CRG Homecare Limited

CRG Homecare - Wandsworth

Inspection report

9 Lydden Road, Unit 33
Earlsfield Business Centre
London
SW18 4LT

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22 February 2022

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

CRG- Home Care – Wandsworth 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 our inspection, 12 people were receiving personal care and support.

People's experience of using this service
There were continued breaches of regulation in relation to staffing and good governance. The majority of the feedback we received was negative about staff punctuality and the amount of time they spent with people when providing care. People and their relatives commented, "Fed up with CRG saying I have no carers to give you.", "It was potluck who you got, and what they knew about you. I complained but got no joy from them" and, "No cover when the main carer left."

Systems were in place to monitor the quality of care people received. However, the electronic system used to monitor staff attendance on their calls did not always work as intended.

People felt unsafe with the care and support provided. Comments included, "On one occasion they were late, and when I rang the office, they said "[carer] couldn't come back" and "I had a lot of problems getting a carer to come to me on a Sunday." Staff did not always visit people as planned or stayed the duration of the planned visits to effectively support people.

Staff did not demonstrate sufficient knowledge about safeguarding of vulnerable adults. Risk assessments and management plans were in place which enabled staff to provide care safely. However, we were concerned staffing shortages impacted on managing risks as staff did not always turn up to provide care. People did not always receive the support they needed to take their medicines safely as staff did not always turn up for shifts.

The provider did not foster a culture of learning from incidents and accidents. Accidents were not recorded and monitored and discussed with staff to minimise a re-occurrence. There were instances of missed calls, people receiving unsafe care and the provider's systems ineffective in monitoring trends to prevent a re-occurrence.

People and their relatives told us staff did not always treat them with dignity and respect. Staff were reported as impatient, rushed people and were always in a hurry. Care and support had not always been delivered. Some staff did not support people with various aspects of their care such as meal preparation, leaving them unwashed, improperly dressed or left them in distress. Staff attended calls much earlier than planned or very late without people's consent to the changes to their preferences of when their care was delivered.

The provider's governance and quality assurances systems were not robust and failed to ensure the delivery of safe care and compliance with regulations. Comments from people included, "[Carer] are always in a hurry. They left early"; "[Carers] shot off early. Never stayed the whole duration" and "Sometimes they stayed for 5 minutes instead of 30 minutes".

People did not always receive consistent and reliable care and treatment. The majority of the feedback we received in relation to the safety of the care provided was overwhelmingly negative. Systems for monitoring staff attendance to care visits, risk management, quality assurance checks and auditing, staffing and supervision were inadequate. The was no registered manager in post and weak oversight on management arrangements by the provider which posed risk of harm to people.

People's care plans were not always followed to show a person-centred approach to care. People and their relatives told us staff did not provide care tasks as indicated in their support plans. Complaints were not resolved or dealt with effectively to improve people's experiences. Comments from people included, "[Carers] didn't understand [person's] needs and they were aggressive"; "The carer and the manager refused to amend my care plan," and, "I had a different carer each time."

Staff knew how to minimise the risk of infection when providing care.

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

Rating at last inspection:
The last rating for the service was requires improvement (published on 03 January 2021) and there were breaches of regulation. The provider also completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider had not consistently maintained oversight of staffing and quality assurance processes to ensure people received the care they needed. Improvements made since our last inspection were inconsistent and ineffective to ensure safe delivery of care.

Why we inspected
This inspection was prompted by a review of the information we held about this service.
As a result, we undertook a focused inspection to review the key questions of safe and well-led only. This inspection was also carried out to follow up on action we told the provider to take at the last 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.

At this inspection we identified continued breaches in relation to ensuring sufficient suitably qualified staff were deployed to meet the needs of people using the service and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will work alongside the provider and local authority to monitor progress. We will return to visit as per our

re-inspection programme. If we receive any concerning information we may inspect sooner.

