

Castlerock Recruitment Group Ltd

CRG Homecare Milton Keynes

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Overall summary

CRG Homecare Milton Keynes provides personal care to people who live in their own homes in order for them to maintain their independence. At the time of our inspection they were providing approximately 57 care packages, 43 of which were adult packages and the remaining seven were children's.

The inspection took place on 6 August 2015 and was announced.

During our previous inspection on 24 March 2015, we found that two regulations relating to care, welfare and records were not being met.

People were not protected from abuse and improper treatment as systems and processes were not established and operated effectively. The provider did not have systems in place to report incidents appropriately,

including to external organisations, such as the local authority safeguarding team or the Care Quality Commission (CQC). This was a breach of regulations 11 (1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 13 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have suitable arrangements in place for establishing and acting in accordance with, the best interests of people who lack mental capacity as set out in the Mental Capacity Act 2005. There was no evidence that people's mental capacity had been assessed, or that decisions had been made in their best interests. This was

Summary of findings

a breach of regulation 18 (1) (b) & (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

During this inspection we looked at these areas to see whether or not improvements had been made. We found that the provider was now meeting these regulations.

The service did not have a registered manager in place, however a new manager had been appointed and they had started the process of registering with the Care Quality Commission. 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.

Systems had been implemented to record, report and investigate incidents within the service.

Mental Capacity Act (MCA) 2005 assessments had been implemented and systems were now in place to regularly assess people’s mental capacity and make best-interests decision.

As both systems had only recently been implemented, it was not possible for us to tell whether or not they were effective during this inspection. For this reason, the ratings from the previous report have not been changed to ‘Good.’

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

New systems had been implemented to record, report and investigate incidents, however these were recent changes and it was not possible to tell if they were effective yet.

Requires improvement



Is the service effective?

The service was not always effective.

There were now systems to ensure that the Mental Capacity Act (MCA) 2005 was being used to help people make decisions about their care. As these systems were new, it was not possible to tell if they were robust.

Requires improvement



CRG Homecare Milton Keynes

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 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 6 August 2015 and was announced. We gave the provider 48 hours' notice to ensure that people and staff would be available for us to talk to.

The inspection was undertaken by one inspector.

We checked the information we held about the service and the provider and saw that no recent concerns had been raised. We had received information about events that the provider was required to inform us about by law, for example, where safeguarding referrals had been made to the local authority to investigate and for incidents of serious injuries or events that stop the service. We also contacted the local authority that commissioned the service to obtain their views.

We spoke with the new manager, the quality and compliance officer and a senior care co-ordinator during the inspection.

We reviewed the care records of three people who used the service and the recruitment and training records of two members of staff. We also looked at further records relating to the management of the service.

Is the service safe?

Our findings

During our inspection on 24 March 2015, we found that safeguarding incidents had not been reported appropriately. There was no system in place to track incidents and demonstrate what actions had been carried out in response to them. For example, we found records of an incident which had not been reported to the local authority or the Care Quality Commission (CQC). There was evidence that an internal investigation had been carried out, however there was no record of the outcomes of this or action taken to prevent a similar occurrence in future. Another incident had been investigated and there were records that stated, 'the local safeguarding team may be informed', however there was no evidence that they, or the CQC were informed, or why the decision had been made not to report the incident. We discussed this with the staff in the office. Both were very new to the service and were unable to clarify this situation for us or determine why the issues had not been reported.

This meant that people were not protected from abuse and improper treatment as systems and processes were not established and operated effectively. This was a breach of regulations 11 (1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 13 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that improvements had been made and that the service was now meeting this regulation.

The manager told us that they had implemented a tracking system for all safeguarding incidents to ensure they were reported and investigated appropriately. They also told us that they were familiar with the requirement to report incidents to the local authority safeguarding team and the CQC. We looked at records and saw that a new system had been implemented to record, report and track incidents. We saw evidence that they had been reported to the local safeguarding team and the CQC and that they had been investigated by the manager where appropriate. Changes had been made to people's care plans as a result to reduce the risks of future incidents recurring. In addition, prior to this inspection we had received notifications from the manager informing us that incidents had taken place, and the action that had been taken.

Office-based staff members were also able to tell us about the systems that were now in place, and were familiar with the reporting procedures for safeguarding incidents. This meant that in the absence of the manager, incidents would continue to be reported and tracked appropriately.

As both the reporting system and manager were new, it was not possible to tell how effective the changes made were during this inspection. As a result, we have not changed the rating we gave in the previous inspection.

Is the service effective?

Our findings

During our inspection on 24 March 2015 we found that systems were not in place to act in accordance with the guidance of the Mental Capacity Act (MCA) 2005. Staff members had received training in this area but did not implement it on a regular basis. In addition, we couldn't see any evidence that mental capacity assessments had been carried out when we looked at people's care records.

This was in breach of regulation 18 (1) (b) & (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

During this inspection, we found that systems had been introduced assess and record people's mental capacity, in line with the MCA. This meant the service was now meeting the requirements of this regulation.

The manager told us that they had worked with the provider to introduce forms to assess people's mental capacity, and that the service was in the process of working through people's care plans to see whether or not an

assessment was required. They told us that they would meet with people and their families to discuss their mental capacity and, where appropriate, make a decision on the person's behalf, using a best interests approach. We looked at people's care plans and saw that the process of assessing people's capacity had begun. Where people were found to lack capacity, the reason was given details of the conversation were recorded.

Staff told us that their own understanding of the MCA had improved since our last inspection. They were able to discuss the MCA with us and the key principles it represented. They were aware that people's mental capacity was being assessed and that, where necessary, decisions would be made in their best interests. One staff member told us, "We presume that someone has capacity." Another said, "We have started introducing the mental capacity assessments."

As the manager and the systems introduced to assess people's capacity were new, we were unable to tell whether or not they were effective during this inspection. As a result, we have not changed the rating we gave in the previous inspection.