Health Care Resourcing Group Limited

CRG Homecare - Hammersmith

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**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this announced comprehensive inspection between 24 July and 1 August.

CRG Homecare - Hammersmith is a domiciliary care agency. At the time of our inspection they were providing care to 391 people in the London Borough of Hammersmith and Fulham and the Royal Borough of Kensington and Chelsea. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger adults with disabilities.

Not everyone using 'CRG Homecare - Hammersmith' receives regulated activity; The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

We last carried out a comprehensive inspection of this service in May 2017. Breaches of regulations were found regarding the management of medicines, consent to care and good governance. We carried out a focussed inspection in October 2017 where we found improvements had been made around consent to care. However, the provider was still not meeting regulations concerning medicines and good governance.

The service had two branch managers who had applied to be registered managers. 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.

People did not always receive the right support to take their medicines and medicines records were frequently incomplete or inaccurate. Audits were not effective at ensuring that standards were improved and actions identified by audits were not always carried out.

Punctuality of calls remained poor which impacted on the standard of care people received. We identified 12 occasions where this meant that people did not receive care from two care workers when this was required. Where the provider had agreed flexible care arrangements with people these were being followed, but these were not in place for most people.

When people had consistent care workers in place people were positive about the service received. However, when people had inconsistent care they did not always feel that they were treated with kindness by staff.

Managers had systems in place for monitoring people's care and ensuring care plans still met their needs. People had consented to their care plans and received regular reviews of their care. Plans were detailed

about the support people required and care was delivered in line with this, but was sometimes impacted by poor punctuality.

There were appropriate systems in place for assessing people's health and care needs in order to design effective care plans. People received the right support to eat and drink. People's communication needs were recorded, but the provider did not have systems in place to make sure that the Accessible Information Standards were followed. We have made a recommendation about this.

There were measures in place to assess and manage risks to people's health and safety, including skin integrity and moving and handling. Safer recruitment measures were followed. Care workers received the right training to carry out their roles and a detailed induction, but did not always have shadowing opportunities and regular supervisions. Managers carried out spot checks of staff skills and yearly appraisals but sometimes these were not of a high standard. There were systems in place to investigate complaints and to safeguard people from abuse.

We found continuing breaches of regulations regarding the management of medicines and good governance and a breach of regulations concerning staffing levels and supervision. We served warning notices against the provider regarding staffing levels, management of medicines and good governance. These informed the provider that they were required to become compliant with these regulations by 16 November 2018 or we may take further enforcement action.

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.

People did not receive the right support to take their medicines. Records of medicines were incomplete and often inaccurate.

A significant number of calls were late, and we found sometimes people did not receive double handed calls as required.

The provider had suitable measures to safeguard people from abuse. Safer recruitment measures were followed.

There were suitable risk management plans to protect people from assessed risks to their health and safety.

Is the service effective?

Requires Improvement

The service was not always effective.

Care workers received the right training to carry out their roles but did not always receive regular supervision. Induction procedures were in place but records of shadowing were incomplete.

The provider had detailed processes for assessing people's needs and ensuring consent was given to care.

People received the right support to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always know who would be coming to see them and sometimes people did not consistently receive care from the same care workers.

People told us that when they had consistent care workers they were kind and caring, but some people expressed concern about the attitude of care workers.

There were measures in place to record people's views and

promote dignity and independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were measures in place to plan and review people's care. People's care plans were person centred and met their needs. However, people told us that punctuality often affected the standard of their care.

There were systems in place for investigating and responding to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to communicate with care workers and to obtain the views of people using the service, their family members and staff.

Audits were not effective at addressing concerns about care workers performance and poor recording. Actions were not always taken in response to these audits which meant poor performance continued.

Spot checks and appraisals were carried out of care workers but these were not always of a good quality.

CRG Homecare - Hammersmith

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.

Why we inspected – This was a planned comprehensive inspection as 12 months had elapsed since we rated the provider 'requires improvement'.

