Health Care Resourcing Group Limited

CRG Homecare Lincolnshire

Inspection report

Mayfields Extra Care Housing Scheme
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17 November 2020

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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:
CRG Homecare Lincolnshire is a domiciliary care agency. It provides personal care to people living in their own homes in the community and two specialist housing schemes. The service operates in and around the towns of Boston and Sleaford in Lincolnshire.

Not everyone who used the service received personal care. The Care Quality Commission (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 our inspection, approximately 300 people were receiving a personal care service.

People's experience of using this service and what we found:
The provider had failed to ensure there were sufficient staff deployed in the Boston area of operation, increasing risks to people's safety and welfare.

Staff did not always comply with the requirement to wear personal protective equipment (PPE), increasing the risk of COVID-19 spreading within the service. The management of people's medicines was not always safe.

The provider had failed to effectively assess, monitor and improve the quality of the service. Notifications about events that had happened in the service had not been submitted to CQC, as required in law.

More positively, staff were generally satisfied with their experience of working in the service. Most people and their relatives also provided positive feedback on the caring, friendly nature of staff.

Staff worked collaboratively with local health and social care services. Staff knew how to recognise and report any concerns to keep people safe from harm. People's individual risk assessments were reviewed regularly.

There was organisational learning from significant events and staff recruitment was safe.

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 19 June 2019).

Why we inspected:
We received concerns about the safety of care delivery and organisational governance. 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 significant issues 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.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

Enforcement:
At this inspection we have identified breaches of regulations in relation to staffing; the assessment of risks to people's safety; monitoring service quality and notification of significant events. For each of these breaches you can see what action we have asked the provider to take at the end the full version of this report.

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.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, 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.

CRG Homecare Lincolnshire

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 registered 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.

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
Our inspection was conducted by one inspector and two Experts 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
CRG Homecare Lincolnshire is a domiciliary care service, registered to provide personal care to people living in their own homes and specialist housing.

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.

Care staff were organised into two teams – Boston and Sleaford. The larger Boston team delivered about 80% of the care calls delivered by the service and was managed directly by the registered manager. The smaller Sleaford team was managed by an assistant manager ("the Sleaford team manager") who reported to the registered manager.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the registered manager would be in the office to support the inspection.

What we did before the inspection

In planning our inspection, we reviewed information we had received about the service. This included information shared with us by other organisations including the local authority contract monitoring and adult safeguarding teams.

We also 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.

During the inspection
We conducted our inspection between 9 and 17 November 2020.

During the inspection we spoke with the registered manager; the Sleaford team manager; the provider's regional director; six members of the care staff team and 53 service users or relatives.

We reviewed a range of written records including four people's care plan, three staff recruitment files and information relating to the auditing and monitoring of service provision.

After the inspection
We reviewed further information we had requested from the provider, including data relating to call scheduling and medicines administration.

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.

Staffing and recruitment

• When we spoke with people and their relatives about the provider's organisation of staffing resources and delivery of their care calls, we received very different feedback depending on which team provided their support. People we spoke with who received care from the Sleaford team were generally satisfied with the staffing arrangements in their area. For example, one person said, "About three months ago [I wasn't satisfied] but things improved. We now have more regular staff. They are mostly on time [and] stay for their allocated time now." A member of staff in this team commented, "At one point it all went to pot, too many calls. But it's a lot better now. [The Sleaford team manager] has done wonders. I've got enough travel time [and] don't run late."

• However, many of the people we spoke with who received care from the Boston team expressed concerns about shortfalls in the delivery of their care calls and the negative impact this had on their lives. For example, one person's relative said, "The problem is with the timings. Sometimes they're ridiculously early or late. The carer for breakfast may not arrive until 10am and then the lunchtime carer turns up at 11am, even though [my relative] doesn't have their lunch until 1pm."

• Staff in the Boston team also told us of their concerns. For example, one staff member said, "There's not enough staff, it's very challenging. We have so many clients to get to. It's a nightmare deciding who is the priority. Sometimes you can't stay as long as you want [and] we are sometimes [late]."

