Castlerock Recruitment Group Ltd

CRG Homecare - Hammersmith

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection at this location between 30 May and 8 June 2017. Breaches of regulations were found relating to medicines, consent and good governance.

After the inspection, the provider wrote to us to say what they would do to meet legal requirements. We undertook this announced focused inspection on 31 October and 1 November 2017 to check whether the provider had followed their action plan and made the necessary improvements to meet legal requirements. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for 'CRG Homecare – Hammersmith' on our website at www.cqc.org.uk.

CRG Homecare – Hammersmith is a domiciliary care agency which provides care to older people and people with physical disabilities in the London Borough of Hammersmith and Fulham. At the time of the inspection the provider was providing care to 312 people.

The location had a registered manager, who was the Area Manager. 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. A new branch manager was in post who had applied to be become registered manager.

We found there had been some improvements in punctuality, but some people we spoke with still identified lateness as a problem, and a high number of visits were late, including some which could impact on people's care. A far higher number of care workers used electronic call monitoring to log in and out to calls, but the provider had not yet been able to ensure that planned visit times on this system were accurate, which meant the system was still not being effectively used.

The provider had improved recording in relation to people's medicines, but sometimes plans contained inaccurate and contradictory information. There were now medicines administration recording (MAR) charts in place, but sometimes these contained errors and audits of these were not sufficient to detect errors and to take appropriate action. We found two cases where the provider was not implementing risk management plans with relation to pressure sores.

The provider was now meeting regulations with regards to consent to care, as they had introduced systems to ensure that people's consent was recorded. Where people were unable to consent to care, the provider assessed people's capacity and demonstrated they were working in people's best interests.

We found that audits did not always clearly address where improvements were required in relation to people's care and people did not always receive regular reviews or quality assurance monitoring. The provider had identified weaknesses in their quality assurance systems and had designed systems to address

these, but some of these were yet to be implemented.

We found continued breaches of regulations in relation to safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of this report.

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

There had been improvements in how call monitoring was used, but this was still not effective in monitoring punctuality.

There had been some improvement in punctuality but this still impacted on people's care.

The provider had improved recording relating to medicines, but this was still often contradictory and medicines were still not managed safely.

We were unable to change the rating in this key question as the provider was still not meeting regulations. We will look at this again during our next comprehensive inspection.

Is the service effective?

Good

The provider now had systems in place for recording people's consent to care and, where people lacked capacity, acted in line with the Mental Capacity Act 2005.

We have changed this rating to "good" as the provider was now meeting this regulation and this change was likely to be sustained.

Is the service well-led?

Requires Improvement

The provider had identified shortcomings in their quality assurance processes and had devised systems to address these, but some of these were yet to be implemented.

People did not receive regular reviews of their care in line with the provider's requirements. Audits did not always identify or address where requirements were needed.

We were unable to change the rating under this key question as the provider was still not meeting this regulation. We will look at this again during our next comprehensive inspection.

CRG Homecare - Hammersmith

Detailed findings

Background to this inspection

We undertook an announced focused inspection of CRG Homecare – Hammersmith on 31 October and 1 November 2017. This was to check that improvements to meet legal requirements planned by the provider after our inspection between 30 May and 8 June 2017 had been carried out. We inspected the service against three of the five questions we ask about services; Is the service safe? Is the service effective? Is the service well-led. This is because the service was not meeting some legal requirements.

Prior to the inspection we reviewed records we held about the service, including information of significant events the provider is required by law to tell us about and the provider's action plan from their previous inspection. The inspection was carried out by a single inspector and a specialist professional adviser in medicines. An expert-by-experience made calls to people who used the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In carrying out this inspection we looked at records of care and treatment relating to 12 people using the service and records of medicines management for eight people. We looked at records from the provider's electronic call management (ECM) system, which is used to log when staff arrive at and leave calls.

We spoke to 28 people using the service or their relatives. We met with the branch manager, area manager, compliance officer and the quality assurance manager. We also spoke with a monitoring officer from the local authority.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection, we found that the provider was not meeting the regulation regarding good governance. This was because the provider was not effectively using call monitoring software to ensure punctuality of care workers to calls. At this inspection we saw that there had been some improvements to punctuality and call monitoring but the provider was still not meeting this regulation.

