

Care at Home Group Ltd

Care at Home Group Warrington

Inspection report

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Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service effective?	Requires Improvement ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

About the service

Care at Home Group Warrington provides care and support to people in their own homes across the Warrington area. 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. At the time of the inspection there were 71 people using the service.

People's experience of using the service and what we found

People's health, safety and wellbeing were sometimes put at risk due to a number of concerns identified during this inspection. Risk management was not always consistent, and people and family members did not always feel assured about their safety.

Staff did not always have the right skills, knowledge or experience to carry out their role safely and effectively. Concerns with staff numbers and the poor organisation of their rotas placed staff under additional pressure. This often resulted in people receiving their calls late and not for the agreed amount of time. Lateness of staff sometimes resulted in people's prescribed medicines not being administered at the right times.

There were not enough assurances that the service consistently met current national guidance and standards in relation to infection prevention and control (IPC). Staff had limited knowledge about some IPC procedures, including the removal and disposal of personal protective equipment (PPE). The provider did not always make sure that adequate measures were in place to prevent the spread of infection; particularly in relation to COVID-19.

Whilst people's needs had been assessed and plans were in place, staff did not always have access to relevant, up-to-date information. Staff told us they often did not have time to read people's care plans and that care plans were not always available in people's own homes.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, systems in place did not always support this practice. For example, the outcome of mental capacity assessments completed by the provider did not always accurately reflect the answers given.

Mixed feedback was received from people and family regarding the management of the service. Some described it as 'disorganised' and 'poor communication and record keeping'. Staff told us they felt the service was disorganised due to lack of consistent management and limited office staff support.

There were widespread, significant shortfalls in the way the service was led which had resulted in multiple breaches of regulation. Governance systems were not robust enough to identify issues and drive

improvement. Staff told us they did not feel involved, appreciated or engaged with.

Rating at last inspection and update - The last rating for this service was requires improvement (published 26 June 2019) and there were multiple breaches of regulation.

Why we inspected

We carried out an announced comprehensive inspection of this service on 30 May and 6 June 2019. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, staffing and governance.

The inspection was also prompted in part due to concerns received about staffing, lack of staff training and infection control. A decision was made for us to inspect and examine those risks.

We undertook this focused inspection to check the provider had followed their action plan, to inspect and examine areas of concerns received and to confirm they now met legal requirements.

This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-led sections of this full report.

The provider took some actions following the inspection to mitigate some risk.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to Regulation 12 (Safe care and treatment), Regulation 11 (Need for consent), Regulation 18 (Staffing) and Regulation 17 (Good governance) at this inspection.

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

Follow up

Following the inspection, the provider submitted an action plan telling us 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

This service was not safe.

Details are in our safe finding below.

Inadequate ●

Is the service effective?

This service was not always effective.

Details are in our findings below.

Requires Improvement ●

Is the service well-led?

This service was not well-led.

Details are in our findings below.

Inadequate ●

Care at Home Group Warrington

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.

Inspection team

This inspection was carried out by one inspector 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.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. However, they had been on long term absence and not present during the inspection. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave a short period notice of the inspection because we needed to give time to prepare in advance for our visit due to the COVID-19 pandemic.

Inspection activity started on 5 November 2020 and ended on 12 November 2020. We visited the office location on 5 November 2020.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. This included the

information we received about concerns. We also sought feedback from the local authority. We used all of this information to plan our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with three people who used the service and nine family members about their experience of the care provided. We spoke with 17 members of staff including, care staff, area manager, interim manager and group operations manager.

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

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

At the last inspection the provider had failed to ensure that assessments to manage people's identified risks were accurate and up-to-date. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had also failed to ensure the safe management of medicines. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvements had not been made and the provider remained in breach of regulation.

- Risk assessments and associated care plans had been completed. However, staff did not always have access to relevant information and guidance in order to safely manage people's identified risks placing them at potential risk of harm.
- Staff did not always have the relevant skills and knowledge required to manage people's identified risks and keep them safe. Some staff told us they had not received training in areas such as wound care, diabetes, and catheter and stoma care despite supporting people with risks in these areas.
- We received mixed feedback from people and family members about how safe and assured they felt. Their comments included; "We don't think [relative] is always safe. He has had a few falls at night when his walking frame has not been left by the bed," "I feel fairly safe most of the time, but sometimes carers don't turn up on time as running late" and "Yes, [relative] is looked after well. The staff are sensitive, respectful and do what is needed."
- Some people and family members told us prescribed medicines were not always given at the right time due to staff being late. One person told us, "My daughter is now doing my tablets as I need them every 4 hours and I wasn't always getting them regularly with the carers running late." A family member told us, "If carers are running late [relative] doesn't get tablets on time."

