Comfort Call Limited

Comfort Call - Kirklees

Inspection report

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Website: www.comfortcall.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Comfort Call – Kirklees took place on 8 November2017, this was the services first inspection since their registration with the Care Quality Commission in November 2016. This service is a domiciliary care agency providing personal care to people living in their own homes in the community within Kirklees. At the time of our inspection the service was providing care and support to 107 people.

The service had a registered manager in place. 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.

Staff were aware of the safeguarding procedures and felt confident appropriate action would be taken in the event of a concern being raised. Risk assessments were in place and action was being taken by the registered manager to improve the level of detail in these documents where staff needed to use a hoist to transfer people.

There were systems in pace to reduce the risk of employing staff who may not be suitable to work with vulnerable people. A number of people we spoke with told us staff arrived late and they did not have a consist team of staff visiting them. The registered manager had taken action where shortfalls were due to staff error an electronic call monitoring system was to be introduced.

Staff received training in medicine management but we were unable to evidence an assessment of staffs competency to administer medicines had been recently completed in two of the four staff files we reviewed.

People felt staff had the skills to do their job. New employees received an induction which included face to face training and shadowing a more experienced staff member. There was a rolling programme of refresher training, management supervision and observational assessments to ensure staff had the knowledge and ability to fulfil their role.

People received support to eat and drink where this was an identified need. Peoples care plans recorded the support they needed from staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, the service needs to ensure, where people lack capacity to make specific decisions, this is clearly evidenced including the process of making decisions in their best interests.

Everyone we spoke with told us staff were caring and kind. Staff treated them with respect and took steps to maintain their privacy. Staff were able to tell us about the actions they took to maintain people's dignity and ensure people's private information was kept confidential.

People had a care plan in place which was person centred and provided sufficient detail to enable staff to provide the care and support required by each individual. Staff made a record of the care they provided and these records were returned to the office in a timely manner.

There was a system in place to manage complaints.

There were systems in place to continually monitor the service, for example, the registered provider had an online management reporting system and audits were completed on people's daily logs and medicines records. Staff felt supported and regular meetings were held to seek feedback and share information. Feedback regarding the service was also gained at regular intervals from people who used the service. However, these systems had not identified or actioned the shortfalls identified within this 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 told us they felt safe.

Risk assessments were in place but they did not always record sufficient detail.

People told us staff were sometimes late and four staff said they felt staffing levels could be better.

Improvements were being made to the records relating to medicine administration.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received induction, training and ongoing management supervision.

People's care plans recorded the support individuals needed to enable them to eat and drink.

Where people lacked capacity to make specific decisions, records needed to be improved to evidence the service was fully compliant with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

People's privacy and dignity was respected.

There was a system in place to reduce the risk of unauthorised access to confidential information.

Is the service responsive?

Good

The service was responsive.

People had care plans in place which were reflective of the care and support needs.

There was a written record of the care and support provided at each care visit or call.

Complaints were acknowledged and responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

People did not always think the service was led due to concerns regarding staffing.

The service had a registered manager.

There was a system in place to monitor the effectiveness of the service provided and to gain feedback from people and staff.

Comfort Call - Kirklees

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 checked whether the provider is 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.

This inspection took place on 8 November 2017 and was announced. We gave the service 24 hours' notice of the inspection visit to ensure the registered manager would be available to meet with us. The inspection team consisted of two adult social care inspectors 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. The experts by experience on this occasion had experience in working within a health and social care setting.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Before the inspection, the provider 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.

During our visit to the office location we spent time looking at five people's care plans. We also looked at four records relating to personnel management and various documents relating to the service's quality assurance systems. We spoke with the regional operations manager, the registered manager and a care co-ordinator. Following the inspection we spoke with seven support workers on the telephone. We also spoke on the telephone with five people who used the service and six relatives of people who used the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "Yes of course I feel safe and comfortable" another person said, "Oh yes, safe, no problem at all." A relative commented, "Yes my relative is safe with the care workers."

