Clarendon Home Care Limited

Clarendon Home Care

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
Clarendon Home Care is a domiciliary care service and is registered to provide personal care and support to people in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

At the time of the inspection the service supported approximately 112 people.

People's experience of using this service and what we found
We found people were sometimes placed at risk of avoidable harm. The provider had not always ensured people received safe care. The provider assessed people's needs prior to supporting them. However, care was not always consistently delivered in a safe manner as indicated in people's care plans. Some care packages that required two members of staff were delivered by a single person. There were instances of missed and delayed calls. Procedures to ensure staff were adequately deployed had not been robustly followed. Improvements were required to ensure people had support from sufficient numbers of staff and to reduce the risk of missed calls.

The provider had systems and processes in place to support the delivery of care. However, the quality monitoring and assurance processes were not used effectively to provide a consistent standard of care.

Most people and their relatives felt safe with the care and support delivered. People had mixed views about the response to their concerns regarding delayed/missed or shortage of staff on their calls.

Staff understood their responsibility in relation to infection prevention and worked in a safe manner to reduce the risk of spread of infection.

The management team were responsive during the inspection and were working in strengthening the systems to address staffing issues.

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

Rating at last inspection
The service was registered with us on 3 December 2010.
The last rating for the service was good, published on 2 May 2019.

Why we inspected
The inspection was prompted in part due to concerns received about staffing. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led.

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 previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified a breach in relation to insufficient numbers of staff deployed to provide care at this inspection.
Please see the action we have told the provider to take at the end of this report.

Follow up
We will review the action plan we have requested from the registered provider. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Clarendon Home Care

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 team consisted of one inspector and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. This included details about incidents the provider had told us about, such as safeguarding events and statutory notifications. A notification is information about important events which the provider is required to tell us by law, like a

death or a serious injury. We also sought feedback about the service from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

We requested the provider send information to us prior to our site visit. This included information on people using the service and staff.

During the inspection
We spoke with 21 people who used the service and seven relatives about their experience of the care provided. We spoke with the registered manager, operations manager, a care coordinator and four care workers.

We reviewed a range of records. This included 10 people's care records and risk assessments. We also reviewed a variety of records relating to the quality assurance and management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found during the inspection. We looked at more quality assurance records. We spoke with two professionals who work with the service and received feedback from three local authority teams that commission care at the agency.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was a risk that people could be harmed.

Staffing

- Sufficient numbers of staff were not adequately deployed to ensure people received the care they required.
- People had experienced delayed and missed calls. There also were instances when a single member of staff attended to a double up call on their own. This meant that some aspects of care such as hoisting, washing or taking someone out of bed that required two members of staff were not provided. This could have a serious impact on the health and well-being of people using the service such as injury or decline in health. Feedback from some health and social care professionals confirmed concerns around delayed or missed visits and the double up calls being carried out by a single member of staff.
- People and their relatives had mixed feedback about the timings of care calls, consistency and right numbers of staff turning up for calls. They told us, "They're very good, they let me know if they're going to be late"; "I am very satisfied and they do what I want them to do"; "Really good band of staff"; "I have two carers four times a day, they might not arrive together, a couple of times, back in the summer, only one turned up"; "[Person] needs two carers to move and wash her as she needs to be rolled over; but sometimes there is only one" and "Often one carer comes when two are needed, times vary considerably, I expect them when they arrive".
- Others felt they had not received care appropriate to their needs as identified in the support plans. They told us; "Sometimes they're late arriving. They don't always let me know and I sometimes have had to cancel a visit because of this"; "Sometimes they're late, they don't always let me know"; "There have been the odd time when they've not turned up but this has improved recently"; "[Person's] carer has left and the office had not arranged for anyone to replace her"and "I have had a few problems with the carer not turning up."
- Staff had mixed views about how the rotas were planned and travel times between calls. A member of staff told us, "I get my rota in advance and that makes it easy to plan my day." However, others commented, "There was a month I didn't do the same run"; "It is difficult to provide cover because of the geographical distance" and "If a double up colleague is late, I have no choice but to do the bits I can by myself." Records showed calls were scheduled at different times and allowed time for travel.

We found no evidence that people had been harmed however, the provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's care and treatment 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.

- The registered manager told us that COVID-19 had caused a slow uptake in recruitment of care staff and had impacted on the timings of calls and continuity of staff. There was an ongoing recruitment for new staff to cater for the widespread geographical area they served.

● Staff told us, and records confirmed they received their rotas and information about people they supported in a timely manner.
● Staff used an electronic system to log in the start and finish of their call. This information was sent to the office in real time and reflected delayed or missed calls. Records showed staff did not consistently log in and out of call visits. This posed a challenge to office staff in monitoring whether care had been delivered.
● The electronic management system used to manage staffing was not consistently monitored to pick up missed calls/delayed calls. The office staff did not always act in a timely manner to provide cover for staff absences.
● Staff told us they were supported in their roles. They received an induction, shadowing and training to enable them to carry out their role safely.

