Health Care Resourcing Group Limited

CRG Homecare - Prescot

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 31 of October and 1 November 2018 and was announced.

We gave the service 48 hours notice of our intention to inspect, as the service provides domiciliary care, and managers and staff are often working in the community, so we wanted to be sure someone would be available to speak to us.

Castle Rock Group, known as CRG is a large domically care agency. They provide support in people's own homes. At the time of our inspection CRG were supporting over 300 people in Merseyside.

CRG provides personal care to people living in their own houses and flats in the community as well as specialist housing. It provides a service to older adults and younger disabled adults. The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks relating to personal hygiene and eating. Where they do, we also consider any wider social care provided.

There was a registered manager in post.

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 and their relatives told us that they received a safe service from CRG.

The service had processes in place to ensure that people were safeguarded against potential or actual harm. There was a safeguarding policy in place which included details from each of the local authorities safeguarding reporting processes.

Staff were recruited safely to enable them to work with vulnerable people. We saw that each staff member had been subject to a disclosure and barring service (DBS) check.

Medication was well managed and administered safely to people in their homes. We saw that people's needs in relation to medication were assessed at the start of the care package which determined what level of support they required from CRG. People who required support with medication had a medication administration record in place which was completed accurately and in full by staff.

There was enough staff employed by the service to provide safe and consistent staffing numbers. People we spoke with told us the staff arrived on time and were rarely late.

There was an electronic call monitoring system (ECM) in place. Staff members had a smartphone, which they would use to electronically 'log in and out' of people's homes once they had completed all care tasks as required.

Incidents and accidents were well documented and analysed to ensure that appropriate action had been taken. We saw the number of incidents per month was documented and there was a description of the type of incident and what action would be taken to prevent this from reoccurring.

There were robust risk assessments in place for each area of care which were regularly reviewed and met the needs of the person. Records we viewed evidenced that risks had been assessed at the time the care package commenced and as an ongoing monthly action.

Staff had the right skills and training to enable them to complete their roles effectively. The training matrix showed that most of the staff had undergone mandatory training. We queried the gaps in the training matrix, as some staff were showing as being 'red' which meant training had expired. The registered manager explained that some of the staff had left or were on long term sick or maternity leave.

Staff completed an induction before they started working at the service.

Staff were regularly supervised and received an annual appraisal. Our conversations with staff confirmed that they regularly met with their line manager to engage in one on one discussions. We checked the supervision schedule in place and saw that each staff member had a supervision every other month in line with the registered providers policy.

The service was working within the principles of the Mental Capacity Act 2005 (MCA).

People's capacity was assessed at the time the care package commenced and their ability with regards to decision making was clearly recorded in their care plans. We saw that most people had capacity to consent to their own care and treatment.

People we spoke with told us they were always encouraged by staff to make their choices and decisions and the care plans we viewed had adopted this culture.

Initial assessments took place when new care packages commenced with CRG which considered people's individual outcomes and what they wanted from their care.

Each person had a care plan which described their preferences for food and drink. This included where in the house they sat to eat their food and what foods they liked and did not like.

Medical advice and attention was sought when people required this type of intervention. Everyone we spoke with said the staff would always call the GP or District Nurses for them if they required.

The service delivered caring and compassionate care in line with people's preferences.

The service involved people in decision making about their care and support. Care plans we viewed had been signed by the person themselves or by their relative if they were legally allowed to do this.

Everyone we spoke with said that they were treated with dignity and respect by staff.

People received care which was responsive and personalised to meet their needs. Care plans we viewed were based around the needs of the person and not the organisation, this is often referred to as person centred.

People's equality and diversity needs were respected and catered for.

Information was available for people in alternative formats. We saw copies of care plans and polices which could be provided in different formats when requested to support people's understanding.

Complaints were handled and responded to appropriately. The registered provider had a complaints policy which contained details of how to raise a complaint and how the complaint would be dealt with including timescales for completion.

There was training in place around end of life care. Staff knew the process of how to care for someone who was on an end of life pathway.

People confirmed the managers were friendly and approachable.

The service undertook three monthly telephone surveys with people to ensure they were happy with their support.

The vision and culture of the organisation was clear. All the organisations promotion material was strap lined with the vision and mission statements of CRG.

There were robust governance framework arrangements in place which highlighted areas of underperformance and produced detailed action plans for areas of improvement.

Other innovative ideas had been trialed and were now successful within the service. Such as male and female welcome home baskets.