This was an 'inspection using remote technology'. This means we did not visit the office location and instead used technology such as electronic file sharing to gather information, and video and phone calls to engage with people using the service as part of this performance review and assessment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

CRG Homecare - Wandsworth

Detailed findings

Background to this inspection

The inspection
We carried out this performance review and assessment under Section 46 of the Health and Social Care Act 2008 (the Act). We checked whether the provider was meeting the legal requirements of the regulations associated with the Act and looked at the quality of the service to provide a rating.

Unlike our standard approach to assessing performance, we did not physically visit the office of the location. This is a new approach we have introduced to reviewing and assessing performance of some care at home providers. Instead of visiting the office location we use technology such as electronic file sharing and video or phone calls to engage with people using the service and staff.

Inspection team
This inspection was carried out by two inspectors 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
CRG Home Care – Wandsworth is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service did not have a manager registered with the Care Quality Commission. This means that the provider was 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. This was because 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

We reviewed information we had received about the service since the last inspection, including information from the provider about important events that had taken place at the service, which they are required to send us. We sought feedback from the local authority. 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.

During the inspection
This performance review and assessment was carried out without a visit to the location's office. We used technology such as telephone and video calls to enable us to engage with people using the service and staff, and electronic file sharing to enable us to review documentation.

Inspection activity started on 21 February 2022 and ended on 7 March 2022

We spoke with seven people who used the service and five relatives.These people used the service between September 2021 and the end of our inspection. We also spoke with seven members of staff including care workers, the branch manager, regional manager and regional director.

We reviewed a range of records. This included people's care records. We looked at and reviewed multiple documents submitted by the provider. These included policies and other information relevant to the running of the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks were assessed to ensure people received care in a safe manner. However, we were concerned staffing shortages impacted on people receiving care leaving risks to their health not being managed well.

●Feedback we received from people included, "No, the managers should employ staff who are suitable, and not just straight from the street"; "[Care] wasn't really good. [Carers] didn't know what they were doing" and "[Carers] were good at saying "we have to go now" and leave early."

● The provider shared with us their action plan on how they were working to resolve the issues we identified to ensure people were not put at risk of avoidable harm.

● People's records identified risks to their health and well-being such as their ability to manage their finances, medicines, nutrition and hydration, mobility and home environment. However, one member of staff told us a person did not have an up to date care plan on the support they required but were fortunate they knew them as they had worked with them for years.

● We were concerned risks to people's health were not always reviewed and management plans shared with staff in a timely manner to ensure people received safe care.

Systems and processes to safeguard people from the risk of abuse

● People were not protected from the risk of abuse. The provider failed to follow the local safeguarding authority's protocol to assess incidents for safeguarding purposes. There was an incident whereby the service had experienced a severe staffing shortage, which meant people were at risk of not receiving care when needed. The provider failed to report this issue to ensure people were protected from the risk of harm.

● The majority of people and their relatives were unhappy with the safety of the care they received. People's dignity was not respected and practices in the service exposed people to unsafe care. Comments included, "On one occasion, [carers] did my breakfast, then immediately gave me my dinner"; "I was supposed to get someone at 4pm, but they arrived at 2pm"; "20% of the time [person] got the care that he needed. There are times when staff refused to [provide him with personal care." "[Carer] wasn't dressing [person] properly. For example, they left [person] without dressing them fully" and "For the last week or so of [person's] life they refused to wash or dress him properly."

● Staff showed a limited understanding of safeguarding procedures. Comments received included being "careful with the client" and taking a "safety first" approach. However, they did not refer to the reporting of any abuse as part of the procedures. Some staff told us they had completed online safeguarding training while one care worker was yet to update theirs.

Using medicines safely

● People were supported to take their medicines. However, we were concerned people may have not

received their medicines when needed as sometimes staff failed to turn up for their calls.
● The majority of staff had received training in the safe management of medicines. One member of staff told us they had not received training in medicines management and the person they were supporting did not require that help. They told us the manager had arranged a training session for them.
● The branch manager told us they were reviewing all training for staff to ensure they had refresher courses as appropriate.
● The provider reviewed and updated their medicines policy and procedures when needed.