Since our last inspection we had received three complaints from people using the service relating to repeated lateness and three safeguarding alerts relating to poor timing or possible neglect. One safeguarding notification concerned alleged financial abuse and the other two related to alleged abuse by third parties such as friends and family.

The provider was in the process of registering a separate branch to provide care to people in the Royal Borough of Kensington and Chelsea. Until this was completed care to people living in this borough was operated from the registered office of CRG Homecare - Hammersmith. We inspected these two branches as one registered location.

We gave the provider 24 hours notice of this inspection. This was so we could be certain that key members of staff would be available to speak with us. The inspection was carried out by two adult social care inspectors on 24, 25 and 26 of July and a single inspector returned to complete the inspection and give feedback on 1 August. On the first day of the inspection the team was accompanied by a specialist professional advisor who worked as a pharmacist. During our office visit we looked at records of care and support relating to 24 people and records of medicines support for eight people. We looked at records of recruitment and supervision of 15 care workers and looked at records relating to the management of the service, including training, background checks, audits, incidents and complaints. We spoke with the director

of care, two branch managers, an area manager, a recruitment officer, the quality assurance lead and five care workers.

Two experts by experience made calls to people who used the service. An expert by experience is a person who has experience of using this type of care service. We spoke with 34 people who used the service and six family members.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with their own care workers most of the time, however 14 of the 40 people we spoke with felt the organisation did not keep them safe in terms of timekeeping and missed calls. Most people who used the service told us that their care workers were late and many people told us how this impacted on their lives. Comments included, "Time keeping is poor" and "They need training in how to manage time – get up earlier and plan your days. It's too casual." A person told us, "My morning call is supposed to be from 9 -10 but sometimes they don't appear until 11.30 and sometimes they arrive to get me ready for bed at 5pm." One family member said, "When they're late [my family member] is left in a soiled pad" and another family member told us, "I have to get [my family member] up and change his/her pad when they don't come. [My family member] gets infections easily and leaving him/her 'dirty' is a big problem and I am meant to be working."

However, six people were positive about the punctuality of their visits. One person said, "Most of the time they are on time. If they are late it's because of traffic. I have to take my medicines at a particular time and they do that for me." A family member told us, "'They come on time and stay for as long as they should."

At our previous inspections we found that the provider's Electronic Call Monitoring (ECM) system did not have accurate information on people's planned times, and so could not give reliable measures of punctuality of visits. At this inspection we found that ECM data more closely matched people's planned visit times. This meant that the provider's punctuality data was more likely to be accurate, which we confirmed by comparing this to a sample of 5% of calls for a seven day period and ensuring that this agreed.

The provider's ECM data showed that punctuality had worsened, and that during the month of June 2018 just 62% of calls took place within 15 minutes of the planned visit time. This continued into July 2018, where just 63% of calls were on time.

The provider told us that they had consulted with some people using the service in order to agree what would be the earliest and latest time they would like their care workers to arrive. Where these were in place, we saw that during a one week period 83% of calls were delivered within these times. However, these agreements were only in place for six of the 16 people whose call data we looked at. This meant that the majority of people did not receive their calls on time.

Most staff told us that they had enough time to travel to their appointments. We looked at six care worker records. These showed that care workers usually had their appointments in the same areas based on postcode. However, these appointments could be up to 10 minutes away, and 62% of calls still had no travel time even though some was needed. However, 48% of calls with no travel time were delivered late, compared with 35% of calls which had adequate travel time. 40% of the time care workers arrived late to their first calls of the day. This meant that travel time was unlikely to contribute to the lateness of calls.

This constituted a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

ECM data showed that sometimes people did not receive two care workers when this was part of the care package. In a week long period we found five people had not received double handed calls when their care plans stated two care workers were needed to safely support them. We found that although two care workers had stayed for the appropriate duration, on four occasions they had been in the person's home together for under six minutes, and on eight occasions had not been in the person's home together at all. One person's family member told us, "One carer has been asked to be taken off as the other carer is constantly late and they are often on their own…my [family member] had to call me to come and put him/her to bed" and one person told us, "They send me to bed at five because that's the time I get reliable carers."

