Clarity Homecare

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Inspection report

Unit 3
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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?	**Inadequate**

Summary of findings

Overall summary

About the service: Clarity Homecare is a domiciliary care service that provided personal care to 82 people at the time of inspection. At the time of inspection, the majority of people receiving personal care from the service were older people, people living with dementia and people with physical disabilities.

Where services support people with learning disabilities or autism we expect them to be developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/ or autism to live meaningful lives that include choice, control and independence. People using the service did not always received planned and coordinated person-centred support that was appropriate and inclusive for them.

People's experience of using this service: We identified widespread and significant shortfalls with the leadership of the service. The provider had not submitted statutory notifications to the Commission to tell us about significant events. The manager and provider did not follow their systems to check safety and quality issues within the service. The issues we found during our inspection had not been identified by the provider. The provider was not responsive when we highlighted our concerns to them.

People and staff were not always engaged in the running of the service. Care workers did not always feel supported. They reported having difficulties accessing the team leader on-call for unplanned or emergency support.

Information was not available to help guide staff about the support people needed to manage risks or specific health conditions. At times this meant staff did not know how to respond. Medicines were not always managed safely. Staff were not clear of their responsibilities to order and collect people's medicines and medicines were not audited effectively to identify any recording issues.

It was not always clear that there were sufficient staff to cover people's care visits.

Training was not delivered by a qualified member of staff. Staff had not received training in key areas.

People told us they received variable experiences of care, with new staff lacking understanding of their care needs. This meant people were not always confident in the care they received.

Care plans were not always available to help staff understand the support people required. At times this meant people did not receive the care they required. Staff supported people with end of life care. They did not have the information and training needed to help them understand this specific life stage.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support as care was not always person-centred and people's choices were not always taken into account or shared

with staff.

People described having positive, supportive relationships with care workers. They felt they were treated with dignity and respect.

More information is in the detailed findings, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection: This is the first inspection of the service since registering in March 2018.

Why we inspected: This was the first scheduled inspection of the service.

Enforcement: We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 around person-centred care, safe care and treatment, good governance and staffing. Details of action we have asked the provider to take can be found at the end of this report.

Follow up: We will work with the provider following this report being published to understand and monitor how they will make changes to ensure the service improves their rating to at least good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Clarity Homecare

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: One inspector and an Expert by Experience who carried out phone calls to people that used the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had expertise in dementia and older people's care.

Service and service type: Clarity Homecare is a domiciliary care service. It provides personal care to people living in their own homes. Clarity Homecare provides care to people living with dementia, learning disabilities or autistic spectrum disorder, mental health, older people, people who misuse drugs and alcohol, physical disability, sensory impairment and younger adults.

Not everyone using Clarity Homecare received a regulated activity; 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.

The service had a manager, however, they were not registered with the Care Quality Commission. The provider is 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 visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did: Inspection site activity started on 23 January and ended on 28 January 2019. We visited the office location on both days to see the provider and review records.

During inspection, we looked at a range of records relating to the running of the service including records of

accidents and incidents, staff training records and the provider's policies and procedures. We looked at the care files of 15 people and six medication records. We reviewed the recruitment files of three staff and four staff supervision and appraisal records.

We contacted six people that used the service by telephone and visited a further two people. We spoke with six relatives and eight care workers, the manager, the trainer and the provider.

Following the inspection, we contacted two social care workers and one care provider for their views on working with the provider.

The provider did not meet the minimum requirement of completing the Provider Information Return (PIR). We made arrangements for the provider to return this after inspection for us to consider this information. The PIR 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 made the judgements in this report.

Requires Improvement

Is the service safe?

Our findings

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

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.

Assessing risk, safety monitoring and management.
- Staff had not received the specialist training or competency checks to ensure they would provide people with specific health needs with safe care.
- The support people required with their health conditions was not consistently recorded. For example, where people had epilepsy their records did not describe the type of seizures they may experience and guide staff in how to respond, including when to request emergency medical attention.
- Staff were not provided with guidance about the safe use of bed rails.
- Risk assessments were not always up to date or used to identify risks specific to people's needs. Control measures to help keep people safe were not always detailed. A risk assessment was not in place for a person at risk of self- neglect to help care workers know how to monitor and manage this.
- Where people presented with behaviours which may challenge the service, care plans were not in place to provide staff with information about when this behaviour may arise. Also, how to support the person should they become distressed. This meant staff were not always able to support people safely.

