Health Care Resourcing Group Limited

CRG Homecare - Burnley

Inspection report

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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 - Burnley is a domiciliary care service, providing personal care and support to people in their own homes. It provides a service to children, people with a sensory impairment, physical disability, learning disability or autistic spectrum disorder, people with substance misuse support needs, mental health support needs, people with an eating disorder, older people and people living with dementia. At the time of our inspection, the agency was also providing a reablement service, commissioned by the local authority. Reablement is a short-term service designed to help people improve their independence while living at home, for example following a fall, a period in hospital or a change in their circumstances. At the time of our inspection the domiciliary care service was supporting to 99 adults and a further 188 adults were being supported through the reablement service. No children were being supported.

People's experience of using this service and what we found
There were not always sufficient staff available to meet people's needs. A number of people had experienced missed, late and short visits and felt rushed when staff supported them. Concerns had been received about these issues for many months, however, the provider had failed to sustain any improvements made. Some improvements were needed to infection prevention and control (IPC) practices to ensure people were protected from the risk of infection. We have made a recommendation about this. The provider recruited staff safely and people received their medicines as they should.

People did not always receive individualised care or care which resulted in good outcomes. They were not always involved in decisions about their care. Most people told us they would recommend the service; however, many people, relatives and staff felt the management of the service needed to be improved. There had been a number of changes in the management of the service over the previous 12 months, which had resulted in a lack of effective management and oversight of the service. Some audits had been completed but had not been effective in ensuring appropriate standards of quality and safety were maintained. We have made a recommendation that the provider ensures they have effective systems in place to protect people from the risk of avoidable harm and to learn lessons when things go wrong.

For more details, please see the full report which is on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 1 February 2018).

Why we inspected
The inspection was prompted in part due to concerns received about missed, late and short visits, staff not providing people with appropriate support and poor management of the service. A decision was made for us to inspect and examine those risks. 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 areas of concern were

identified in the other key questions, we therefore did not inspect them. Ratings from the previous comprehensive inspection 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.

During this inspection we found breaches of regulation relating to staffing and a lack of effective oversight of the service. You can see what action we have asked the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety at the service. 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 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 - Burnley

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
The inspection was carried out by an inspector, an assistant inspector and three 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 - Burnley is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A new manager had started at the service on 2 November 2020 and had started the process of applying to become the registered manager. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the provider 48 hours' notice, to ensure they would be available and to give them time to gain people's consent for us to contact them for feedback.

Inspection activity started on 20 November 2020 and ended on 25 November 2020. The Experts by Experience, inspector and assistant inspector contacted people supported by the service, their relatives and staff by telephone on 20 November 2020, to gain their feedback about the service. The inspector visited the office location on 25 November 2020.

What we did before the inspection

We reviewed information we had received about the service since their last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used 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 to us to give us 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 on the telephone with 21 people supported by the service and 22 relatives about their experience of the service. We also spoke with nine staff on the telephone, and the manager and Regional Director during our visit to the office. We reviewed a range of records, including four people's care records and a selection of medicines records. We reviewed three staff recruitment files and staff supervision and appraisal records. We also reviewed a variety of records related to the management of the service, including policies and audits.

After the inspection
We reviewed additional documentation received from the manager and regional director.

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 requires improvement. At this inspection this key question has remained the same. 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

● There were not always enough staff available to meet people's needs. Two people we spoke with had experienced missed visits and 12 people/relatives told us visits were regularly much shorter than they should be. One relative commented, "They are here for 20 minutes but need at least 45 minutes to get their task done, so they can't do what they need to. You can't say that is giving a good service." In addition, a number of people did not know how long their visits should last, so could not comment on whether staff stayed for the right amount of time. Many people felt rushed when staff supported them, and some told us staff did not always provide the support they needed during visits.

● A total of 19 people/relatives told us staff regularly visited outside of the agreed time, either too early or too late and 15 people/relatives told us they were not informed when staff were running late. One relative commented, "Sometimes the timing is a bit hit and miss. Someone is meant to be here at 8am but will come at 11am, when the next person (staff) is due to come." Staff told us missed visits happened due to the service being short staffed or staff not being aware of additional visits that had been added to their shift at short notice. They told us they were often too busy to stay for the full duration of the visit, as they had too many people to visit and were not given enough travel time to get from one visit to another. Some staff told us additional visits were routinely added to their already full shifts, which meant they had to cut other visits short. They told us staff turnover was high.

● A number of safeguarding concerns about missed, late and short visits had been raised about the service over the previous 12 to 18 months and many had been substantiated by the local authority. Most related to the reablement service. Similar concerns had been raised prior to the last inspection and at that inspection we made a recommendation that the provider ensured there was an appropriate number of suitably skilled staff available at all times, to meet the needs of people using the service.

We found no evidence that people had been harmed, however, the provider had failed to ensure there were sufficient staff available to meet people's needs. This placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the manager and the regional director. They advised that the service was constantly recruiting but denied that there were insufficient staff to provide the level of support required. They told us lateness sometimes occurred due to issues such as traffic, road works and staff ringing in sick at short notice. They told us they would investigate this issue further and take action to address it.

● The provider recruited staff safely, to ensure they were suitable to support people.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● There was a lack of effective systems in place to protect people from the risk of avoidable harm. A high number of safeguarding concerns, whistle blowings (staff reporting poor practice) and complaints had been received since the last inspection about a variety of issues, including missed visits, short visits, late visits, thefts, neglect, staff not doing what they should in line with people's care plans during visits, a lack of staff training, staff not wearing appropriate PPE during visits and poor management. Many had been substantiated by the local authority. Since the last inspection, there had been some periods of improvement, however, these had not been sustained and further concerns about similar issues were raised again.

