Castlerock Recruitment Group Ltd

CRG Homecare - Blackburn

Inspection report

Suite3, Business first
Davyfield Road
Blackburn
Lancashire
BB1 2QY

Tel: 01254416135

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07 July 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 07 July 2016. This was an announced focused inspection undertaken due to concerns that had been raised with us since our last inspection. In line with our current methodology we contacted the service one day before our inspection and told them of our plans. This was because the location provides a domiciliary care service and we needed to be sure that the registered manager would be at the office.

This report only covers our findings in relation to the concerns raised. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for CRG Blackburn on our website at www.cqc.org.uk

The service had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were systems in place to record and report incidents that affected the health and well-being of people who used the service.

Training around pressure area care and pressure sore prevention had been undertaken by all staff to ensure people were protected from possible harm.

Team meetings, quality assurance audits, spot checks and staff supervision sessions were undertaken to ensure staff understood their responsibilities in reporting incidents.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

There were safe systems for the protection of people who used the service. This included the recognising and reporting of pressure sores.

Is the service well-led?

Good

Management had arranged suitable training around pressure area care.

There were auditing systems in place to protect the health and welfare of people who used the service.

CRG Homecare - Blackburn

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.

We undertook a focused inspection on 07 June 2016 due to concerns that had been raised with us since our last inspection. The concerns raised were around the failure of some staff in not recognising or reporting a pressure sore.

The inspection team consisted of one adult social care inspector.

We have attended meetings with the police and also a multi agency meeting to keep up to date with the current situation.

During this inspection we looked at what the service had done to prevent any further incidents of this kind. We looked at staff training records, safeguarding policies and procedures and how management were monitoring staff in relation to recording adverse incidents to people who used the service. We also looked at supervision and spot check records. We spoke with the registered manager, a care coordinator, two care staff and the operations director.

Good

Is the service safe?

Our findings

Following an incident around staff not reporting a pressure sore we looked at what the service had done to keep people safe. Following the disclosure of the incident the service and local authority staff contacted people who used the service to ensure no-one else had a pressure sore or had other concerns about the care given by CRG staff. Managers at the service had fully co-operated with the enquiries.

Following the incident staff visited people with their consent and completed a body map to check if any other person had a pressure sore. No further sores were found. Body maps show where any bruising, cuts or red areas are. We looked at the records for one person and noted this had been completed. This was a person who may be at risk of pressure sores and all action and care was taken to prevent any occurring. The person had signed an agreement that he was happy with care and support from staff. We were shown a record of all actions taken in this way for people who used the services of CRG Homecare Blackburn.

The service had a copy of the Blackburn with Darwen safeguarding policies and procedures to follow a local initiative. This meant they had access to the local safeguarding team for advice and to report any incidents to. There was a whistleblowing policy and a copy of the 'No Secrets' document available for staff to follow good practice. A whistleblowing policy allows staff to report genuine concerns with no recriminations. Staff told us they would not hesitate to use the policy. The service also had their own safeguarding policies and procedures for staff to follow good practice. The policies were reinforced to staff following the incident. The service had always reported any incidents in a timely manner.

Good

Is the service well-led?

Our findings

The service had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A care co-ordinator told us, "I had the pressure sore training. It was very useful. There were some things I was not aware of so it was useful. We were reminded to report any issues at supervision and the team meeting. Since the incident we have reported a further four people to the district nurses to check on any red areas people had". Two care staff we contacted told us, "I attended the training for pressure area care and found it very interesting. It was very good. We were told what to look for and what to report. At our team meeting we were also told what to report but I was aware I have to report any changes and have done previously to district nurses and office staff. I will report any issues I am not sure of to get advice and know I can contact the local authority or the CQC if I need to" and "I have been here six months and when I started we had pressure area care training. I have since had further training which was more in depth and very useful. I have not seen anybody with any pressure area problems since the training but today I had to report a care issue to the district nurses and emailed the registered manager so it was recorded in the office. Reporting any issues was reinforced at a team meeting and supervision. I would be confident to report anything."

Following the incident management had arranged further training for pressure area care. We noted that some staff who may have had minimal involvement in the incident had also had refresher training in the two hour course. Managers had also brought up reporting incidents at one to one sessions and at the team meeting of 15 June 2016. At the meeting it was recorded that staff had to report the first signs of a pressure sore. This meant if they saw a red area they must tell office staff and record in the daily record sheets. They had to log in the communication book that the office had been notified and they must record who they had spoken with. Office staff would put this on the system so there was a clear track of information coming in from care staff. This reporting system was to be used for any adverse incident. Senior staff would notify relevant professionals such as district nurses and ensure people received the care they needed. District nurses were responsible for providing any equipment.

At our previous inspection we noted pressure area care training had been given to staff. We found at this inspection that management had arranged for all staff to have a two hour refresher course and we looked at the training matrix which confirmed this. Staff then had to answer questions around what could cause a pressure sore, areas commonly affected, what were the indicators and what could be underlying causes. Staff also had to understand what steps could be taken to prevent sores from developing, the care of immobile service users and any equipment that could be used, who to report pressure areas to and how staff could help people prevent pressure sores themselves such as by regular turning, standing, good diet and checking for red or sore areas. The training given was sufficient for care staff to know what the causes of pressure sores were, how to prevent them and their responsibility in reporting quickly to prevent them.

At supervision staff were reminded of the importance of reporting any changes in a person's care or

condition. This should ensure good communication between staff, managers and allied professionals.

Spot checks were being conducted regularly by team leaders to ensure staff were following good practice and to talk over any care issues with people who used the service. We saw records of the various times and dates of when staff had been supervised or spot checked.

A new tier of management had been added to undertake quality assurance. This included the care and support of people who used the service. There was also a new system whereby staff could report any concerns or incidents to another office within the group. This was to help staff who wished to raise a concern anonymously. This information was available for staff to read in the office. A care coordinator said the information was posted on the office wall for staff to use but had not had to raise any concerns. A care staff member said, "I am aware of this new system but have not had to use it thankfully."