The service worked in partnership with the local authority and various other fundraising organisations.

There were policies and procedures in place and staff knew their roles within them. Polices were available for staff in the office and via the company's secure intranet site.

The registered manager knew what was expected of them and their roles and responsibilities regarding reporting any information to CQC. We discussed this with the registered manager during our inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medications on time.

Staff recruitment was robust and checks were undertaken on staff before they started working for the service.

Risks to people were assessed, and there was information on how to manage and reduce these risks.

People told us they felt safe receiving care from CRG.

Is the service effective?

Good

The service was effective.

The staff had the correct training to support people effectively. Some dates were past due, however this was explained during inspection.

Staff received regular supervision and annual appraisals.

People were supported to eat and drink appropriately.

The service was working in accordance with the principles of the Mental Capacity Act and associated legislation.

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and treated them with dignity and respect.

People's preferences were reflected throughout care plans. This helped staff to get to know people and provide care based on their needs and preferences.

Care plans promoted people's choice and independence.

Is the service responsive?

Good

The service was responsive.

There was a process in place for recording, acknowledging and responding to complaints. People we spoke with told us they knew how to complain.

People received care which was planned and personalised in accordance to their preferences. Staff demonstrated that they knew people well.

Staff were trained to support people who were on an end of life pathway to remain comfortable in their home with additional support from other medical professionals.

Is the service well-led?

Good

The service was well-led.

There were polices and procedure in place for staff to follow.

The registered manager was aware of their role and had reported all incidents to the CQC as required.

People and staff told us they liked the registered manager and knew them by name.

There was regular auditing taking place of care files, medication and other documentation relating to the running of the service.

CRG Homecare - Prescot

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection started on 31 October 2018. This is when we visited the registered office to speak with the registered manager and to review documentation. We made phone calls to people who used the service and spoke to service commissioners on 1 November 2018. We also requested some additional information was sent by email after the initial inspection visit.

The inspection was announced. The provider was given 48 hours' notice as the service provides domiciliary care, and we wanted to be sure staff and people who used the service gave consent and would be available to speak with us.

The inspection was conducted by an adult social care inspector and three experts by experience with expertise of care services at home.

Before our inspection visit, we reviewed the information we held about CRG. This included looking at the notifications we had received from the provider about any incidents that may have impacted on the health, safety and welfare of people who used the service. We also looked at the Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We had not requested a PIR on this occasion. Additionally, we approached local stakeholders for feedback about the service. We received one response. We used this information to help us populate our 'planning tool' which determines how the inspection should be carried out.

We contacted 27 people to speak about the care they received from CRG. We spoke with nine staff including the registered manager and the regional manager. We looked at the care plans belonging to 11 people and other related records. We checked the recruitment files for four staff. We also looked at other documentation associated with the running of the service.

Good

Is the service safe?

Our findings

People and their relatives told us that they received a safe service from CRG. One family member whom we spoke with said, "I think my [relative] feels safe and secure although he doesn't always say how he feels, this is a new service for us though, they are pretty good."
"They wear uniform and everything, we know who they are." Another person told us, "I feel happy and safe in my home during my carer visits"

The service had processes in place to ensure that people were safeguarded against potential or actual harm. There was a safeguarding policy in place which included details from each of the local authorities safeguarding reporting processes. All the staff we spoke with were able to describe the course of action they would take if they suspected abuse had occurred. This included reporting the abuse to their line manager and whistleblowing to external agencies such as CQC. Staff also attended training in safeguarding as part of their induction process and completed regular training refreshers.

Staff were recruited safely to enable them to work with vulnerable people. We saw that each staff member had been subject to a disclosure and barring service (DBS) check. A DBS check is a check performed by potential new employers to enable them to make safer recruitment decisions. There were also at least two references for each staff member we viewed, which covered their employment history. Relevant identification had been obtained by the registered provider and copies of medical questionnaires were also kept in the staff members files.

Medication was well managed and administered safely to people in their homes. We saw that people's needs in relation to medication were assessed at the start of the care package which determined what level of support they required from CRG. People who required support with medication had a medication administration record in place which was completed accurately and in full by staff. People's care plans in relation to medication described what level of support they required, such as "support needed to open caps, pop into medication pot." There was a medication policy in place which referred to recent NICE guidance for managing medicines for adults receiving social care in the community. Staff had signed this policy in acknowledgment and had undergone training in medication. Completed MAR charts were audited by the registered manager when they were returned to the registered office.