• The provider used an online system to schedule and monitor people's care calls. In the light of the feedback from people and staff, we asked the provider for an analysis of recent calls. When we reviewed this data, we found extensive evidence of 'call-clipping' ie staff staying for less than the scheduled call time, increasing the risk of rushed, unsafe care. Call-clipping was particularly prevalent in the Boston area. In the five weeks preceding our inspection visit, 34% of all care calls delivered by the Boston team were shorter than scheduled. People told us that some calls were extremely short. For example, one person's relative told us, "[We] should have 20 minutes morning and evening for meal and medication [but] they are often staying less than 10 minutes. One call was three minutes."

• We also identified a high incidence of early and late calls, increasing potential risks to people's safety and welfare. Again, this was particularly prevalent in the Boston area. In the same five-week period, 40% of care calls delivered by the Boston team were early by 20 minutes or more and 17% were late by 20 minutes or more. People told us that some calls were extremely early or late. For example, a relative commented, "Turning up within 30 minutes is acceptable but turning up two hours late is no good." Commenting on the impact of late calls on their well-being, one person told us, "It would be nice if they rang me to say they're going to be late, so I don't need to panic."

When we discussed the issue of staffing with the registered manager, she told us staffing levels in the Boston team were "just sufficient". However, it was clear from the call monitoring data supplied and the feedback from people, relatives and staff that the provider was failing to ensure sufficient staff were deployed to meet people's needs, safely and effectively. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• More positively, we reviewed recent recruitment decisions and saw that the necessary checks had been carried out to ensure that the staff employed were suitable to work with the people who used the service.

Using medicines safely; Preventing and controlling infection; Assessing risk, safety monitoring and management
• Staff received training in handling medicines management and senior staff conducted medication audits, reviews and competency spot checks to ensure people's medicines were being administered safely. However, despite these measures, in the six months preceding our inspection, there had been a total of 42 medicine administration errors in the service, an average of seven each month.
• This was a particular issue in the Sleaford team, where there was a monthly average of five errors, a figure which had not improved over the six month period. Describing what constituted an administration error, the Sleaford team manager told us, "It could be night-time medicines given in the morning, one missed tablet or no medicines given at all."
• Although there was no evidence that anyone had yet come to any harm, the continuing prevalence of significant medicine administration errors created potential risks to people's safety and welfare.
• The provider had reviewed and strengthened existing infection prevention and control measures in response to the COVID-19 pandemic. For example, COVID-19 individual risk assessments had been prepared for each service user and staff had been provided with additional personal protective equipment (PPE). Reflecting national guidance, staff were required to wear this PPE to reduce the risk of COVID-19 spreading within the service.
• Almost everyone we spoke with who received care from the Sleaford team told us staff always wore PPE during their care calls. However, of the people who received care from the Boston team, almost half (43%) of those we spoke to about this issue, told us staff did not always comply with PPE requirements. For example, one person said, "The two girls I normally have … wear masks. But the one I had this morning didn't. And there are two or three others who don't."
• When we discussed the issue of PPE with the registered manager, she said, "I would like to think they are wearing it." However, in the light of the feedback we received, it was clear that staff were not consistent in their use of PPE, increasing risks to service users' health from COVID-19.

The provider's failure to properly assess and manage potential risks relating to the administration of people's medicines and the wearing of PPE was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• More positively, the provider had systems in place to ensure other potential risks to people's safety and welfare were assessed and managed. For example, one person had been assessed as being at risk of skin breakdown and staff had been provided with guidance on how to prevent this. Senior staff reviewed people's care plans and individual risk assessments regularly.

Learning lessons when things go wrong
• The provider reviewed incidents and events to help reduce future risks to people's safety and welfare. For example, in response to one recent significant event, the registered manager had changed the way new client referrals were managed in the service.