The staff we spoke with said they thought people were safe. They were aware of the safeguarding procedures and would feel confident that their line manager or the registered manager would respond appropriately to any concerns they raised. One staff member said, "I did raise an issue with the manager, the manager raised it with their social worker who went to see them." Staff said they had never witnessed anything that gave them cause for concern but would not hesitate to report concerns regarding the conduct of their colleagues to a senior staff member staff if they thought they needed to. The registered manager was also knowledgeable about the actions they would take and where they would need to report any issues in the event of any safeguarding concerns. The staff we spoke with were able to describe different types of abuse and were aware of their responsibility in reporting any concerns. One staff member said, "If I had any concerns I would tell the office." This demonstrated the registered manager and their staff were aware of their responsibilities in keeping people safe.

All staff members we spoke with said they knew how to respond to an emergency while visiting people in their own homes. One staff member said, "If someone could not answer the door I would let myself in using the key code on their doors." Another staff member said, "I would stay with the person if they were unwell or had fallen. I know to contact the office and emergency services if needed. I would also contact relatives." Another staff member said, "We know people very well and would know who was at risk from falls."

Each of the care plans we reviewed contained a generic risk assessment regarding the person's home, for example, access, lighting, fire safety and security. Care plans also contained a risk assessment relevant to the persons care and support needs. For example two people required the use of a hoist to enable them to transfer from one place to another, however, the documentation did not always record a sufficient level of detail to reduce the risk of harm to the individual or staff. The registered manager told us a recent contract monitoring visit by the local authority had highlighted these deficiencies in peoples moving and handling assessments and as a result, changes were being made to the assessment documentation. We reviewed the moving and handling information for another person where these changes had already been implemented and saw the documentation recorded details of the equipment and how it should be used. This included how the sling should be fitted and which loops should be used. This showed action was being taken to ensure care and support was planned and delivered in a way that reduced risks to people's safety and welfare.

We checked and found staff had been recruited in a safe way. The registered manager told us recruitment was a continual process. Potential candidates completed a numeracy and literacy test, which if they completed successfully, they were shortlisted to attend for an interview. Each of the recruitment files we reviewed contained a completed application form, references and a Disclosure and Barring Service check (DBS). The DBS is a national agency that holds information about criminal records. This showed there was a system in place to reduce the risk of employing staff who may not be suitable to work with vulnerable

people.

People we spoke with raised a number of concerns regarding missed calls and staff arriving late. People told us; "No I cannot say they come on time, it varies at lunchtime and evening. The other two calls are ok. The care workers are always busy; they can come over an hour late at lunchtime. The care workers rush in and out", "They do not keep to the times they should. Sometimes in the past they have been as late as 10.20pm in the evening. It is hit and miss in the afternoon, we get rotas but these change when care workers come", "Communication is not good with them, the rotas are not done properly." And, "Sometimes late, sometimes early, they will ring me."

Relatives comments included; "Most of the time them are fine but we have double up's (two staff are required to attend the call), care workers do not turn up for the double up call. It depends on the time of the day, the morning call is fine but the afternoon call is a problem. One care worker could be waiting for over 20 minutes for their partner", "The care workers sometimes do not turn up and they do not bother even telling us. Sometimes they will be late but they still do not let us know." And "Lateness is a problem. They can come as late by as much as an hour and a half. The other day they came so late I rang them not to bother to come as I had done all tasks for my relative."

Feedback regarding the consistency of staff providing people's care was also variable. People's comments included; "Before I did have consistency but the last month it has gone to pot. There is no consistency at all", "I have a team of care workers that come", "I have 2 regular care workers." and "They keep changing the care workers. There is not a lot of consistency. I have about 3 care workers who are regulars." Relatives told us, "We have consistency in the morning and afternoon only- evening varies", "There is no consistency at all; this can upset my relative sometimes." "We have a team of care workers who attend." And, "We do have different care workers but this is not a problem for us."

