was identified in the audit records. Although the registered manager had issued memos to staff, and additional training had been provided, the actions had not been sufficiently robust to ensure MARs were always completed properly. We saw the errors were still being made.
- Calls were arranged using computerised planning software, which sent information to mobile phones which staff used whilst working. Some staff showed us how they planned the order of visits themselves after receiving this information. We asked how people would know when staff were due to call - there was no evidence this information was shared with people. One person told us, "The carers come anytime, there are

no set times."
● We looked at one week of evening calls for one person and saw they were scheduled for irregular times, and a review of the evening administration of medicines for the same period showed staff had administered medicines at times which did not match this scheduling.
● The registered manager had written to one person in response to concerns about irregular call times and durations and said, 'I can assure you that the staff will be informed to visit on time and stay the allocated time.' We saw the call times were still regularly shorter than planned. The person told us they would prefer staff to stay longer, stating they often felt lonely.
● Although the audit process found multiple instances where call start and finish times had not been recorded in people's notes, there was no audit of call management to enable the registered manager to monitor performance.

The above evidence contributed to a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●The service followed safe recruitment practices, with appropriate checks made to ensure people were protected from the employment of unsuitable staff.
● The registered manager told us they did not use agency staff as their own staff were willing to cover for any absences if needed. The registered manager told us they were confident their staffing levels were sufficient to provide care at all times, and said they added additional shifts to increase cover, although these were voluntary and therefore not always covered.

Preventing and controlling infection
● Staff had access to personal protective equipment (PPE) which we saw in use. The provider did not have responsibility for the maintenance or cleanliness of the building.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Ensuring consent to care and treatment in line with law and guidance; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● 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". People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA

● The registered manager told us there was no one currently using the service who lacked capacity to make any decisions. They said they would refer concerns to other professionals such as social workers in order for assessments of the person's capacity to be made.
● Hand-written documentation in one person's care plan showed that a best interest's decision had been made about their medicines, although there was no evidence a capacity assessment for decisions about medicines had been carried out.
● People told us staff offered them choices and asked for consent before providing any personal care or support, however we found the recording of consent in care plans needed improvement.

Supporting people to eat and drink enough to maintain a balanced diet
● The review of one person's needs completed by the local authority said the person was losing weight and asked for staff to record what the person had eaten. This was not identified as a need in the person's care plan and the nutritional risk assessment did not identify any issues with weight loss.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

●The review of one person's needs completed by the local authority said the person would need ongoing support with their mental health. There was nothing in the person's care plan about their mental health needs or of any involvement from mental health professionals.

The above evidence contributed to the breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Staff had regular supervision meetings at which a topic was discussed with them, for example medicines management. In addition to an annual appraisal staff told us they were able to ask for informal support at any time.
- Staff had an induction which covered training in areas such as medicines management, safeguarding and moving and handling. There was a programme of training in place which ensured all staff received full refresher training each year. Where poor practice was identified, the registered manager told us staff could repeat areas of their training at any time.
- Refresher training for the MCA was not robust and we recommended the provider to review their provision in this area.

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

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

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

● Care plans lacked robust evidence to show how people were involved in making decisions about their care. People we spoke with did not feel they have been involved. One person told us they had read their care plan, but had not been involved in writing it.

Respecting and promoting people's privacy, dignity and independence

● People told us staff were mindful of their privacy and dignity, for example being discreet when providing personal care.

●Care plans lacked detail to show how people's independence was being promoted.

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

● People told us they found staff approachable and friendly. Care plans contained limited information about the person's life experiences which staff could use to help build meaningful relationships.

● The registered manager told us no one needed adaptation to the information they received to assist them to read it, for example larger print or alternative formats. They told us information could be adapted if needed.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support.

● Care plans were very brief, lacked personalisation, and did not show people had been involved in writing or reviewing them. Not all care plans we looked at contained information about the person's life history, likes and dislikes.

● Care plans contained goals that people wished to be supported with, however they were vague and lacked information about what support should be given or how the goal might be met. For example, one person's care plan stated the goal was 'To get my legs better and get my mobility back.' There was no information about why these goals would improve this person's life. Two people's care plans stated they wished to maintain their independence, however there was no information about what staff could or should do to help with this.

● There was no information in people's care plans to show how people could be supported in accordance with their wishes at the end of their lives, or to indicate they had been asked but had preferred not to discuss this.

● The above evidence contributed to the breach of Regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● One complaint had been raised on behalf of someone who used the service. Although there had been a response to the issues raised, there was no evidence the registered manager had carried out an investigation or spoken with the person during the process.

● One person had raised concerns about their experience of using the service during a quality review. The registered manager had responded to these concerns in writing, however the concerns had not been logged as complaints. This meant records which could be used to assess overall performance and quality of the service would not have been complete.

The above evidence contributed to the breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

●Systems for auditing in the service were weak, and there was no overview of quality or safety of care. Auditing processes listed individual errors, such as gaps found on MAR charts, however there was no analysis to enable the registered manager to assure themselves that action taken to correct these errors had been effective. We saw the same errors were still being found.
● There was some evidence a quality monitoring form was used when visiting people, however there was no evidence the outcomes of these were combined to give an overview of satisfaction with the service.
● The governance processes were not sufficiently robust to check the content and personalisation of care plans, and we identified a breach of regulations relating to this.
● The provider carried out branch visits to review areas such as timesheets and rotas, internal audit review, complaints and recruitment. The visit report dated 22 October 2018 indicated that an internal audit was scheduled for 25 and 29 October 2018. When we asked to see the outcome of that audit the registered manager told us it had not yet taken place.
● The lack of robust auditing meant there was no evidence of the service using people's experiences or complaints as a tool for improving quality in the service.
● The above evidence contributed to a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A survey of people using the service had been conducted in August 2018, with five responses from 29 people. The responses had been combined to produce outcomes, although there was no evidence this feedback had been acted on or explored.
● Staff meetings were held, however records did not show how staff had contributed with feedback or ideas to help drive improvement in the service. The registered manager told us staff were reluctant to speak up in meetings and discussed with us some changes they may make to improve this.

Working in partnership with others
●The registered manager told us they had a good relationship with the housing association, and was able to

tell us about contact they had with other health and social care professionals as a part of providing care and support to people.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans lacked personalisation and information to show how people were being supported to achieve their goals.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of robust oversight and audit of the service.