Comfort Call Limited

Comfort Call - Astley Court

Inspection report

Astley Court
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Astley Court is an extra care scheme, which has an additional scheme (Amblecote Gardens) attached to its registration. Both schemes operate in purpose-built properties, which provide support and housing for older people who are unable to live completely independently. Each person lives in their own flat but has access to a communal room and dining area. The service can support up to 124 people in total, and 72 people were receiving support with their personal care at the time of the inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People did not always receive support in line with their care needs. Moving and handling risk assessments were not always robust. People received their medicines, however people and relatives told us about the lack of organisation for reordering medicines when people were coming to the end of their prescribed cycle. People's medicine records were not always maintained.

Incidents that involved contacting the housing provider to report faults were not always clearly recorded. We have made a recommendation about the provider reviewing their documentation processes in relation to reporting faults.

Staff told us about the pressures they had experienced and the need for more staff to support their workload. We have made a recommendation about the provider reviewing their staffing structures.

Governance systems required improvement. Staff told us there was a lack of presence form the registered manager and support from the wider management team in the care co-ordinator's absence. Robust monitoring and auditing systems were not in place. We received mixed feedback from people and their relatives about the service and care.

Staff received appropriate safeguarding training and had a good understanding of how to safeguard people. Recruitment checks were robust to ensure staff were suitable to work with vulnerable adults. We were assured that the provider was working with the housing provider in relation infection prevention and control.

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

Rating at last inspection
The last rating for this service was good (published 06 October 2017).

Why we inspected
We received concerns in relation to the management of medicines, staffing and management structures. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all extra care scheme inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to assessing risk and governance systems at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

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Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors and two Expert by Experiences carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

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
We gave the service 24 hours' notice of the inspection. This was because we needed to ensure the registered manager was available to support the inspection process and inform people of our planned visit.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 17 people who used the service and 19 relatives about their experience of the care provided. We spoke with twelve members of staff including the registered manager, regional manager, care manager, care co-ordinators and care workers.

We reviewed a range of records. This included 10 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- Moving and handling risk assessments were not always robust. Where people required the use of moving and handling aids to support their mobility and transfers, risk assessments were not detailed and did not always reflect their care needs.
- Care plans and risk assessments were not always updated when required. One person had a visit from and Occupational Therapist (OT) to assess their moving and handling needs, and they had made recommendations on how best to support the person. Care plans and risk assessments were still awaiting updates two weeks after the OT's visit.
- People did not always receive support in line with their care needs. One person had not received adequate support to maintain their person care in line with their care plan. People told us, "I have been here for a month and still haven't had a bath, my hair is dead greasy" and "I just wish they would give me a bath, I`ve been asking for weeks."
- The registered manager told us all people receiving support in the Amblecote Gardens scheme required a review of their care needs by the local authority. However, there was a lack of evidence of escalation to the local authority.

People's care needs and associated risks had not been robustly assessed and managed. This placed people at increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Using medicines safely,

- People received their medicines, however people and relatives told us about the lack of organisation for reordering medicines when people were coming to the end of their prescribed cycle. One relative told us, "They [staff] give [person] their tablets on time but they [staff] sometimes run out of tablets and they [staff] ring up when [person] has none, instead of ringing when [person] has about a weeks' worth."
- People's medicine records were not always maintained. Where people had prescribed creams, body maps were not always in place to direct staff where prescribed creams were required to be applied.
- The service was not following the provider's medicine policy in relation to 'as required' medicines or best practice in medicines. The National Institute for Health and Care Excellence (NICE) guidelines were not adhered to. NICE provides national guidance and advice to improve health and social care. We found guidelines for 'as required' medicines were not in place, therefore staff had limited direction of when people may have required specific medicines.

We found no evidence that people had been harmed however, systems were not robust enough to

demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager took immediate action to implement body maps during the inspection process.

Learning lessons when things go wrong
● Accidents and incidents were recorded and monitored. Quality calls were conducted with the person involved after an incident. Lessons learnt were identified.
● Incidents that involved contacting the housing provider to report faults were not always clearly recorded and the contact was not always logged.

We recommend the provider reviews their documentation processes in relation to reporting faults.

Staffing and recruitment
● Recruitment checks were robust to ensure staff were suitable to work with vulnerable adults. Staff had the necessary safety checks in place before starting work and completed a full induction.
● The provider used an electronic system to determine staffing levels. Staff rotas we saw confirmed people had staff allocated for their visits. However, staff told us about the pressures they had experienced and the need for more staff to support their workload. Their comments included, "It is very stressful at the moment, about the [number] of calls [allocated to rotas]," "It is terrible with being short staffed" and "No not enough staff, don't always get cover, sometimes rotas have to be split between the staff there and this puts more pressure on and sometimes we don't give people the length of time they need."

We recommend the provider reviews their staffing structures.

Systems and processes to safeguard people from the risk of abuse
● People said they trusted staff to keep them safe. People and relatives told us, "They [staff] are very good in every way, very kind and I feel safe" and "They [staff] do keep [person] safe."
● Staff received appropriate safeguarding training and had a good understanding of how to safeguard people. There was a safeguarding and whistleblowing policy in place, which set out the types of abuse and how to raise concerns. One member of staff told us, "I would report concerns to my line manager. I am aware I can contact the local authority or the CQC if needed."

Preventing and controlling infection
● We were assured that the provider was working with the housing provider to prevent visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was working with the housing provider and accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Governance systems required improvement. Staff told us there was a lack of presence from the registered manager and support from the wider management team in the care co-ordinator's absence. Their comments included, "We were left for six weeks with nobody [management]. I did not meet the registered manager until three weeks ago" and "When the care co-ordinator left, we had no manager, it was manic."
- The provider had recently implemented a care manager role to support the registered manager. The care manager had been recently recruited, however, the role had not been in operation long enough to make an impact on governance systems.
- Robust monitoring systems were not in place to monitor the length of visits people had been commissioned against the length of time it was taking staff to complete the visits. Staff told us they had escalated the concerns to management when people needed more time for visits, however, action was not always taken. Staff comments included, "We are constantly running around and rushing the residents. We always raise this with the manager when we are spending longer than allocated, but nothing gets done, we are still rushing around" and "We run the home without a manager. There has been no manager about and we have been clueless."
- Auditing systems were not always robust. Auditing processes had not picked up on the discrepancies we found during this inspection.

The provider had not operated robust systems and processes to assess, monitor and improve the quality of the service. This contributed to the breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People's views had been sought through regular contact and surveys.
- We received mixed feedback from people and their relatives about the service and care. Comments included; "[Relative] is well looked after," "Generally it is good I suppose," "Things could be better," "[Management] don't know what they are doing" and "Sometimes we are treated like a care home instead of supportive living."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

● The provider understood their responsibilities under the duty of candour and there was evidence the provider had informed people when something went wrong.

● Although the service worked in partnership with the housing provider and local authority. Improvement was required with their processes of escalating care package reviews to the local authority.

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 People's care needs and associated risks had not been robustly assessed and managed. Moving and handling risk assessments were not detailed and people's care plans were not always updated as required. People did not always receive adequate support with their personal care needs.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not operated robust systems and processes to assess, monitor and improve the quality of the service. They had not maintained accurate and complete records. Systems were not robust enough to demonstrate medicines were effectively managed.