Four of the staff members we spoke with said they felt staffing levels could be better. One staff member said, "We are sometimes asked to cover at short notice for colleagues that phone in sick, but they are generally okay if I say I can't cover." Another staff member said, "I am not aware of any missed calls and we cover for each other. Sometimes I am asked to cover extra but I don't mind." Another staff member said, "I have asked to reduce my hours and the manager was very good about it. Sometimes when the unexpected happens we could be running late. I let the office know and they sort out cover."

Prior to the inspection the registered manager had informed us about the action they had taken where they had identified people had not received their scheduled call which had often occurred as a result of care workers error with their rota. When we visited the service the registered manager and the care co-ordinator told us an electronic monitoring system was being introduced over the following couple of weeks. They explained staff would electronically log in and out as they arrived and left people's homes; this would enable the office based staff to monitor staffs attendance at calls, pre-empting late calls and reducing the risk of missed calls.

All staff spoken with said they had received training on how to support people with their medicines. One staff member said, "People's medications are in dosage boxes, we can prompt people to make sure they are taking them correctly." Another staff member said, "I know there are different levels of support and it is usually written in the person's care plan." All staff members we spoke with said they completed the medication administration record [MAR] when they had given any assistance with medication. When we spoke with the care co-ordinator they were able to tell us the action they would take in the event they were notified of an error being made with a person's medicines.

Each of the care plans we reviewed contained a medicines risk assessment. This noted the level of support people required with their medicines, details of the dispensing pharmacist and other information deemed pertinent to the management of the person's medicines, for example if the persons medicines were time critical. We reviewed the medicine administration records (MAR) for two people and saw there were no gaps in administration; the back of the MAR contained an audit form, this had been completed in a timely manner and no concerns had been identified. The MAR for another person had one gap where staff had failed to sign to confirm they had applied the persons prescribed cream, however, this had been identified though the registered providers audit system.

A recent inspection by the local authority contract monitoring team had identified where improvements could be made to the management of peoples medicines. The registered manager showed us the amendments which had subsequently being made to the MAR, this included an additional code for staff to record if they did not administer a medicine due to the person being at day care and where staff had to transcribe entries onto MAR charts, a place for both the transcriber and the 'checker' to sign the MAR. This showed action had been taken to improve medicines management at the service.

The registered manager told us all staff received annual training in medicines management, this was confirmed when we reviewed the staffs' training matrix. They also said an annual assessment of staff's competency to administer medicines was completed and we saw evidence of this in two of the four staff files we reviewed. In a third file we saw an observational assessment of the staffs performance had been competed but the section regarding medicines was blank, this was because the person did not require staff to assist them with their medicines. We could not locate the medicine competency assessment in the fourth staff file. We shared our findings with the registered manager who assured us these assessments would be completed at the earliest opportunity.

All staff members we spoke with said they always had plenty of personal protective equipment (PPE) such as gloves and aprons. Some staff said they carried hand sanitizers which they had purchased themselves. The registered manager told us PPE was available for staff to collect from the office as and when they needed further supplies. Staff told us that they had received training in infection prevention and control, this was confirmed when we reviewed the staffs' training matrix.

However, one relative we spoke with raised concerns regarding staff practice when completing personal care, they said, "We have gone to the length of giving two different coloured cloths, one for the private part and the other for the face but staff have failed to adhere to this. We have now stopped the towels and give the care workers wipes." Following the inspection we brought this matter to the attention of the registered manager to enable them to take appropriate action.

Where shortfalls were identified, we saw the registered provider took action. For example, there had been a choking incident at another service and following a review by the registered provider, an amendment had been made to the relevant module of staff training and information was shared with staff at supervision. We also saw this incident was recorded as being discussed at a staff meeting in October 2017 and both the registered manager and the care co-ordinator were aware of the incident and the action taken afterwards. Accidents and incidents were also recorded, the registered manager analysed this information on a regular basis to identify any patterns or trends, enabling prevention measures to be put in place to reduce future risks. These examples showed improvements were made when things went wrong.

Requires Improvement

Is the service effective?