There were cream charts in place for people who required this, and this was recorded by staff when applied. Some people were prescribed medications to be administered as and when required often referred to as PRN medication. We saw in the care plans viewed, that each person had a PRN protocol in place which included details of when the medication should be administered by staff and what the medication was for.

There was enough staff employed by the service to provide safe and consistent staffing numbers. People we spoke with told us the staff arrived on time and were rarely late. Comments included, "The young lady [Staff member] comes I know her face, she is very good, sometimes I get three, they are nice and they remind me to take my medicine." Also "I've never felt unsafe with them, I see the same one and they are mostly on time." One person said that staff can sometime be late, but they always apologise. We viewed a sample of

staff rotas and spoke to staff about their calls. All the staff we spoke with said they were happy with the rotas, and always felt the calls were manageable.

There was an electronic call monitoring system (ECM) in place. ECM is system which logs when staff arrive at people's homes to complete their care. Each staff member had a smartphone, which they would use to electronically 'log in and out' of people's homes once they had completed all care tasks as required.

Incidents and accidents were well documented and analysed to ensure that appropriate action had been taken. We saw the number of incidents per month was documented and there was a description of the type of incident and what action would be taken to prevent this from reoccurring. For example, one incident involved staff attending a supervision to discuss the incident and we saw this had taken place.

There were robust risk assessments in place for each area of care which were regularly reviewed and met the needs of the person. Records we viewed evidenced that risks had been assessed at the time the care package commenced and as an ongoing monthly action. Risk assessments covered areas such as falls, mobility, and nutrition. Each risk assessment was specific to that person. For example, one person who was partially sighted was at risk of eating food which was out of date, because they could not see the dates on the labels. Therefore, there was a risk assessment in place which instructed staff to ensure all out of date food was disposed of. Another person had a risk assessment in place which instructed the staff of how to move the person up and down the bed without compromising the person's dignity or pressure areas. All risk assessment had been subject to a monthly review, and we saw when there was a change in risk management this was reflected in the person's care plan.

Risk assessments took place on the environment to ensure staff had a safe place to work. These risk assessments included factors such as the carpets, stairways, electrical equipment staff were expected to use such as microwaves, and whether there were any pets on the premises which could cause an obstruction to staff.

Staff were provided with personal protective equipment (PPE) in line with infection control standards. Gloves, aprons and hand sanitizes were provided for staff in the community by the Care Quality Officers. Staff we spoke with all confirmed they had access to this equipment and they knew how to report illness such as flu and vomiting to prevent the spread of infection.

Good

Is the service effective?

Our findings

Staff had the right skills and training to enable them to complete their roles effectively. People we spoke with said "[Staff member] is well trained, works hard, nice to me and very good at their job" Someone else said, "Yes I think they [Staff] are trained because when they come they are polite. They know what they are doing."

The training matrix showed that most of the staff had undergone mandatory training. We queried the gaps in the training matrix, as some staff were showing as being 'red' which meant training had expired. The registered manager explained that some of the staff had left or were on long term sick or maternity leave. There were certificates in staff files to evidence the training courses they had attended. Training covered areas such as safeguarding, manual handling, medication, first aid, fluid and nutrition, dementia, and health and safety. Staff we spoke with said they enjoyed their training and felt they received enough training.

Staff completed an induction before they started working at the service. The induction was aligned to the principles of the Care Certificate. The Care Certificate is a set of 12 standards which should be covered as part of the staff members first 12 weeks of work. These consist of written and practical units. This induction is then signed off by a senior member of staff and the staff member receives a certificate of completion.

Staff were regularly supervised and received an annual appraisal. Our conversations with staff confirmed that they regularly met with their line manager to engage in one on one discussions. We checked the supervision schedule in place and saw that each staff member had a supervision every other month in line with the registered providers policy.

The service was working within the principles of the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's capacity was assessed at the time the package commenced and their ability with regards to decision making was clearly recorded in their care plans. We saw that most people had capacity to consent to their own care and treatment. We saw for two people, they were unable to sign the consent form due to medical conditions. In this case, it was documented that verbal consent had been given to provide care and share their records with the local authority or CQC.

We saw that one person, who was assessed as not having capacity to consent to decisions made in relation to their care, had a best interest decision documented. This was in relation to the use of bedrails. The service had recorded the rationale for the use of bedrails, and had consulted appropriately with all people involved in the person's care and support.