In response to our concerns the provider identified the care workers who had not attended calls together and had arranged for supervisions to take place to address this issue. They also sent a memo out to staff outlining expectations around double handed calls. We also relayed our findings to both local authorities commissioning care with the provider and raised a safeguarding alert in relation to one person's care.

This constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People did not receive the right support to manage their medicines safely. Two people also told us that their medicines were affected by poor timekeeping. One person told us, "I have to juggle my medicines because of their poor time keeping. One tablet I have to take half an hour before food but I never know when they are coming – it's very difficult. Sometimes, at the moment, I'll make myself something just so that I can take the tablet at a reasonable time." A family member said, "Morning tablets have to be given by one of us as the call is often too late to fit in with the medicines."

The provider told us that they only ever prompted people to take their medicines, but care workers were often confused about the difference between prompting and administering, and sometimes referred in daily logs to 'giving' or 'administering' medicines when this did not form part of the agreed package of care. Care plans and risk assessments were clear about the level of support people needed. However, one person's plan instructed staff to prompt medicines by removing tablets from the blister pack and placing them in an eggcup. This action is a clear description of the administration of medicines. Another person's plan said, 'Prompt my medication and give it to me in a small container'. It also stated the person was totally blind and it was not clear how they could manage their medicines.

The provider's policy stated that wherever possible medicines administration recording (MAR) charts should be constructed and supplied by a pharmacist, but we did not see this taking place. All MAR charts were constructed by a staff member based at this office. The provider had implemented a system whereby MAR charts were compiled with reference to photographs taken of pharmacy labels, however there were flaws with this approach. For example, these pictures did not include prescribed creams or inhalers which were not recorded on the MAR charts. Sometimes this information was up to seven months old and changes to people's medicines were not always recorded on MAR charts. The provider's policy also stated that MAR charts were to be checked by a second member of staff after they were drawn up. This was not happening, and the provider's format did not include a space for a second signatory.

Audits of MAR charts were effective at recording where medicines had not been recorded as prompted, but did not pick up on errors in listing what the person's prescribed medicines were. Audits were carried out at the end of the month when MAR charts were returned to the office, which meant that the provider had no way of examining the blister pack to ensure that people's medicines had been taken as intended.

The provider's policy stated that, 'There must be no gaps in service user medication records.' However, the majority of MAR charts we looked at had significant gaps in recording. One chart we looked at had a medicine which had only been accounted for on 12 of 31 days and a second medicine was completed on 10 out of 31 days. Another person's chart had not been completed at all during the entire month from 24 May 2018. Although these issues had been identified on audit, this had not led to improvements and this continued in the subsequent month.

People received their medicines from blister packs supplied by a pharmacy. This reduced the risk of a medicine being given in error. However, in some cases medicines were recorded as prompted at times that a medicine was not due, and the provider was unable to identify whether the person had wrongly taken their medicine at this time. There was no system in place to show that care workers had checked the blister pack to ensure that no medicines had been missed.

This constituted a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

In response to our concerns the provider had sent a memo to all care workers clearly explaining their requirements for the completion of MAR charts and the difference between prompting and administering medicines. A care worker told us, "They're trying to reinforce that [care workers] need to use the MAR chart all the time."

Care workers received annual training in safeguarding adults, and care workers we spoke with were able to describe the signs of abuse and their responsibilities to report suspected abuse. Care workers told us they thought their managers would act on their concerns when these were reported. A care worker told us, "I'd go straight to the manager. They do take it on board but I'm like a dog with a bone." Where concerns had been raised about people's safety the provider had reported these to the local authority. When these concerned care workers, the provider had investigated these appropriately. This had included conducting disciplinary investigations and hearings against staff members in response to concerns raised.