Our findings

The registered manager was aware of how to access relevant evidence based guidance to achieve effective outcomes for people. They told us they attended good practice events provided by the local authority as well as registered manager forums. We reviewed a sample of the registered provider's policies and saw they each referenced relevant legislation and guidance. For example, the infection control policy referenced 'Infection prevention and control, NICE quality standard (NICE, 2014)'. The care co-ordinator said the office received a weekly bulletin via email from the registered provider which updated them on key changes within the organisation, for example, policy changes or amendments to current guidance. This meant the service used good practice to ensure effective care and treatment was delivered in line with legislation and standards.

People felt staff had the necessary skills to meet their needs. One person said, "Oh yes they do know what they are doing." Another person said, "They are not bad, they (staff) know what they are doing."

Staff told us new employees received a week of induction and two or three shifts where they shadowed another member of staff. The registered manager confirmed this saying all new staff attended a five day induction programme which included the completion of all their initial training. This was followed by shadowing other staff before they were assigned their duties. The manager explained new staff were initially allocated to people who required two staff as this extended the time they spent working with another staff member prior to being allocated people who only required a single care worker.

We also saw evidence, where appropriate, staff had completed the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that all workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

All staff members we spoke with said the training they received was very good. They described the training as face to face, and included, moving and handling, first aid, safeguarding, medication and personal safety (lone working). Staff told us they had received training to use hoists, ceiling hoists, turn tables and stand aids. We reviewed the training matrix and saw this recorded individual staff names and the training they had completed. However, neither care co-ordinator was on matrix so we were unable to evidence their training was up to date. The registered manager also showed us a set of laminated prompt cards which staff had been supplied with to ensure they had access to key information regarding moving and handling, mental capacity, medicines and skin integrity.

Staff said they felt supported by their line manager and the registered manager and they had the opportunity to have one to one discussions. Personnel files also evidenced staff had received recent supervision, and annual appraisal, where relevant, and a field based spot check on their performance. The registered manager told us this was to ensure staff were meeting the requirement and standards expected of the service.

People were happy with the support they received to eat and drink. One person said, "The care workers warm the food properly." Another person said, "The care workers make whatever I would like." Staff said they supported people with meals. One staff member said, "One person I go to is able to prepare their meal and I just warm it up for them." Another staff member said, "Most people I support have family members that prepare meals, if not I can cook them bacon and eggs or soup and a sandwich."

The registered manager told us some people they supported had specific dietary needs due to their health needs, religious beliefs or cultural heritage. We saw this was reflected in the care plans we reviewed, for example, one care plan recorded the person was diabetic, another care plan noted their meals had to be pureed and a thickening agent added to their drinks. The manager was also aware of how to initiate a referral to speech and language therapists or dieticians in the event a person's nutritional or hydration needs changed.

Staff members we spoke with were clear about the needs of people they were supporting. Some staff member said they had been supporting the same people for a long time so knew what was important to them. All staff members we spoke with said they would notify their line manager or the registered manager if they felt the person they were supporting had changing needs. One staff member said, "One person that I was supporting was deteriorating and we were unable to meet their personal care needs in the time that we were allocated. I told the manager and they spoke to the social worker who agreed to increase the care package. I feel the manager listens to us if we feel people's needs have changed."

All staff we spoke with were aware that they were expected to record any changes to the person's wellbeing. One staff member said, "I have worked with the same group of people for a long time so I would know if they were not up to the mark. I would make sure family were aware so that they could contact the person's doctor. I would also notify the office of any concerns." Another staff member said, "We are expected to read the notes if we have been on our days off. This helps us to understand how the person has been or if they have been ill." Care records noted the contact details for the person's preferred family contact and relevant healthcare professionals, for example, the GP and pharmacist. This enabled staff to contact family and external support if required.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

Both the registered manager and the care co-ordinator we spoke with expressed an understanding of the MCA. The care co-ordinator said, "It is about someone being able to make their own decisions, including making what we think are unwise decisions."