Assessing risk, safety monitoring and management
● Individual risks to people were assessed prior to them using the service. Staff understood the support people required to reduce the risk of avoidable harm.
● Care plans contained risk assessments and guidance for staff to follow deliver care in a safe manner.
● Care plans were reviewed and updated to reflect changes in people's needs and support required.
● The provider continued to review the number of their care packages in view of the staff shortages. The provider had handed back some care packages to service commissioners to ensure sufficient staffing levels. This minimised the risk of people not receiving safe care.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us overall, they felt safe with the care delivered. Comments included, "I do feel safe, they do care" and "The carers are excellent".
● Staff received safeguarding training and understood their responsibility to provide safe care. They knew how to recognise potential signs of abuse and how to raise any concerns about people's safety.
● The registered manager reported safeguarding concerns as required to the local authority. Records showed matters were investigated and changes made when necessary to improve care practices.

Using medicines safely
● There had been occasions when missed calls resulted in people not taking their medicines as prescribed.
● Medication administration charts were audited. The registered manager acted on concerns identified to learn from them and minimise repeat incidents.
● Staff were trained and assessed as competent to administer medication.
● The provider had plans to improve the way staff delivered care and how medicines were managed using the existing electronic management systems.

Preventing and controlling infection
● Staff were trained in infection prevention and control.
● Staff had access to correct personal protective equipment (PPE) and used it appropriately.
● Staff received information and regular updates in relation to the COVID-19 pandemic.
● People were happy staff knew how to minimise the risk of infection. They commented, "They wear PPE and seem to be well trained to do their jobs. I feel safe with them"; "COVID-19 has made a difference, they have extra things to do to be safe" and "They wear masks and gloves".

Learning lessons when things go wrong
● Lessons were learnt when things had gone wrong. Staff understood their responsibility to report any incidents and accidents. The registered manager and provider reviewed reports and incidents and took

action to prevent any recurrences.

● The registered manager understood their responsibility to ensure that any learning was shared across the organisation.

● The provider and registered manager were open and transparent about when things had gone wrong, where they had made improvements and where further improvements were still needed.

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.

This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the quality assurance systems in place did not always support the delivery of high-quality person-centred care.

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

- Quality assurance systems such as the electronic monitoring system were not used effectively to deliver consistent care to people. The electronic call monitoring system flag ups of delayed/missed calls were not always picked up and acted on in time. We raised this with the registered manager who highlighted the management team had increased its monitoring of the electronic monitoring system to enable them respond quickly to delayed or missed calls. In addition, the operations manager had now increased their oversight of rota planning to ensure sufficient numbers of staff were deployed to deliver care. We were satisfied with the response but needed to review this plan over a period to ensure a consistency in the delivery of care. The registered manager was open and honest about the times when people had experienced missed calls and staffing shortages.
- The registered manager and management team supported staff when needed to cover short term sickness or unforeseeable circumstances.
- Staff feedback was positive about the management of the service. Staff told us the registered manager was approachable and considered their views about how to improve the service.
- The registered manager was supported by a team who had specific roles and responsibilities to ensure staff received the support they required to deliver safe care.

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

- People and their relatives had mixed experiences when they contacted the office for support. Some commented the office staff were helpful and responded to their concerns. However, others felt the office staff took long to respond and address their concerns. We raised this concern with the operations manager who told us they were working to improve the communication between people using the service and office staff.
- The management team and care coordinators met with people and their families or contacted them by telephone to assess or review their individual needs. Care plans reflected a person-centred approach.

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

- The provider sought views from people or their family members through home visits, telephone calls, care reviews and surveys and acted on their feedback

● Staff meetings at the offices were paused due to the COVID- 19 pandemic. The registered manager and management team sent out regular communication through emails, messages, newsletters and carried out supervision through telephone calls. Staff were supported in their roles and felt able to feedback their views about the service.

●The management team continued to support staff during the COVID-19 pandemic to ensure their well-being.

● The registered manager was responsive to feedback given throughout the inspection. They had plans on focussed on ensuring adequate staffing and improving communication with people for a delivery of consistent care. The management team showed commitment to improving service delivery and understood their responsibility to make sure people received care as planned.

● The service worked in partnership with others, such as commissioners, health professionals and other social care professionals. Safeguarding concerns had been investigated by some local authorities and showed staff deployment and communication between the office staff and people using the service were not always managed effectively. There was positive feedback from a health and social care professional who commended the management and staff on their proactiveness in meeting people's needs as they changed.

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 Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to provide care. Regulation 18 (1)