The provider was able to identify the root cause of what had led to poor care and take action to provide a recurrence. For example, a safeguarding alert had been raised in respect to a person who had missed an episode of care and a subsequently delayed visit. The provider had fed back to the local authority and to the inspection team how this had occurred due to a previously unknown flaw in the computer system, and were working with the local authority to amend the rostering system to prevent a recurrence.

The provider also had systems in place for recording incidents and accidents. This included detailing what had happened and what actions had been taken. This included reporting lost or stolen items to the police and to record unexplained bruising and to report this to the local safeguarding team.

People were protected from risks as the provider had detailed systems for assessing risks to people using the service. This included assessing people for skin integrity, risks from their home environment, personal safety and those relating to mobility and falls. These were used to determine a risk score, and based on the level of risk specific action plans were followed. When people were at high risk of pressure sores, the provider kept daily records of when their skin had been checked. When a risk management plan involved repositioning the person regularly accurate records were kept of this. In a small number of cases we saw that risk management plans were not being followed in their entirety. For example, some mobility risk assessments stated that they needed to be reviewed bimonthly but this was not taking place, although there did not appear to be significant changes to these people's needs. Three people's plans stated staff needed to check that people were wearing pendants when they left, but this was not routinely recorded by

care workers.
The provider had a detailed bed rail assessment in place, which was used to check whether these were properly fitted and prompted the assessor to check particular hazards which may place a person at risk of entrapment. Assessors checked whether people's premises were safe, including any health and safety hazards and whether the person had a working smoke alarm.

There were detailed assessments of people's moving and handling needs. This included assessing the needs and number of staff required to support people with specific transfers and risks from specific concerns such as pain, weight or a tendency to become easily tired. There were not specific moving and handling plans but when people needed to be transferred by care workers care plans had detailed instructions on how to do this. When people had equipment for this purpose the provider recorded what was in place, who supplied it and verified that the equipment was serviced as required.

The provider ensured that care workers were suitable for their roles by following safer recruitment measures. This included obtaining evidence of people's identification, their right to work, proof of their address and obtaining references from previous employers where this related to previous health and social care. Where references could not be obtained the provider made repeated attempts to follow these up and obtained alternate references. Where care workers had transferred from another organisation the provider checked references were held and met with care workers if they had any concerns about the contents of these. Interview assessment forms showed that the provider asked questions to determine the suitability of candidates and assessed staff experience and skills in key areas such as medicines and moving and handling.

All care workers had been checked with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. Where there was concern about the contents of a DBS check a risk assessment process was carried out to ensure people were suitable for their roles. The provider's policy was for care workers to repeat their DBS check every three years, and a system was in place to ensure this took place. Managers checked that recruitment processes were followed before care workers started work.

Requires Improvement

Is the service effective?

Our findings

Care workers received a combination of formal supervisions and spot checks of their competency. The provider told us they did not have a requirement for how often formal supervision took place, but their supervision booklet stated that this was to be carried out every three months. Care workers typically received either a spot check or a formal supervision every three months on average. However, one care worker had not received a formal supervision between when they started in October 2017 until June 2018, another had started in October 2017 and did not receive a formal supervision until May 2018, but had had one spot check in April 2018. Another care worker had not received a formal supervision at all despite having been employed for 12 months and another care worker had not had a supervision from April 2017 until May 2018. In total, we found six care workers had gone eight months or more without a formal supervision.

This constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Care workers received the right training to be able to carry out their roles. This included a three day induction which was based around the 15 standards of the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should be covered if a worker is 'new to care' and should form part of a robust induction programme. Care workers completed a booklet with competency observations and demonstrations of staff knowledge. However, we found that observations of competency were not always taking place. The provider told us that new care workers would shadow for two or three days before working independently, however there were no records to indicate that this was taking place for the five files we reviewed.

Care workers received annual refresher training in first aid, safe moving and handling, health and safety, medicines and safeguarding adults. Care workers received training every two years in food hygiene and infection control and three yearly training in mental capacity and dementia. Managers maintained an up to date list of training that was in place and the date that refresher training was required. This showed that care workers received training in line with the provider's requirements. Care workers told us that they received the right training to do their roles, although some stated they would like more specialised dementia training which the company was planning to deliver.