We found no evidence that people had come to harm, however the provider had failed to ensure the safe management of individual risks and medicines. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Where people needed support with their medicines, this was clearly recorded in their care plan.
- The provider had recently changed to electronic medicine administration records. Staff told us these were easier to use and provided all the information and guidance they needed to safely administer people's

medicines.

Infection prevention and control

- We could not always be assured that measures were in place to prevent the spread of infection, particularly in relation to COVID-19.
- Some staff told us they were given incorrect guidance if they displayed COVID-19 symptoms. One staff member told us; "Staff have been told to come in to work when they have symptoms until they have had a test. We're told we have masks so it should be fine."
- Staff had limited knowledge about how to correctly remove and dispose of personal protective equipment in order to minimise the spread of infection. They told us they had not received adequate training or guidance in this area.
- Staff were not always given calls in specific areas or zones. This increased the potential for infections such as COVID-19 being spread wider.

The provider had failed to ensure robust measures were in place to prevent the spread of infection. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There were not always enough staff to meet people's needs which often resulted in them not receiving calls at the agreed times.
- Staff told us they felt under pressure due to the lack of available staff and they confirmed they were not always able to attend calls at the right times. Their comments included; "It's been dreadful. So many staff have left. We don't get enough time in between calls which makes us late" and "We don't get enough time to travel between calls. We're given tasks at the last minute. Rotas change daily and we never know what our calls or hours are until the day."
- People and family members told us staff were often late and did not always stay the agreed amount of time. Their comments included; "It's a bit hit and miss, some [staff] are on time, some not. Supposed to be there for one hour but don't always stay that long" and "Staff often running late, and my [relative] has to wait a long time for his wash."
- The provider acknowledged that staffing was an issue and told us efforts were being made to recruit more staff.

The provider had failed to ensure there were enough staff to safely meet people's needs. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Safe recruitment processes were mostly followed to ensure new staff were suitable to work with vulnerable people. Appropriate background checks were completed before new staff started to work. However, references were not always obtained and not all interview questions were asked to determine an applicant's suitability.

Learning lessons when things go wrong

- Robust systems were not in place to ensure that learning occurred when things went wrong.
- There was a lack of manager review and analysis of accidents and incidents to look for patterns and trends and ways to prevent them occurring in the future.
- Managers and office staff did not always have access to relevant information about accidents and incidents. Staff did not always know how or where to record accidents or incidents; some staff told us they were recorded in people's daily records and others through their electronic device.

The provider had failed to ensure robust systems were in place to monitor and review accidents and incidents. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Staff had good knowledge and understanding about how to recognise and respond to allegations of abuse or safeguarding concerns.
- A record was kept of any safeguarding incidents. Those recorded showed evidence of appropriate action and referrals to relevant external professionals.

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.

At the last inspection this key question was rated requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At the last inspection, the provider failed to provide staff with adequate training and supervision. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvements had not been made and the provider remained in breach of regulation.

- The manager provided us with a record of all staff training which indicated that staff had received training relevant to their role. However, we were not assured all staff had the relevant skills, knowledge and experience to carry out their role safely and effectively.
- Some staff told us they did not feel they had received the training needed to carry out their role confidently. Their comments included; "I have been supporting [name] for a few weeks. They have a lot of care needs. I haven't been trained I have learnt from [relative name]" "I support someone with a stoma. The training was a 20-minute YouTube video" and "Not had catheter training and I have one person who has a catheter."
- New staff received an induction before working on their own. However, some records showed staff were being signed off as 'competent' without areas such manual handling being observed.
- We received mixed feedback from people and family members about staff knowledge and skills. Their comments included; "I have seen them [staff] in action and I'm happy with what they do for my [relative]," "Some [staff] don't know what they are doing. My [relative] must tell them what to do" and "I have had to show most of them [staff] what to do for [relative name]. He has a lot of needs and staff aren't given the training."
- Although some staff had received supervision, they did not feel supported in their role. They told us when concerns or issues were raised, they were never addressed.

The provider had failed to ensure staff received the right training and support to carry out their role. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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 when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection (CoP) for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At the last inspection, the provider failed to ensure staff received training in the MCA. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvements had not been made and the provider remained in breach of regulation.

- Whilst assessments had been completed to determine whether a person lacked capacity to make certain decisions, the outcome of some assessments did not accurately reflect the answers given to specific questions. This resulted in consent for care not always being obtained by the right person.
- Staff lacked adequate knowledge and understanding around the MCA and how this should be applied when providing care and support.
- There were no systems in place to check staff knowledge and competency in respect of the MCA.

The provider failed to ensure the service was working within the principles of the MCA. This is a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People's needs had been assessed, and in most cases, care plans were in place to guide staff on how to provide people with effective care. However, some staff told us they did not always have access to care plans or have time to read them prior to supporting new people.
- Some staff told us care plans were not always updated in a timely manner following a change in people's needs.
- People's oral health needs were assessed and planned for.