Each of the care plans we reviewed contained a section for the person or their authorised representative to sign their consent to the care package being provided. Care plans also recorded people's ability to make decisions regarding the care and support they were receiving. For example, one care plan noted, 'I am able to verbalise my consent to take my medicines'.

The registered manager told us the majority of people who used the service had capacity to make day to day decisions about the care and support the received. We reviewed the care plan for one person who the registered manager confirmed, lacked capacity to consent to the support they received; however there were

no capacity assessments or evidence of best interests' decision making in their care file. The registered manager said that following a recent inspection by the local authority contract monitoring team a couple of people had been identified as lacking capacity regarding some aspects of their care. They said they were therefore in the process of arranging best interests meetings with relevant healthcare professionals and family members. It is important this process is followed as it demonstrates openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005, and evidences, decisions made are in the persons' best interests.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring and kind. Peoples comments included: "They are always nice to me. They do have an accent, sometimes it is difficult to understand but they are nice", "They are always kind to me, polite and good", "The care workers themselves are caring- they are nice to me" and "I have a laugh with the care workers, they are so good with me, I am really happy to have them." Relatives told us, "They are great, we are really pleased with the care workers", "They are friendly, caring to my relative. We are happy." Two of the relatives told us their family members were 'very comfortable' with their care workers.

Staff told us the care they provided was individual and designed to meet people's needs. One staff member said, "We treat people as individuals and respect their wishes." The registered manager also told us, "We listen to what the service user wants and we deliver the care how they want it."

Staff received a regular field based observation from a senior member of staff. We saw this included an assessment of their conduct, that they maintained professional boundaries with people and ensured people privacy and dignity was respected. This meant staff's conduct in the field was monitored.

The registered manager told us when they accepted a new service user, one of the care co-ordinators visited the person to meet with them and to explore how they wanted their care package to be delivered. They explained this enabled them to develop the care plan around the person's individual needs and preferences. A relative said, "Yes we do discuss the care plan." A recent survey dated July 2017 recorded 79% of respondents felt listened to and involved in decisions about their care. This demonstrated the service involved people in the development of their care plan.

People's privacy, dignity and individual preferences were respected. A relative said, "Yes they are very respectful, they give dignity to my relative especially when they bathe [name of person]." Another relative said, "The care workers are good on the whole, they are polite, caring and do respect my relative."

Staff said they would always knock and wait to be invited into a person's house. If they used a key safe to enter the person's home they said they would shout to the person to let them know who was entering their home. They said they would always ensure people were respected and maintained their dignity by covering them up when delivering personal care.

Care plans reflected people's right to privacy, for example, one care plan detailed the support the person needed to access the toilet and prompted staff to 'give me privacy for a while'. Each of the care plans we reviewed also contained evidence of regular contact with the person or a relative, to gain feedback about their care and support package. This included asking if staff respected their privacy, dignity, culture and lifestyle.

Information was stored confidentially. For example the registered manager explained how key safe numbers were recorded to reduce the risk of unauthorised access. They also told us staff were provided with a

company mobile phone which enabled them to access their rota which included details of the people they were supporting. They said the phone was not issued to new employees until they had completed their induction and shadow shifts. They also said each phone was password protected and could be de-activated by the registered provider in the event the staff member left the service and did not return their phone.

Good

Is the service responsive?

Our findings

The registered manager told us peoples care plans were drafted using a combination of sources. This included, information provided to them by the funding authority, the person themselves and other relatives and healthcare professionals involved in their care.

Each of the care files we reviewed was organised, relevant information was easy to locate and the details about people's care needs was consistently recorded throughout their care plan. The care plans were person centred and detailed how the person wanted staff to deliver their care at each of their allocated call times. For example, one plan recorded, 'I have top dentures but my own teeth at the bottom'. Another care plan noted, 'Please help to straighten my leg as sometimes I get cramp'. Having this information ensures staff are aware of people's individual preferences.