The provider carried out a detailed assessment before people started to use the service. This included people's perceptions of their needs and those of their family members, their current physical wellbeing, past and present medical history and the information about their living situation and personal history. There were particular sections of this assessment for assessing people's abilities relating to personal care, communication, mobility and their preferences in this area.

Assessments were used to clearly record people's desired outcomes from their care, including support with personal care, medicines, housework and mobility.

People received the right support to eat and drink. The provider carried out detailed assessments of people's nutritional needs. This included assessing the support people required and any areas of concern such as swallowing, low appetite or specialist diets. Where people were assessed as being at high risk of malnutrition or weight loss, staff kept food charts in order to monitor people's intake. Care plans contained detailed information on the support people needed to eat and drink well and their dietary preferences. Care workers recorded in detail what people had eaten and drunk on each visit. One person said, "They support me with making my meals because I can't manage the cooker by myself" and another person told us, "The carer makes my meals for me, always asks me what I want"

Our inspection took place during a sustained heatwave. Managers had sent memos out to care workers reminding them of the importance of preventing dehydration in hot weather. People we spoke with told us that their care workers had been reminding them to drink plenty of fluids during the hot weather.

People's plans were detailed about the support they required to stay healthy. For example, when a person was living with diabetes their plan clearly stated the actions that care workers were required to take if they appeared to be hypoglycaemic and that the person needed to be prompted to record their blood sugar level. Logs recorded both of these taking place. The provider obtained a full medical history including recent treatment, and used this to inform assessments of risk.

The provider worked in line with the Mental Capacity Act 2005 (MCA) in order to ensure people had consented to their care. The Act 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.

In most cases people had recorded their consent to care by signing their care plans. When people had capacity to make decisions but were physically unable to sign the provider had systems to record and witness verbal consent to care. If there were doubts about a person's capacity to consent to their care the provider carried out detailed assessments in line with the MCA. This included recording what the specific decision was, whether the person was able to retain information and use it to weigh up a decision and what measures were taken in order to aid the person's understanding. If a person lacked capacity the provider followed a process to demonstrate why they believed the care was in the person's best interests. This included consulting with relevant people and considering the person's previously expressed wishes.

Requires Improvement

Is the service caring?

Our findings

17 people we spoke with told us they did not receive a rota and frequently did not know who would be coming. Comments included, "I did ask for one but I have never had one" and, "'You just wait to see who turns up and hope that it will be one of the good ones."

We received mixed feedback about whether people felt their care workers were caring. One person told us, "Some of them are very kind. Some people's heart and soul is in their work, others are just in it for the money and it shows." Another person said, "I think it's a mixed bag and you're lucky or not depending on who you get."

People told us their regular staff were caring. Comments included, "The carer today is so nice and she's told me that she'll pop back later and bring me a paper" , "We can usually have a laugh" , "There are a few that my [family member] has got to know and they are very good" and "Overall they are respectful of our faith and background."

However, some people's experience was less positive with 10 people raising concerns about the approach of care workers . Comments included, "You can't train someone to get off their phone and pay attention to me" and "Some can be very abrupt and not listen even though they don't know me, my place or my equipment." One person said, "They do treat me with kindness and respect, (the regular ones) and they will chat to me. Some of the stand in carers are useless."

10 people we spoke with told us they did not receive support from consistent care workers. Comments included, "I don't like not having regular staff, I'd feel more comfortable having the same ones each time", "Just lately there's a lot of different people – you never know who's coming. And I forget their names", and "Someone came and said, 'I'm your carer'. I asked to see her identification and she hadn't brought it so I wouldn't let her in. She could have been anyone. That's happened twice in the last months." Consistency varied between people who used the service. We saw some people received consistent care, for example one person who had just four care workers who attended their 22 calls during the week, and another person who had 23 calls attended by five carer workers during the week. Other people had less consistent care, for example one person had seven care workers attend 15 calls in the week and another person had nine care workers attend 26 calls.