At the last inspection the majority of people who we asked told us that care workers were often late. At this inspection one third of people we spoke with told us that punctuality was still a problem for them, which indicated there had been some improvement. Comments from people included "They are mostly late, sometimes up to an hour", "I call the office and ask them what happened? They tell me it will be half an hour, sometimes it takes more time" and "Sometimes it feels like I'm always calling." Other people were more positive, with comments including "The carers are on time" and "I made it (the provider) understood that lateness was not in my category."

The provider had an electronic call monitoring (ECM) system, which care workers used to log in and out from people's houses. At our last inspection we found that this wasn't in use for the majority of calls. At this inspection we found that this had improved significantly, from 44% during the week of 14 August to 71% for the week of 16 October. However, this system was still not effective for monitoring calls. This was because the planned times recorded on the system were often different to what was recorded in practice. The provider told us that they had inherited this data from the previous provider and due to issues with their system had been unable to update this, but showed us that they had recently started this process.

The provider's ECM data showed that for the week of 16 October, 33% of calls were late, and this data was unlikely to be reliable. We looked at a sample of 515 visits for 12 people for the period from 25 September to 22 October. Of these, 13% were more than 15 minutes late. This suggested an improvement from the last inspection, where 16% of calls were more than 30 minutes late.

However, there were still some cases where the punctuality of care workers was likely to cause problems. For example, one person was supported to take a time critical medicine where the manufacturer's instructions stated "Take at regular time intervals. Do not change the times at which you take your tablets without first consulting your doctor." The person's care plan stated that their visit should take place at 9am, but over a two week period we found five mornings where care workers arrived after 10am and five visits which took place before 8:30am. For two people's records we looked at care workers provided support with meals, medicines and personal care on their visits. One person had 54 visits, of which 15 were more than 15 minutes late and three were more than 30 minutes late, and the other person had 44 visits, of which seven were more than 15 minutes late and three were more than 30 minutes late.

This meant that, despite improvements, the provider was still in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At the previous inspection we found that the provider was not meeting regulations regarding safe care and

treatment. This was because care workers were not recording when they had prompted people to take their medicines and there was insufficient and frequently conflicting information on the support people required to take their medicines.

At this inspection we found the provider had made some improvements. These included improved detail on care plans and using medicines administration recording (MAR) charts to record when people had been prompted to receive their medicines. However, in some cases these had revealed further discrepancies, and medicines were still not always being managed safely.

The provider had completed needs assessments and medicines risk assessments, however these often contained contradictory information. For example, one person's plan stated they were not taking medicines, but care workers had recorded on daily logs that they were prompted with medicines and supported to apply creams, but it was not clear what these were. For another person, their care plan stated their partner was managing their medicines but there was a MAR chart in place and staff recorded they were prompting. This person's log also stated creams were applied but it was not recorded what these were. Another person's plan stated they required no assistance with medicines but again, a MAR chart was in place without further explanation, and another person's care plan stated no assistance was required, but the risk assessment stated "blister pack, carer to prompt". There were also two people whose documentation stated that they were to be prompted to take their medicines, although the provider had recorded that they did not have capacity to manage their medicines.

We saw some errors with how medicines were transcribed onto MAR charts. For example, one person had a high risk medicine which their care plan stated they should take twice daily, but the MAR chart stated this was "two daily". For another person a medicine to be taken twice daily had been transcribed as "12 x a day". Another person's MAR chart showed that they had medicines prescribed three times a day; these had been signed for even though the person only received two visits per day. For another person they received two visits a week, but care workers were signing for medicines on days that they had not attended.