People we spoke with told us they were always encouraged by staff to make their choices and decisions and

the care plans we viewed had adopted this culture. For example, one care plan stated, "Always encourage [Person] to make their own choices of food." Also "Staff are to make sure they ask [Person] what they want to wear each day." One person told us, "They [staff] ask me what I want all the time and do it."

Initial assessments took place when new care packages commenced with CRG which considered people's individual outcomes and what they wanted from their care. Initial assessments were completed with people in their homes by a senior member of staff. The person's preferences for support were documented in their care plans.

People were encouraged and supported with their eating and drinking needs. People we spoke with told us that staff supported them to make their meals. One person said, "They ask me if I want anything to eat and drink."

Each person had a care plan which described their preferences for food and drink. This included where in the house they sat to eat their food and what foods they liked and did not like. The care plan also included people's preferences for large or small meals and what their appetite was like.
We viewed a sample of completed daily records. Staff had recorded what food people had requested and how much of the meal they had ate.

Medical advice and attention was sought when people required this type of intervention. Everyone we spoke with said the staff would always call the GP or District Nurses for them if they required. There was information recorded in each person's care plan which stated the names and contact numbers of any professionals who were involved in their care.

Good

Is the service caring?

Our findings

The service delivered caring and compassionate care in line with people's preferences. We spoke with one person who told us, "They treat me like a human being even though I am old, they are very respectful." "My carer is kind and gentle when she washes me, she takes her time." "Yes, they are nice they asked me what I want to be called (Mrs or first name)". Also, "I like them all and treat them as friends, I've got to know them all, I know who they are." "They help me get washed and dressed, they ask me what I want give me choice (of clothing)." Someone also said, "If I'm upset they always have an 'ear' (Meaning listening ear)." Additionally, one person said, "They are very caring and respectful, because they never rush you and I don't like to be rushed, it's a job they care about." Other comments we received included, "Always able to have a drink and chat with me about anything and everything which I do enjoy and appreciate a human person to talk with" "Being on my own it is so difficult to find someone to talk with. Our conversations are fun and informative. I believe they care about me and happy in their job" Another person said, "Yes, the carers and management are very good. I would recommend this service. They are very good at caring and helping me with my daily needs, a great help". Additionally, the same person also told us, "I am unable to do without them and need their help each day. They really do help and look after me. No problems and I think they are a good service who I would be happy to recommend."

The service involved people in decision making about their care and support. Care plans we viewed had been signed by the person themselves or by their relative if they were legally allowed to do this. People told us that someone from the office called them up regularly to check that they were still happy with the care and whether there were any changes they would like to make. This was documented in people's care plans.

Everyone we spoke with said that they were treated with dignity and respect by staff. Comments included, "If I can do things for myself staff let me. Or they ask first." Care plans were written in a way which put the person's dignity at the forefront of the care. For example, in one care plan it stated, "I would like full privacy when using the commode."

Good

Is the service responsive?

Our findings

People received care which was responsive and personalised to meet their needs. Everyone we spoke with told us staff cared for them in way which they had requested. One person said, "I make my own decisions about my care plan and requirements. I discuss my daily needs, cleaning, drinking and eating. My wishes are carried out by the Carers who help me and talk with me about all manner of things not just their job."

Care plans we viewed were based around the needs of the person and not the organisation, this is often referred to as person centred. We saw care plans contained information about people's background, hobbies and likes and dislikes, as well as their preference for support. One care plan stated, "I like to use a straw to drink, and I watch my television with the subtitles on." Other information included, "I like to watch and bet on the horse racing."

Other person-centred information was centred around people's direct support. The routine carers were expected to follow was clearly documented for each call. We saw that one person liked to have specific coloured bowls for their personal care, and another person liked to have their feet soaked first in a bowl of water. Our conversations with staff evidenced that they appreciated each person's unique support plan. One staff member said, "Everyone is different, aren't they? We need to respect that."

People's equality and diversity needs were respected and catered for. We saw how one person's call times were specifically adapted on Sunday to enable the person to attend church as this was important to them. Additionally, another person was supported to express themselves verbally, in a way which meant they were understood by care staff and involved in their support routine.

Information was available for people in alternative formats. We saw copies of care plans and polices which could be provided in different formats when requested to support people's understanding. The service was further developing their procedures in relation to this to enable them to offer even more accessible way of providing information to people. We discussed some of these ideas with the registered manager.