People's communication needs were assessed which highlighted whether people required glasses or hearing aids and the support they received with this. In one instance we saw that a person's plan stated a person needed mental stimulation and that chess was suggested as way of doing this. Care workers were routinely playing chess and card games with a person, and had recorded whenever the person had won a match or played a strategic move on the chess board. Assessments often showed signs of people being engaged with staff, including recording people's views on how they felt about receiving care but also recording discussions about their memories of late partners.

The provider used telephone monitoring to obtain people's views of the service, which typically took place

every three to four months. This included checking how people were finding the service, whether they were happy with the length of calls, whether care workers did the things they were asked to do. People were asked if they had complained and whether they were happy with how it was addressed.

There was a system in place for 'barring' care workers for particular visits when concerns had been raised about their performance or conduct. This was part of the rostering system and meant that people could not be sent back in error.

Plans were clear about what people could do for themselves and how care workers could promote independence. Comments included, "She encourages me to do as much as I can for myself and always encourages me with comments like 'well done, that's really good'.", "It helps you keep going, keep trying" and, "I think they help me to stay independent". People told us that staff supported their right to privacy and that staff always knocked on their bedroom door before entering which they found respectful.

Care workers were asked to sign a dignity in care challenge. This outlined the provider's aims to have zero tolerance to all forms of abuse, to respect people as if they were the care worker's own family, respect privacy and to listen to people and let them express their wishes.

Requires Improvement

Is the service responsive?

Our findings

People's plans contained detailed information about the support they needed on each visit. This included information such as the order in which they wanted to receive care, how people preferred to receive their care and what people could do for themselves. There was key information on people's routines, such as when people liked to have a cup of tea in bed before breakfast, information about whether people preferred baths or showers and how people preferred to be addressed. Plans included information on people's cultural and religious needs in regards to their diets. One person said, "The care plan was talked though with me when we set it up and everything is done as per the plan. I've had no reason to complain." Care workers told us they found the documents useful. One care worker said, "When I'm covering other people looking at the plan is crucial. They're always in the folder" and another told us, "everything's covered."

Care workers maintained accurate logs of the care they had provided, and only a relatively low number of visits were not recorded. Logs detailed the exact support people received and these showed that people had care tasks carried out in line with their care plans. This included personal care tasks, transfers and meals. Sometimes logs were less detailed about how the person was, such as their mood and what had been discussed with care workers.

10 people we spoke with told us that sometimes timings impacted on the quality of their care. Comments included, "Sometimes they arrive to get me ready for bed at 5pm", "Everyone accepts that traffic may result in a 10-15 minute delay in getting to you but sometimes it's an hour or an hour and a half. Then the help becomes a hinderance", "Dinner is meant to be 12–12:30 but they often come way after that." One person said, "I had given the Agency notice that I was going out with my daughter at 1pm and needed the carer to be on time. At 12:45 I rang to ask what was happening and was told that the carer had been delayed and would be with me soon. I ended up cancelling the call. "Another person said, "It was 10pm before they got me into bed and then I couldn't sleep. Awful night."

People had received reviews in the past year to make sure their care was still suitable. These checked whether there had been any changes to people's needs, whether a change in the service was requested and any further comments. We saw examples of families being involved in these; one person's reviews were timed to coincide with when their family member was in the country. We saw examples of people's care times being changed in response to their views, and packages were changed in order to meet people's needs.

At times most of the review content restated what was already in the care plan, but it was clear that people's care was reviewed and their comments about the service were recorded. In a small number of cases these missed inaccuracies in care plans. For example one person's review noted that the person wore pads. Care logs showed that the person was being supported to change these every day but the care plan had not been altered to reflect this.

The provider was not always meeting the Accessible Information Standard (AIS). AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way

they can understand. It is now the law for the NHS and adult social care services to comply with the AIS. In most cases care plans were concise and easy to follow and consent forms were clear about what people were consenting to. The provider noted when people had sensory loss or a disability which could affect their ability to read or communicate. We saw two cases where people's sight loss and how it affects them had been recorded in their assessments. However, there was no process in place which would flag this up to managers in order to consider whether a person should be offered their plan in an accessible format.