Staff recorded the care and support they provided in a log book which was kept in the person's home. We saw the entries provided a brief synopsis of the care and entries were dated and timed. The log book contained a section for staff to record, where needed, peoples dietary intake, their skin integrity, if staff had supported them to re-position themselves and any financial transactions completed, for example if staff had made a food purchase for the person. The registered manager said the log books were returned to the office on a monthly basis. We saw returned books were recorded on a matrix, this enabled office based staff to identify if daily logs had not yet been returned.

A record was kept of calls received by the office which related to peoples care and support. This helped to improve communication between office and field based staff.

Complaints were being managed appropriately. A relative said, "I have a good relationship with the management. We do not have any issues so we don't have a lot of contact. If I do need them I know I can ring them." Staff were aware of the complaints procedures. One staff member said, "If a person told me they were unhappy about something I would assist them to make a complaint by telling them who to contact."

Complaints were kept in a file. There was a log at the front of the file which recorded the date of the complaint, the name of the complainant and a brief description of the complaint, investigation and a note of the outcome. We saw there were eight complaints recorded for 2017, one was unsubstantiated and seven were upheld. We reviewed the documentation regarding one of the complaints; this included a letter to the complainant to acknowledge their complaint and a further letter detailing the findings of the investigation and the outcome. The letter also detailed the action the complainant could take in the event they were not satisfied with the outcome.

The registered manager told us the service did not have a contract to provide services for people whose primary need was end of life care. Where people were already using the service, but their health deteriorated, then care was provided, within the scope of that agreed by the funding authority. The registered manager told us, in the event a person had a Do Not Attempt Resuscitation (DNAR) in place, the location of the document would be recorded in their care plan. At the time of the inspection no one using

the service was requiring this level of support.

Requires Improvement

Is the service well-led?

Our findings

We asked people if they felt the service was well led. People told us; "I can recommend the company due to the care workers being good", "I would recommend the service, the management are fine" and "I could never recommend this company, there is inconsistency, the rotas not adhered to." Relatives said, "They put too much on the care workers, they need to be more organised", "They need to have a little more consistency with care staff so relatives can build up a relationship" and "Yes I can recommend the service on the whole. The big problem they have is short staff due to sudden sickness."

The registered manager had worked for the registered provider for five years, transferring to the Huddersfield branch in May 2017. They were clear about their role and responsibilities within the service. They said their key achievements during their time at the Huddersfield branch had been ensuring staff had the appropriate attitude towards the people they supported and reducing the number of missed calls.

There were a number of systems in place to continually monitor the performance of the service. Daily log books and MAR'S had an audit section at the back of the booklet. We saw this had been completed in each of the records we reviewed. The care co-ordinator said they had set criteria they audited the records against, this included; consistency of call times and that people's care and support was in line with their care plan. This helped to ensure a consistent approach to auditing and provided a pre-determined baseline upon which judgements could be made.

The regional operations manager showed us the registered provider's online management system. We saw this enabled the registered manager to see a variety of reports relevant to the performance of their branch. The registered manager told us they used this on a regular basis as it enabled them to prioritise aspects of their work load to ensure the branch was compliant, for example, staff training was refreshed, supervisions were completed and care plan reviews had been completed. The regional operations manager also completed a monthly report when they visited the branch. We reviewed the most recent reports dated September and October 2017. They noted the topics discussed records which had been reviewed and actions to be taken by the registered manager.

An internal audit was completed by a senior manager on a monthly basis; this included an audit of staff files, service user records, health and safety matters and key performance indicators, such as staffs' training compliance. We saw although the service risk rating was recorded as 'high' the percentage compliance score had improved from 74% in June 2017 to 80% in September 2017. The registered manager said, "At our recent internal audit they said I was making a difference." It is important that registered providers regularly audit and review the records and practices within services to ensure that they are picking up on any shortcomings, identifying any areas for improvement and that they are working to continuously improve the services they provide.

The regional operations manager told a quality governance group met on a weekly basis at the registered providers head office. They said feedback from these meetings was provided to individual branches via quarterly branch manager meetings. A recent contract monitoring visit by the local authority had identified

some issues which needed to be addressed. The registered manager told us with the support of the regional operations manager the issues had either been actioned or steps had been taken to address them.