The provider had recently implemented a MAR chart audit system. However, we found this to be of limited use and ineffective in detecting issues or ensuring actions were taken when concerns were raised. The audit system required the auditor to ask questions about the MAR chart and award a percentage score based on the answers to these; but this was not weighted in any way. One person's MARs showed multiple gaps over two periods of four days, but the audit had recorded these were "good" or "outstanding", even though there were serious issues. Four audits had rated the MAR as either "inadequate" or "requires improvement", but there was no action plan in place for addressing these concerns. Another audit had rated two MAR charts as 100% compliant and "outstanding", but the audit process had failed to recognise that a medicine was prescribed twice daily, but had only been signed for in the evening for an entire month.

The audit system was based on auditing the record made by one member of staff transferring information in the person's home, but staff in the office had no primary point of reference as to whether this information was correct. The provider acknowledged that audit tools were not being used effectively. The provider showed us records relating to the refresher training that staff received to administer medicines. At the time of the inspection, there were 51 staff who were due to receive this training, the provider showed us records to demonstrate that they were in the process of organising this.

In addition, we saw records for two people who were at risk of pressure sores. For one person there was no risk management plan. Another person's care plan stated that they were to be repositioned on each visit, but care workers did not maintain a consistent record of this. This meant that people were not adequately protected from the risk of pressure sores.

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

Good

Is the service effective?

Our findings

At the previous inspection we found that the provider was not meeting regulations relating to consent. This was because in some cases family members had signed on behalf of people even though the people who used the service had capacity to do so, and in other cases the provider had not carried out assessments of people's capacity to make decisions about their care before they obtained consent from a relative with lasting power of attorney or carried out best interests meetings.

At this inspection, we found the provider was now meeting this regulation. People who were able to do so had consented to their care. Where people had capacity but were physically unable to sign documents recording their consent to care, the provider was recording the reasons why they were unable to do this and were recording the person's verbal consent to their care. The provider had a framework for assessing people's capacity in line with the Mental Capacity Act 2005, and where people lacked capacity a person's representative had recorded that they believed the plan was in the person's best interests. The provider checked appropriate consent had been recorded as part of their monthly audit.

We have changed the provider's rating to "good" in this area as the provider was now meeting this regulation and had systems in place to show that that this was likely to be sustained in future.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we found that the provider was not meeting the regulation with regards to good governance. This was because monitoring of people's care was not happening regularly to ensure that people were satisfied with their care. At this inspection we found that the provider was aware of the weaknesses in their quality assurance systems and were working to overhaul these, but these were not meeting this regulation.

We found that telephone monitoring was being carried out. For most people there had been a review within the last six months, but on one case there was no review or monitoring visit for 12 months. The provider told us that people's care should be reviewed every three months.

Some people we spoke with told us that managers did not check up on care. For example one person said "The manager promises to come and see me, but never does" and another said "It would be nice if they did call to check if everything was alright, then I can tell them what I want." Other people told us they had received calls and found these useful in addressing particular needs.

Monthly audits were in place for all care plans we reviewed since they were introduced two months ago. These included checking whether there was a completed needs assessment, whether appropriate consent had been obtained and whether the care plan had reflected assessed needs. These had been effective in some areas, for example in ensuring appropriate consent was obtained. However, in some cases these did not always highlight where improvements were needed, for example with regards to medicines support and the risks of pressure sores, and there were not clear action plans or evidence of follow up where improvements were required.

The provider told us it was their policy to audit 10% of care logs monthly. We found that there were some gaps in recording on care logs and that the provider did not check these against whether calls had been missed, however we found no evidence of missed visits. The provider's internal audits had shown that spot checks did not show consistent reviews of care plans, and showed us a new care plan format they intended to implement, which included quarterly monitoring and review.

This meant the provider was still in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

During the inspection, we met members of the provider's quality assurance team and saw copies of the provider's action plan for improving the performance of the branch. A full time quality assurance officer had recently been appointed. The provider told us "We found our paperwork wasn't fit for purpose." They had also introduced a monthly workbook for managers to complete, with a summary of audits which had been carried out and records of complaints, safeguarding, accidents and incidents.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not undertake all that was reasonably practical to mitigate risks to the health and safety of service users or ensure the proper and safe management of medicines 12(2)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not operated effectively to assess, monitor and improve the quality and safety of the services provided in carrying on the regulated activity, including the quality of the experience of service users in receiving those services 17(2)(a)