The evidence above shows there was a breach of regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider agreed to seek advice from health professionals regarding competency assessments for specialist health needs.
- Following our inspection, the provider reviewed how health conditions were recorded in people's care plans and was working to improve this.
- People felt staff understood their health needs.
- Recognised tools were not used to identify risks. The provider agreed to implement them.

Using medicines safely.
- Arrangements for ordering and collecting people's medicines were unclear. Staff were unsure of their responsibilities.
- Medication Administration Records (MARs) did not always contain guidance about when medicines should be administered or their storage instructions.
- 'When required' protocols were not in place to identify when people may need these occasional medicines.
- The provider's medication policy and best practice guidance were not always followed. For example, when people received variable doses of medicines the dose was often not recorded.

● There were no medication audit systems in place. MARs were not returned to the office for several months after they had been completed. This meant any recording or medication errors could not be identified and addressed in a timely way. There was no system to ensure a consistent approach was used to check records.

The evidence above shows there was a breach of regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider updated MARs following our inspection to include medication storage instructions.

Staffing and recruitment.
● It was not clear that the service was sufficiently staffed to ensure people received care. Rotas showed care visits for the week of our inspection had not been allocated to staff. One person had nine out of their ten hours of support to be arranged.
● Arrangements for informing staff of rota changes were unclear. Staff told us changes were made to their rotas on a daily basis without notice. The provider advised staff were notified, including by telephone. Travel time was not always arranged to give staff time to travel between visits.
● When people required two care workers to support them this was not always coordinated.
● People had varied experiences of receiving support from consistent care workers. One person told us, "There is a lack of continuity."
● When people expressed concerns about the variations in their care this was addressed by the provider. However, people said they had to follow up subsequent issues.

The evidence above shows there was a breach of regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and their relatives told us their care visits were usually on time.
● Safe recruitment processes were followed.

Learning lessons when things go wrong.
● The manager responded to medicine errors when they were alerted to these and took action to improve staff practice,
● The manager did not keep a record of accidents and incidents to identify trends and patterns in-line with the provider's policy. We could not be sure preventative actions had been taken and wider learning shared with staff to help keep people safe.
● Group texts were sent to staff to remind them of good practice.

Systems and processes to safeguard people from the risk of abuse.
● Staff understood their safeguarding responsibilities and raised concerns when required.
● People were supported through safeguarding processes. The manager attended safeguarding meetings.
● Staff were aware of how to raise concerns about the service with their manager and escalate them to other organisations such as the Care Quality Commission (CQC) if required.

Preventing and controlling infection.
● Care plans contained information about precautions staff should take to prevent the risk of infection, including wearing Personal Protective Equipment (PPE) such as disposable aprons and gloves.
● Staff identified when PPE was needed and how to dispose of this appropriately.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience; Staff working with other agencies to provide consistent, effective, timely care.

- Training was delivered by staff who were not appropriately qualified to deliver the training.
- Staff advised the training provided did not always aid their learning. One care worker described repeating training to improve their understanding.
- Care staff did not receive training relevant to the needs of the people they supported. This included training in learning disabilities and drugs and alcohol misuse. One relative told us staff did not have training in dementia and behaviours that could challenge. They told us, "I asked a care worker about their training, they said [person with dementia] was like a child with special needs and they would treat them the same, I sent them home."
- The manager's supervision followed the same format as care workers' supervisions. It was not specific to their management role and responsibilities.
- People felt new staff lacked understanding of their care needs. Comments included, "I have new care workers that do not know what they are doing." One relative said, "A couple of new staff were a bit rough trying to get [person's] trousers off over their shoes." They advised this had been addressed. People were not always confident they were receiving effective care.
- Information about people's presentation and support was not always shared with other care providers to deliver effective joined up care.