Learning lessons when things go wrong
● The provider's system for promoting continuous learning improvements was not adequately supported by the practices in place. For example, staff were not always spot checked which could have identified the shortfalls highlighted throughout the report. A "spot check" is an unannounced visit made by a supervisor to a service user's home to ensure that care staff are delivering good quality care as agreed with the person.
● Systems for learning from incidents and near misses were in place but not consistently followed. For example, some staff told us they were not given feedback after they had reported incidents. This would include checking whether there were pattern or adequate numbers of suitably qualified staff to support people.

We found evidence some people had experienced poor care and treatment, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm including risks of neglect and unsafe or inappropriate care and treatment.

These issues were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People did not receive their care as planned. They did not always know the care staff who were coming to provide their care.
● We found some staff had failed to respond to a person when their needs changed. People told us staff turned up too early or too late to provide care which subjected them to undignified treatment, for example, sometimes they were served their meals a short time apart
● Feedback from people and their relatives showed that the service did not always have sufficient numbers of care staff to meet people's needs. Comments included, "I sometimes went three days without care"; "Some days I didn't have any carers. Possibly due to transport problems" "One carer turned up at 7pm, signed in then left as they had to go to another client" and, "Yes one regular carer, otherwise all different people. Some of these didn't even turn up".
● We highlighted our concerns to the branch manager who told us they had started to address these issues prior to our inspection. The service was working with the local authority to minimise the risk of people not receiving care. However, we were not assured of the availability and consistency of staff as the problems had continued since our last inspection.
● The provider had introduced new systems to monitor and improve staffing levels and allocation of staff to provide care to people. We found these had not been fully imbedded and were not effectively monitoring and responding to ongoing risk to people.

The failure to ensure sufficient staff were available put people at risk of harm. The issues raised above were a continued breach of Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were protected from the risk of infection. One person told us, "[Carer] wears gloves and masks and wash their hands frequently".

● Staff had access to Personal Protective Equipment such as masks, gloves and aprons they needed to deliver care safely. People told us staff wore aprons and gloves when preparing food or carrying out personal care.

● Staff were aware of the provider's policies on infection prevention and control and COVID-19. The policies were up to date and in line with national guidance. Staff received training about infection prevention and control including COVID-19 and knew how to minimise the risk of cross contamination and spread of disease.

Inadequate

Is the service well-led?

Our findings

Well-led - this means we looked for evidence that the service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open fair culture

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- People did not receive care and support from a service that was well-led as the provider did not have sufficient knowledge of their role and responsibilities.
- Feedback from people and their relatives showed people were not provided with the care as planned. Comments included, "[Carers] did the best they could sometimes, because there was not enough staff" "No [carers] visited me for a day or two. I made a formal complaint (last June/July 2021), but the manager was useless" "No, the management is not functioning properly"; "[Management] are of no use at all" and, "The staff run the company, not the manager."
- The governance systems were inadequate and inconsistently applied to ensure effective monitoring of the quality of the care delivered, to respond to incidents and accidents, concerns and ensure compliance with regulations.
- The provider had established a new management team including a new manager. However, there had been a series of change in management and field supervisors. An interim manager was appointed. We noted a continued high turnover of managers in the service had resulted in a negative impact on the care provided.
- There was a lack of oversight from the provider on the running of the service and the interim management did not effectively monitor the care provided by staff and respond to gaps in the quality of care delivered. Comments included, "Very poor (90%) in regards to the management of the service"; "[Carers]'s presentation and communication skills with clients were useless. The whole company was a shambles" and "The biggest problem was [carers] not turning up."
- Issues we identified showed the provider was not proactive in checking the quality of support provided and the performance of the service which had led to a period of inconsistent and poor care delivery.
- The record keeping systems were not fit for purpose as the provider was not aware of the issues people and their relatives raised with us. People told us they had raised concerns about the poor care delivery to field supervisors but the sharing of information between the nominated individual, office management and staff had failed. This meant no action was taken to address shortfalls in a timely manner.
- There was a lack of awareness of the regulatory requirements in records management and ensuring staff followed policies and procedures to ensure compliance with regulations.
- The provider had failed to carry out regular quality assurance checks in a number of areas including auditing care staff visits to ensure these were as scheduled and they stayed for the allocated time, complaints, staffing levels, staff training and supervision and maintain of care records.
- People's feedback about care delivery was not regularly sought and their feedback was not taken