● Staff had completed safeguarding training and understood the action to take if they witnessed or suspected abuse.

We recommend the provider ensures they have effective systems to protect people from the risk of avoidable harm and to learn lessons when things go wrong.

Preventing and controlling infection

● Some improvements were needed to ensure people were protected from the risk of infection. Most people told us staff wore PPE and followed safe infection prevention and control (IPC) practices when they visited, however, two people told us staff did not always wear personal protective equipment (PPE) as they should. Most staff told us they had access to adequate supplies of PPE, however, two told us this was restricted.

● Staff had completed infection control training, though some had not had refresher training during the pandemic. Not all staff we spoke with were aware of how to put on and take off PPE correctly. The manager and regional manager were in the process of arranging additional IPC training for staff.

We recommend the provider ensures staff follow safe IPC processes when supporting people.

Using medicines safely

● People's medicines were managed safely. Staff had completed appropriate training and had been assessed as competent to administer people's medicines safely. People and relatives were happy with how medicines were managed.

● People told us they received their medicines as they should. One relative commented, "I check a couple of times a week and it's all recorded and seems to be thorough. I don't have any concerns."

Assessing risk, safety monitoring and management

● The provider had processes to support people to manage risks to their health and wellbeing. Risk assessments guided staff on how to support people and were updated regularly.

● People and relatives told us staff provided safe care. They commented, "They do make you feel safe. They help you in lots of ways. It gives me security" and "They always make sure (person) is supported if she's moving around, they make sure there's nothing in her way."

● The provider had systems to manage accidents and incidents appropriately. Staff completed accident and incident records, and these were overseen by the manager and provider to ensure appropriate action was taken.

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 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

- Improvements were needed to ensure staff were clear about their roles and responsibilities. Prior to the inspection, a number of concerns and complaints had been raised about staff not providing people with appropriate support during visits and poor staff attitude. A small number of similar concerns were received from people/relatives during this inspection. Clear, consistent action had not always been taken to address poor staff performance.
- There had been a number of changes in both the day to day management of the service and the provider's senior management during the previous 12 months, which had contributed to a lack of effective management and oversight of the service. Some audits of quality and safety had been completed, however, they had not identified or addressed the issues we found during our inspection. Senior managements audits had not been completed regularly prior to the new regional director taking over responsibility for the service in September 2020. The most recent prior to that had been completed in December 2019. Where audits had identified shortfalls in practice, the necessary improvements had not always been made. For example, regular audits of care logs identified inconsistencies in the times and duration of people's visits, but no action had been taken to address this issue. In addition, audits identified the number of complaints and safeguarding concerns received by the service, but there was a lack of information about the nature of the concerns, any themes or trends or the action to be taken to address them. This meant audits had not been effective in maintaining the quality or safety of the service.

We found no evidence that people had been harmed, however, the provider had failed to monitor the quality and safety of the service and make improvements where needed. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Appropriate statutory notifications had been submitted by the service. There had been issues with CQC receiving these in the past, but this had improved since the regional director had taken over responsibility for the service in September 2020.
- The manager was new to the service and had only been in post three weeks at the time of our inspection. She was still completing her induction and was being supported by the regional manager, the deputy manager and a number of support staff. The manager told us she was familiarising herself with the provider's systems, policies and procedures and was getting to know the staff. She was based in the main

office with the majority of the support staff, so that she could gain an understanding of the service and any issues as they arose.

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, fully considering their equality characteristics

● People did not always receive individualised care or care which resulted in good outcomes. Some people told us they were happy with the support they received, however, many people had experienced late and short visits, felt rushed by staff and some told us they did not always receive the support they needed. One person commented, "I feel sorry for the carers, they're very polite and overworked. I think the management has been chaotic. They need a system where they're not sending carers to areas not close to them."

● Most people told us they would recommend the service to others, however, five people/relatives told us they would not. In addition, some people told us they would recommend the domiciliary care service, but not the reablement service and others told us they would recommend the service based on the care staff but not the management of the service.

● People were not always involved in decisions about their care. Of the people/relatives we spoke with, 12 told us they had not been asked for their views about the support provided. Many people told us their visits regularly took place at a time that did not suit them, and they were often not informed when staff were going to be late. Two people told us they had specified their preferred gender of staff, but this had not always been respected. Some people/relatives told us they had raised concerns, but improvements had not always been made.

● Most staff felt the management of the service needed to be improved. They told us the service was short staffed, rotas were poorly planned, they did not receive adequate travel time to get from one visit to another and they were often given additional visits at short notice to fit into already full shifts. Many staff identified a difference between the management of the reablement service and the domiciliary care service. They told us the domiciliary service was more organised and struggled less with staffing issues, while the reablement service was poorly planned and office/support staff often did not reply to their queries and concerns. None of the staff we spoke with knew who the new manager was.

Continuous learning and improving care

● Some people/relatives told us this they felt the management of the service had improved in recent weeks. Shortly after our inspection, the manager told us she had identified a number of areas for improvement which she intended to address as a priority. These included staff recruitment, improved staff contracts to improve staff retention and morale, clarifying staff roles and responsibilities, improved management of poor staff performance and staff sickness, improved communication with staff and restructured shifts to ensure support staff were available for longer to deal with any issues quickly.

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 had a duty of candour policy. We were not aware of any incidents occurring which required duty of candour action, however, it was difficult to know if this was accurate as complaints and concerns had not always been logged on the provider's system and followed up appropriately. The regional director assured us during the inspection that this issue had been addressed and all concerns, complaints and incidents were being addressed appropriately.

Working in partnership with others

● The service worked in partnership with people's relatives and community health and social care professionals. These included social workers, GPs, community nurses and hospital staff.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to monitor the quality and safety of the service and make improvements where needed.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient staff available to meet people's needs.