Complaints were handled and responded to appropriately. The registered provider had a complaints policy which contained details of how to raise a complaint and how the complaint would be dealt with including timescales for completion. There had only been one formal complaint raised within the service which we tracked through and saw it had been appropriately responded to. People we spoke with told us that the complaints policy had been discussed with them and they knew how to complain. One person said, "No complaints but, I would call the office if I had an issue however I do not have any problems with my carer to complain about. They are all good nice and friendly."

There was training in place around end of life care. Staff knew the process of how to care for someone who was on an end of life pathway. We spoke to the registered manager and regional manager for the Norwest because they were in the process of sourcing more in-depth training around this for staff so they had a clear understanding of what would be expected of them once a person passes away. The registered manager had identified that there were gaps in knowledge with regards to this.

Good

Is the service well-led?

Our findings

There was a registered manager in post who had been at the service for a number of years.

People confirmed the managers were friendly and approachable. Comments included, "The office call me, I know who they are." Staff we spoke with said they felt well supported by the managers. Comments included, "The manager is lovely, really down to earth." Another staff member gave us an example of how the registered manager had supported them through a difficult circumstance.

People were happy with their support from CRG and felt engaged and involved. Everyone we spoke with said they enjoyed being supported by CRG, and they would not hesitate to recommend the service to friends and family. One person said, "Yes I would definitely recommend them." Someone else said, "Great job looking after me when they are here, I appreciate their efforts and good work. This is a nice company and who I would be happy to recommend"

The service undertook three monthly telephone surveys with people to ensure they were happy with their support. Additional surveys took place every year, where people were asked about their support and overall experience of CRG. We saw that the responses to these annual surveys were very positive and people were clearly happy with their support and felt the organisation was well – led.

The vision culture of the organisation was clear and credible. All the organisations promotion material was strap lined with the vision and mission statements of CRG. Induction training for staff was based around core learning objectives which were aligned to the ethos of teamwork and person-centred support. Staff we spoke with knew the visions and mission of the service and said they felt proud working for CRG. There was a closed social networking site for staff to be part of, which shared important information about the company, any polices and blogs and updates from managers and trainers. Staff we spoke with said they regularly accessed this app via their company smartphones and found it was a good way to keep 'up to speed with things.'

There were robust governance framework arrangements in place which highlighted areas of underperformance and produced detailed action plans for areas of improvement. All audits had action plans, which the registered manager was expected to complete, this was then discussed with the quality auditor every month. Weekly progression was checked by the regional manager. Key Performance Indicators (KPI)'s in areas such as hours, staff, recruitment pipeline, and number of packages were in place to give an indication of how the service was performing in these areas. The area showed that the service was 83 per cent complaint in the area recruitment and this was ongoing.

Another audit identified the need for restructuring within the staff teams. This was in response to the recent takeover of new care packages. The outcome was that each area had a staffing structure in place, which was overseen by the care needs and risk assessor who fed back to registered manager. The end result was that this benefited the organisation as it has helped the registered manager maintain a safe and consistent staffing structure.

Oversight of an 'end of day handover' was also completed by the coordinators and shared with the management team. The registered manager fed back this was to minimise the level and complaints and to ensure they knew the day to day operation of the service.

Audits highlighted 'room for improvement' and evidenced lessons had been learnt. For example, one audit, that we viewed, the registered manager had highlighted room for improvement (when someone passed away) and concluded that more in depth end of life training would be beneficial for the staff. The training and policy was reviewed as an additional action. Also, more advanced care planning and training was introduced to enable staff to understand their roles and responsibilities when someone passes away.

Other innovative ideas had been trialed and were now successful within the service. For example, we saw that a 'welcome home' basket was provided to people who had recently been discharged from hospital after a long stay. There was a male and female basket, and they consisted of a wash bowl and sponge, shower gel, toothbrush toothpaste and other important items someone might not have had time to purchase if they were discharged from hospital unexpectedly.

The service worked in partnership with the local authority and various other fundraising organisations. We saw there was a considerable number of charitable organisations that CRG were connected to and had arranged fundraising activities both in and outside of work time.

There were policies and procedures in place and staff knew their roles within them. Policies were available for staff in the office and via the company's secure intranet site.

The registered manager knew what was expected of them and their roles and responsibilities regarding reporting any information to CQC. We discussed this with the registered manager during our inspection.