The evidence above shows there was a breach of regulation 18 staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received an induction and shadowing opportunities to help them learn and familiarise themselves with their role requirements. A probation period was used to assess staff suitability.
- Staff received supervisions and appraisals to support their development.
- People's preferences for male or female care workers were respected.
- Information about any changes in people's needs was shared with their relatives.
- The provider advised, following our inspection, that training in dementia and alcohol and drug abuse was delivered to staff.

Supporting people to live healthier lives, access healthcare services and support.

- The provider did not use documentation, such as hospital passports to share key information about people's social care needs with health professionals to inform their approach.

● The provider worked with other professionals to facilitate hospital discharges.
● People received support to access healthcare services such as chiropody.
● Staff made referrals to relevant professionals, such as occupational therapists when needed.

Supporting people to eat and drink enough to maintain a balanced diet.
● One person had diabetes and had said in written feedback to the service that care workers did not understand their dietary needs. There were no details of the action taken.
● People received support to access meals and drinks.
● Some people's care plans referred to their preferred meals and drinks.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
● People received an assessment prior to receiving support to identify their care needs.
● People were involved with their assessment and informed of how their care arrangements would work.

Ensuring consent to care and treatment in line with law and guidance.
● Written consent was obtained from people to ensure they agreement with their care arrangements. At times, staff supported people with their medicines despite this not being agreed in their consent forms. The manager agreed to review this.
● Consent was reviewed regularly.
● Staff obtained consent before providing care.

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 can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In the community this is authorised through the Court of Protection.

We checked whether the service was working within the principles of the MCA.

● Staff were aware of which people may lack capacity and how to support them. This was not always recorded in people's care plans.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity.
- Although we received positive feedback from people about staff care, the provider's ways of working and arranging care meant that the service was not always caring.
- Limited records meant staff did not have the necessary information about people's background and preferences to provide support.
- Staff lacked the training to provide a good standard of care.
- People described having supportive relationships with care workers based on open communication.
- Staff spoke positively and respectfully about people. One care worker said, "It's a pleasure to care for the people."
- People received emotional support when they needed this. One person told us, "I do call the office when I suffer from depression."
- Staff were aware of recent significant events in people's lives and supported them with these.

Supporting people to express their views and be involved in making decisions about their care.
- People were supported to live as they chose. One person told us, "I'm supported to live my life as I want."
- Staff were aware of people's communication needs. The provider was aware of the accessible information standard and their responsibility to provide information in a format people could understand.
- The manager understood advocacy and had worked with a person's advocate.

Respecting and promoting people's privacy, dignity and independence.
- People's privacy and dignity were respected. People and their relatives felt staff provided care in this way without thinking about it.
- People were supported to be independent. One person had not previously lived independently and told us, "I now have the freedom to be an adult."
- Support from care workers enabled people to continue to live in their own homes.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support.

- Care plans were not always available in people's homes to advise staff them of the support people needed. One care worker said, "I went to see one person and there was no care plan, I didn't know their needs and the person and their relative couldn't tell me because of their dementia."
- Care plans did not always contain information staff needed to know to provide care. For example, two people's care plans did not detail the support they needed for their continence and bowel care. There had been an occasion where this meant a person had not received support with their catheter and urgent support was requested.
- People had not been asked about their preferences for end of life care.
- Staff had not received end of life training to help prepare them for this care. One care worker said, "I feel under qualified to support people with end of life care, a bit more knowledge would be useful."
- One person was receiving end of life care during our inspection. Staff were aware of the professionals involved with their care.

The evidence above shows there was a breach of regulation 9 person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider advised their new electronic care system would ensure staff had access to care plans.
- People's religious beliefs were asked about as part of their care planning. It was not always clear if or what considerations had been made for people's care.
- People's care was reviewed.
- People received support to access employment and voluntary opportunities.
- Changes to people's care visits were accommodated.
- People were supported to attend activities they enjoyed, such as bingo or going to the seaside.