We recommend the provider take advice from a reputable source on how to meet the Accessible Information Standard.

People told us that they knew how to make complaints and that usually these were addressed. One person told us, "I have complained in the past about a member of staff that came, she had such a bad attitude and wouldn't do food preparation, I asked her to leave, she wasn't fit to do the job. Now I have four different carers that come to me and they are good and do what's in the care plan and we are building a rapport."

The provider had a complaints policy in place. When people had complained about the serviced a manager carried out an investigation and relayed their findings to the person. Where the service was found to be at fault the provider had apologised and put an action plan in place to address findings. There was evidence of concerns about individual care workers being raised in supervisions and where appropriate investigations and disciplinary action had been taken against care workers. This had also included carrying out additional spot checks on care workers to ensure that their performance had improved.

The provider told us, "When we get a complaint we put the service on monitoring for four to six weeks, and we call them on Fridays and Mondays." We saw that when a person had complained about the standard of their care that additional telephone monitoring was taking place. We looked at the call times for a number of people who had complained about the times of their visits and saw that there had been improvements. Where people had complained in telephone monitoring about punctuality or poor staff consistency, follow up calls showed that this had been addressed effectively.

Requires Improvement

Is the service well-led?

Our findings

Audits were not always effective at addressing areas of poor performance by care workers. For example, two care workers had been identified as not correctly completing medicines records in audits and an action point was for this to be discussed in supervision. However, this had not taken place despite the audit having taken place three weeks ago.

One staff member had been identified as not correctly recording medicines in separate audits in May and June 2018. They had received a supervision after the first audit but this did not make reference to medicines recording or the findings of any other audits. Two staff members were identified as not correctly completing records in a May audit, but the intended supervisions to address these had not taken place, and both care workers were identified in subsequent audits of different people's medicines as continuing to make mistakes. There was no evidence of additional medicines training being carried out in order to improve staff knowledge. The provider told us they would follow this up with the care workers to address poor performance.

For most people's logs of care an audit had been carried out in the past quarter. This checked whether entries were completed, legible, factual and whether issues relating to safeguarding, medicines or health needs had been followed up appropriately. Audits lacked a clear timescale for follow up actions. A care plan audit from May 2018 had shown 50% compliance achieved, which was considered 'inadequate' according to the provider's systems, however there was no follow up to ensure that required actions had been carried out.

Audits of medicines were poorly designed. They gave equal weight to 28 questions such as whether the MAR chart was properly constructed and correctly completed. This meant that noting a high number of blank spaces on a chart could still result in an acceptable score. Auditors frequently gave equal weight to the use of seven codes and whether they had been properly applied, even though only one was relevant to the person and would have been sufficient to raise a concern. Auditors sometimes recorded that a double signatory had checked the construction of the chart even though this was not taking place, and although audits checked whether the correct medicines were recorded this was not checked against complete or in date information. Auditors had noted when MAR charts were not fully completed but where incomplete information was recorded audits had recorded that a full investigation had taken place and appropriate actions taken, but this had not taken place.

All recording of medicines and care delivered was carried out on paper based records and brought back to the office for monthly checking. This meant that sometimes auditors would be looking at an issue dating from several weeks prior, which meant that the concern could not be properly audited. For example, if a medicine was not prompted, an auditor would not be able to refer to the person's blister pack as this would have been returned to the pharmacy by this time. The provider told us that care workers would check this in the person's home, but there was no record of this taking place.

An external audit from 2 May 2018 had identified issues relating to the completion of medicines records,

however the provider had not taken action to address this, and this continued to the time of the inspection.

The provider was breaching regulations regarding the safe management of medicines in two previous inspections in 2017. On both occasions they had submitted action plans for how they would ensure that they would meet this regulation in future, but on this inspection they continued to be in breach and therefore governance systems were not being operated effectively.