Staff said they felt supported by their line manager and the registered manager and they had the opportunity to have one to one discussions and also attended staff meetings. They said they could go to their line manager or the registered manager to discuss any concerns. One staff member said, "I had some health problems and the managers were very supportive. They reduced my hours and told me to contact them if I needed some time off." Another staff member said, "I have worked at Comfort call for five years and feel they are a very good company to work for." Staff also said there was always somebody available on the telephone if they needed advise. They said there was always someone on call when the office was closed at the weekend. Both the registered manager and care co-ordinator told us they felt supported and 'listened to' by the regional operations manager and other senior managers.

The registered manager told us they operated an 'open door' policy. Although they said they were happy for staff to call in at any time they said they kept their diary free on a Thursday afternoon as this was 'open afternoon' and ensured they were available should staff wish to meet with them.

The registered manager told us a weekly office meeting, team talk, had just been implemented for the office based staff. They said this discussion included feedback from any concerns over the weekend and enabled work for the forthcoming week to be allocated. Minutes of the meeting had been taken and we saw discussions included staff recruitment, timesheets and new employees. The minutes noted the service was currently 96% compliant with the registered provider's performance indicators. Team meetings had been held in December 2016 and April, June and October 2017. The minutes were easy to read, informative and covered a range of topics. The registered manager told us the format and topics were pre-set by the registered provider although this included a section for branches to add in topics for discussion relevant to them. They said a copy of the minutes was posted out to staff in the event they were unable to attend. We also saw a file contained copies of memos which had been issued to staff, these included guidelines on the use of social media, late calls and information regarding how to support people during a heatwave.

Where the service had received positive feedback about particular staff members this was recorded The registered manager also said they telephoned the relevant member of staff to inform them of the feedback. We saw one entry from a person who used the service, thanking a staff member for their prompt action in 'putting out a smouldering sofa'. A Care Heroes Award was also operated by the registered provider. An entry in the June 2017 team meeting minutes recorded these were 'to help recognise individuals and teams that go above and beyond'. The minutes from the October 2017 detailed the winners for each category. This showed there was a system in place to recognise achievements in the workplace.

Regular feedback was also gained from people who used the service. The registered manager told us there was a rolling programme in place to ensure each person, or their relative received a phone call every three months from a member of office based staff and we saw evidence of this in each of the care files we reviewed. For example, one file recorded feedback had been sought in April, May, August and September 2017, in another file feedback had been obtained in March, June and October 2017.

We saw newsletters had been posted out to people who used the service. These were dated February, Spring and Autumn and included information regarding safeguarding, how to complain, making decisions and staffs' professional boundary guidelines. We also saw the results of a survey which had been sent out to people who used the service and/or their families in July 2017, 108 surveys had been distributed and 40 returned. The survey covered a range of areas including; privacy and dignity, consistency of care workers and handling complaints. At the back of the results document we saw an action plan was in place which

recorded the action taken to date and timescales for completion. The registered manager told us a copy of the survey results was to be posted out to people with the next newsletter. These examples demonstrate the registered manager shared feedback about the quality of the service in an open manner.

The registered manager and the care co-ordinator were aware of how to involve other agencies if required. For example, they were aware of how to initiate a care package review in the event someone's care package needed increasing or reducing.

Under the regulations registered providers are required to report specific incidents to the Care Quality Commission. Notifiable incidents include safeguarding concerns and serious injuries. Records we saw showed all such incidents had all been reported appropriately.

During this inspection we found some improvements still needed to be made relating to safe care and treatment and the Mental Capacity Act 2005. A key concern gathered during feedback from people who use the service was in regard to staffing, late calls and inconsistency of staff attending their calls. The systems of governance had not identified or addressed these matters. Therefore the rating for this domain is requires improvement. Future inspections will seek to evidence these issues have been addressed and people have received a consistently high level of service.