Improving care quality in response to complaints or concerns.

- A complaints procedure was in place.
- The manager advised no formal complaints were received in the last year. Although based on feedback from people, relatives and staff and deficiencies with record keeping at the service we could not be sure this was the case.
- People and their relatives knew how to raise complaints if needed.

Inadequate

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility when things go wrong; Continuous learning and improving care.

- There was a lack of oversight and monitoring of the service. Audits were not always completed by the manager or provider in-line with the provider's policy. One audit had been completed by the provider in June 2018. Actions identified in the audit had not been addressed or followed up. This meant there was little evidence of continuous learning, reflective practice and service improvement.
- The provider's audit been ineffective and failed to identify deficiencies in the quality and safety of the service.
- When we raised concerns with the provider they were not responsive to the significant shortfalls identified.
- The service had been without a registered manager since November 2018.
- Up to date and complete care records were not in place. This meant staff did not have information to guide them in providing safe, effective care for people.
- Staff did not always feel supported. They reported difficulties accessing support from the team leader, on-call or the manager. One care worker told us, "On-call have their own calls to go to, they support a person at bingo, they can't be contacted for up to three hours when this happens." When staff managed to contact on-call they told us they did not always receive support. One care worker said, "If I ring the on-call at the weekend they will tell me to wait until the office is open on Monday."
- Care workers reported inconsistent levels of staff satisfaction. Three out of the eight staff we spoke with did not feel valued by the provider.
- Staff did not always feel able to take time off work including for sickness. One care worker said, "I rang in sick yesterday and was told to do the visits."

The evidence above shows there was a breach of regulation 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We wrote to the provider following our inspection to raise serious concerns with them and to require them to tell us urgently what they intended to do to put these matters right and by when.

- The provider had not submitted statutory notifications to the Care Quality Commission to tell us about significant events that had happened in the service. This is being addressed outside of the inspection process.

● The provider informed us they were working with staff to ensure they understood the on-call system was for emergencies only and this was responded to.
● The provider advised their audit had been delayed due to the previous registered manager being absent and then terminating their employment.
● Staff were not familiar with senior members of the provider's management team and were unclear what their responsibilities were. The provider advised this was being addressed.
● People and their relatives knew who the manager was and felt they were approachable and professional.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
● Staff did not always feel engaged in the running of the service. A care worker told us, "We don't get a say in the service."
● The provider did not always support staff engagement and share learning. Team meetings did not take place.
● People and their relatives had the opportunity to provide feedback on the service through telephone calls and a questionnaire. When people were not able to use the telephone due to their communication no alternative arrangements were made.
● When people provided feedback it was not always clear that the provider had listened and acted on this.

The evidence above shows there was a breach of regulation 17 good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had sent a survey to staff to rate different aspects of the service. It was not clear how this information had been acted on.
● Staff were able to contact management during working hours to seek advice.

Working in partnership with others.
● There was little evidence the service had established links with the local community. However, we noted that staff worked in partnership with other agencies to access advice and support when they had concerns about people's wellbeing.
● Professionals reported having difficulties contacting the provider when needed.
● A care provider told us Clarity Homecare had been unhelpful when they had requested information.

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 9 HSCA RA Regulations 2014 Person-centred care (1)(a)(b)(c)(3)(c) Care was not designed or carried out in ways that were appropriate to service user's needs or preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1)(2)(a)(b)(e)(g) Care was not provided in a safe way. Risks to the health and safety of service users were not assessed and measures were not in place to mitigate any such risks. Information was not available to support the safe use of equipment. Medicines were not managed properly and safely.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1)(2)(a)(b)(c)(e)(f) Governance and record keeping processes were ineffective in monitoring and improving quality and safety of the service, assessing and mitigating risks to people who used the service and maintaining an accurate, complete and contemporaneous record in respect of each person using the service.

Regulated activity	Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

(1)(2)(a)
Staff were not sufficiently qualified, competent, skilled and experienced to meet service user's care and support needs. Staff did not receive appropriate training and supervision to enable them to carry out their duties.