Supporting people to eat and drink enough to maintain a balanced diet

- Where risks associated with eating and drinking were identified, such as choking risks, these were recorded in people's care plans. However, some lacked guidance for staff on how to identify and respond to specific incidents. We have reported on this further within the key question, 'is this service safe'.
- Where people needed support with their meals, this was clearly recorded in their care plans.
- People and family members told us staff prepared meals where needed and always made sure drinks and snacks were easy to access before leaving. Comments included; "They [staff] make [relative's] meals. She likes what they do" and "They [staff] have a set menu which [relative] enjoys."

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

- Staff and managers worked effectively with healthcare professionals to ensure that people received the care they needed.
- Advice from other health and social care professionals was obtained for people when needed.

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 requires improvement. At this inspection, this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection, the provider had failed to implement governance systems robust enough to identify issues and make improvements to the quality of care provided. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and additional concerns were identified. The provider remained in breach of regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Delivery of high-quality care was not always assured by the leadership, culture and governance in place. This was evidenced by the concerns identified and the multiple breaches of regulation found.
- Staff told us they experienced high levels of work overload and felt undervalued and unappreciated by managers and senior leaders. Their comments included; "I feel stressed a lot and emotional and don't get supported. Staff are going to get burnt out if things don't change," "It's terrible. There's no support and no consideration for staff wellbeing" and "Communication is poor. [Provider] doesn't care about the Warrington branch."
- Staff told us they did not feel that their wellbeing was protected or considered, particularly where reasonable adjustments were needed to support individual needs. This sometimes led to increased difficulties and pressures in carrying out their role.
- We received mixed feedback from people and family members about the management of the service. Their comments included; "Sometimes it is [well-managed], sometimes it isn't. I told them [office staff] that some carers weren't wearing aprons and it took them quite a lot of time to sort it out," "It's [the service] not as good as it used to be. It's not well organised. It's like headless chickens and a lack of communication between staff" and "Seems to be ok, staff polite and helpful. The girls in the office come out and help if they are short staffed."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Staff told us they felt management of the service was poor and disorganised. Their comments included; "There is no organisation and no structure. Communication from managers is poor" and "Lack of organisation and communication from managers to staff."
- Whilst people and family members spoke positively about the care received from staff, they felt areas such as staff punctuality and better organisation and communication were needed in order to improve the

quality of the service provided.

- The registered manager was on long term absence during the inspection. An interim manager had been recruited but had only been in post a month. They were supported by the area manager during the inspection.
- Due to staffing issues, office staff were required to support with the delivery of care and therefore unable to carry out their designated tasks. This had resulted in some of the concerns identified during this inspection.

Continuous learning and improving care

- The quality assurance systems in place were not effective or applied consistently in order to drive improvement.
- Audits and checks were not carried out on a regular basis. Those that had been completed identified some issues. However, there was no evidence that actions had been set to address them and make improvements.
- The provider recognised the need to make improvements. Following the inspection, they completed an action plan telling us what they would do to improve the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Managers failed to engage with staff effectively in order to gain their views and make them feel involved in the way the service was run. Staff told us; "I don't feel listened to or involved. I never get asked my views or opinions" and "Not involved at all. I just get told I am wrong."
- Staff told us there was very little engagement from managers about the service or any important changes. The manager acknowledged that meetings with staff did not take place and understood the impact this would have on their morale.
- Whilst satisfaction surveys and quality monitoring reviews were completed with people and family members, there was little evidence that improvements were made when issues were raised. One family member told us; "I report things but nothing happens."
- Whilst the service worked in partnership with external agencies, managers had not always provided necessary information when requested in response to concerns being raised. Professionals could not always be assured that issues were being addressed.

The provider failed to implement robust and effective governance systems which had resulted widespread, significant shortfalls in the way the service was led. This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider complied with their duty of candour responsibilities.
- The provider notified CQC of events as required by regulation.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Outcomes to assessments to determine whether a person lacked capacity to make a particular decision did not always accurately reflect information received. This meant consent for care was not always obtained from the right person.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>There were not always enough staff to meet people's needs and provide care and support at the agreed times.</p> <p>Staff had not always received adequate training and supervision to carry out their role safely and effectively.</p>

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Staff did not always have access to relevant information or guidance on how to manage people's identified risks and not always received adequate training to manage people's identified risks.</p> <p>People did not always receive their prescribed medicines on time.</p> <p>Robust measures were not in place to prevent the spread of infection, particularly in relation to COVID-19.</p>

The enforcement action we took:

Warning notice for Regulation 12; Safe care and treatment.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Leadership, governance and culture in place did not always ensure the delivery of high quality care.</p>

The enforcement action we took:

Warning notice for Regulation 17; Good Governance.