Systems and processes to safeguard people from the risk of abuse

• The provider had a range of measures in place to help safeguard people from the risk of abuse. For instance, staff had received training in safeguarding procedures and how to report any concerns relating to people's safety and welfare.

• Almost everyone we spoke with told us they felt safe using the service. For example, one person said, "I feel very safe. The staff are very helpful, pleasant and friendly. I trust them implicitly."

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

• Many of the people we spoke with told us how highly they regarded the care staff who came to their home. For example, one person said, "All the girls are very good; they're very conscientious and they do anything I ask."

• However, when invited to comment on the overall management of the service, people had very mixed views. Almost everyone who received care from the Sleaford team was generally satisfied. For example, one person said, "I think it's well managed. They look after me very well and I am happy with everything." In contrast, just over a quarter (27%) of the Boston service users we spoke with who commented on this issue, expressed their dissatisfaction. For example, one person said, "I'd like to see a better management team and a proper rota [with] carers coming to people at the right time. I wouldn't recommend the service because it's not reliable."

• The provider maintained a variety of systems to monitor the quality of the service. These included care plan reviews; audits of communication and medication records and reports from the electronic call monitoring system. However, despite this investment in quality assurance systems, the provider had failed to effectively assess, monitor and mitigate potential risks to people's safety in respect of medicines administration and the wearing of PPE.

• The provider had also failed to address long-standing shortfalls in the deployment of staffing resources in the Boston team. For example, in July 2020, we asked the provider to provide an analysis of care call timings for the week ending 26 July 2020. For the Boston team in that week, the provider told us 47% of calls were delivered early or late and 38% of calls were short. Since then, there had been almost no improvement. As detailed in the Safe section of this report, in the five weeks preceding our inspection, 47% of calls were early or late and 34% were short. Expressing their frustration, one person told us, "I don't think it's well managed. I think they've taken on too many clients for the staff to handle. The timings have got worse over the year."

The provider had failed to effectively monitor and improve the quality of the service, and to monitor and mitigate risks to people's safety. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• In preparation for our inspection, we reviewed notifications submitted by the provider to CQC. Notifications are events which happened in the service which the provider is required to tell us about.

• In the four months preceding our inspection, the local authority safeguarding team had initiated investigations into three allegations of abuse of people who used the service. The provider had failed to notify us of any of these allegations, as required in law.

The provider's failure to submit notifications was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

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; 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; Working in partnership with others
• Care staff told us they felt well supported by their managers. For example, talking of the Sleaford team manager, one staff member said, "[Name] is lovely. Any problems, you go to her." Describing the registered manager, another staff member said, "[Name] is pretty fair. And very approachable."
• Staff also told us there was a generally positive atmosphere in the service. For example, one member of the Boston team said, "It's very challenging [because] there is not enough staff. [But] we've got a good team and morale is … quite upbeat. It's hard work, but enjoyable." A member of the Sleaford team commented, "I am basically happy. It's a lot better than previous companies [I have worked for]. They've been very good with me."
• The provider used a variety of methods to engage with people and staff, including regular satisfaction surveys. We reviewed the report of the most recent service user survey and saw that feedback was generally very positive. Although we noted that only 44% of respondents said staff were always 'punctual and come at times that suit their lifestyle'.
• We also reviewed the report of the most recent staff survey. Again, the feedback was generally positive. Although we noted over 30% of respondents in the Boston team had said "no" to the question, 'Are your rotas planned effectively to allow enough time for you to travel between visits, be on time and provide good quality care?'. In the Sleaford team, no one had responded "no" to this question.
• Staff maintained contact with a range of other professionals including GP's and community nurses. The registered manager told us she also found the local care providers' association was a good source of advice and support to her and her team, particularly during the COVID19 pandemic.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of significant events.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to properly assess and manage potential risks relating to the administration of people's medicines and the wearing of PPE.

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively monitor and improve the quality of the service.

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient staff were deployed to meet people's needs, safely and effectively.

The enforcement action we took:

We issued a Warning Notice.