This constituted a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Systems to ensure that care workers were carrying out their roles effectively were not always operated effectively. For example, competency observations of new staff were not always completed, and in some cases managers had recorded that particular areas had been 'observed' without further feedback or areas for development. All care workers had received an annual appraisal but we saw seven supervision records which were identical in content with no evidence of personalised discussion. In all of these themed questions were asked in key areas such as safeguarding and skin integrity, and these recorded identical responses by care workers.

Spot checks were carried out of care workers. These were used to assess that care workers arrived on time, communicated well with people and their families and completed and recorded tasks as planned. Managers used these to obtain feedback from people and their families. However, often statements were not supported. Managers made statements such as, 'Care worker makes sure they respect people's privacy and dignity' but did not explain why or give any examples of this.

Care workers were positive about the support they received. Comments included, "I get great support from CRG", "I feel they are more open and helpful", "They are doing well and they are well organised" and, "It's not 100% but it's getting better." However, some staff commented that they could not always access support when they needed it. One staff member said, "It's very difficult to get hold of the on call" and another said, "The on call people need to give us better support than now."

The provider told us that they had a project team from head office visiting from August 2018 in order to address performance issues. There was also a new quality assurance lead in place, who was in the process of carrying out an audit of the branch at the time of our inspection.

The provider carried out surveys to check people's satisfaction with the service. This included checking that care workers were punctual, wore ID, whether people were confident making a complaint and whether they felt care workers were of a good standard. The survey findings were based on speaking with 35 people who used the service in Hammersmith. These were generally positive but sometimes overstated people's satisfaction with the service. For example the provider's summary stated 90% of survey respondents stated that their care workers were mostly or always on time. However, a more detailed breakdown of this question said that 53% percent of people had said their care workers were 'sometimes' punctual, which had been recorded as 'mostly'. This stood in stark contrast to the people that we spoke with, with more than half of whom raised concerns about punctuality. The provider also carried out staff surveys, which showed that care workers were positive about the support they received from managers and that they felt valued.

The provider had carried out more detailed consultations with people about the quality of their care, and were in the process of sorting concerns they had received in order to make an action plan to address these. Managers also collected compliments they had received about the service, such as thanks from relatives for their support at the end of their family member's lives.

Managers had systems in place to communicate with care workers. This included sending memos out to care workers when concerns had been raised about standards of care and clearly set out what was expected of staff. Memos were also sent out to care workers to remind them to support people to avoid dehydration in hot weather and to ensure people were kept safe in unusually cold weather. Care worker meetings took place monthly and were used to discuss staff responsibilities and management expectations as well as procedures around leave, sickness absence and the use of electronic call monitoring (ECM).

Care workers had been supplied with mobile phones which they could use to log in and in order to see their rotas, and managers were in the process of implementing a new app. This was designed to be a social network for care workers, which would allow direct communication between care workers and to allow care workers to have access to policies and procedures. The area manager told us, "We can conduct surveys, send them all messages and use it as a staff handbook." The provider was also considering whether the app could be used in order to carry out a weekly review of key documents such as medicines and repositioning charts.

Managers had also implemented a 'listening lunch' system in the branch. This was where care workers were invited to meet with members of the provider's senior management team and discuss engagement with staff, the results of staff surveys and awards and incentives for care workers. A staff member said, "The CEO was down, he gave us a wonderful listening session about how we felt and he said he was going to introduce specific training." Awards were given to care workers to recognise achievement in line with the provider's values.

The provider was meeting requirements to display the ratings of their most recent inspection and was notifying the Care Quality Commission (CQC) of serious incidents and allegations as required.

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 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in provision of a regulated activity did not receive such appropriate supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform. 18(2)(a)

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 Care and treatment was not provided in a safe way for service users as the provider did not ensure the proper and safe management of medicines 12(1)(2)(g)

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity 17(1)(2)(a)

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed 18(1)

The enforcement action we took:

We issued a warning notice.