seriously. The provider had failed to consistently review the systems and arrangements at the service to understand the concerns raised by people to enable them to maintain high standards and to identify shortcomings in the quality of care delivered. This placed people at risk of harm.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

● The provider's system to support high-quality, person-centred care were ineffective. We received negative comments from people, comments included. "The carer complained about their rota to me" and "No [the staff and management] are all useless. Seven or eight times the carer didn't turn up. Not enough staff, and bad time keeping."

● There was no oversight to ensure people knew the care staff allocated to provide their care. The systems for allocating and monitoring care staff visits and ensuring people received the care they required were haphazard and not adequately implemented to ensure people received safe care. People living with dementia, complex or deteriorating health needs were particularly affected by the inconsistent, erratic, and poor quality of care delivery by some care staff.

● The majority of people and their relatives felt the service was not well managed.

● There was a lack of robust systems for ensuring staff received essential training to meet the needs of people to promote high quality and person-centred care.

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

● The provider did not actively encourage feedback from people to improve the care delivered. One person told us, "Communications with clients could be better". We found no consistent evidence of previous meetings with people or their relatives, or staff surveys to show how the provider had engaged with people and staff.

● Staff told us they could share their views with the registered manager however, said they did not always feel listened to and their concerns regarding people's safety were not taken seriously or investigated.

● The changes in management team had an impact on continuity of relationships with people who used the service. There were very strong sentiments about the management of the service. Comments included, "The management did not look after the staff. They need more staff. There are too many clients, for the existing staff to attend to properly"; "Retrain all the staff, and management, employ the right people. One carer worked 14 days on the trot." and "Shut it down and restart [the service]. I never did meet the manager or hear from them."

● A new interim management team was put in place in January 2022 and was working with the local authority and commissioning teams to develop close links and good working relationships. However, we were not assured the changes would be consistent as concerns around the management of the service had gone for a period. In addition, the provider required time to embed the practices.

● The provider lacked awareness of their legal responsibility to share information with relevant parties, when appropriate. We were concerned in relation to the provider's willingness to share information about the management of the service with people and other agencies and promote transparency. This included notifying CQC of events, that could stop the service from running.

● The provider had not submitted notifications to the CQC in majority of the cases, we found incidents that had not been reported to CQC, the safeguarding adults authority and to the local clinical commissioning group in line with local reporting arrangements and regulations. This included missed calls, severely delayed visits, an allegation of abuse and/or an incident involving the police. The failure to report incidents meant that CQC could not undertake its regulatory function effectively.

● We were advised the provider had handed back 27 care packages to the local authority because of

extreme care staff shortages.

The provider failed to ensure the service was managed well which put people at risk of harm. The issues raised above are a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The interim manager and new management team were working with the provider and local authority to improve this area to promote scrutiny and independent oversight on the support and care provided.
● Following our inspection feedback with the provider, they submitted a notification about the significant event that may stop the service from running as required by regulations. We will continue to monitor the provider's fulfilment of this requirement.

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 had failed to adequately assess risk and monitor safety at the service. Regulation 12 HSCA RA Regulations 2014 Safe care and treatment.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes in place were not effective in monitoring the quality of care and the provider was in continued breach of Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2)(a)(b

The enforcement action we took:

We issued a Warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not enough improvements had been made at this inspection and the provider was in continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

The enforcement action we took:

We issued a Warning notice