Pharma Homecare Ltd

Clarity Homecare Ealing

Inspection report

46 Broadway
London
W13 0SU

Tel: 02088472462
Website: www.clarityhomecare.co.uk

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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
Clarity Homecare Ealing provides personal care for people living in their own homes in the community. The majority of people funded their care privately. At the time of our inspection, there were 14 people using this service. 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.

People's experience of using this service and what we found
The provider had systems in place to monitor, manage and improve service delivery, however these were not always effective. During the inspection we found staff were not always punctual to their home visits and this had not been addressed.

We also identified administration of a prescription cream was not being recorded appropriately. We recommended the provider consider current guidance on giving people topical medicines and take action to update their practice accordingly.

People were satisfied with the care from care workers and felt safe. There were risk assessments and mitigation plans in place. The provider followed safe recruitment practices to help ensure suitable people were employed. Staff received appropriate training to meet people's care needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for the service at the previous premises was good, published on 4 March 2021.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clarity Homecare Ealing on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Clarity Homecare Ealing

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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. However, after the inspection a manager was appointed and submitted an application to CQC to register. We are currently assessing this application.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 22 September 2022 and ended on 14 October 2022. We visited the location's office on 22 September 2022.

What we did before the inspection
We reviewed information we had received about the service. We also sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used this information to plan our inspection.

During the inspection
We met with the director and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We looked at records the provider used for managing the service, including the care records for four people who used the service, two staff files, and other records used by the provider for monitoring the quality of the service. After the office visit, we spoke with three people who used the service, three relatives and four members of staff.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

This meant 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.

Staffing and recruitment
• The nominated individual told us they had recruited a number of new staff and they had enough staff to support people using the service and to help keep them safe.
• However, people and their relatives told us care workers were sometimes late and on occasion did not arrive for the call at all. Comments included, "Sometimes they are late", "I have one or two that arrive late" and "Timekeeping is very poor particularly in the morning". One relative noted if the carer worker was not coming, the provider did not tell them in advance. Another relative also agreed staff arrived late and said there was not enough time for staff between calls to get to people. One person told us the carer workers' arrival times were not consistent and they always seemed in a hurry to leave so they could get to their next visit on time.
• Although staff logged their care visits using an electronic system, the provider was only able to provide evidence of actual hours worked and could not produce actual start times against planned start times so staff could be monitored for punctuality.
• The system displayed care workers' locations in real time which meant punctuality could be addressed in real time and the nominated individual told us they monitored visits each day via the live system and 10% of people each month. However, there was no written record of monitoring or analysis over a period of time to identify trends and resolve any discrepancies between the planned time of the visits and the actual time of the visits.
• The provider's system was not effectively monitoring late and missed calls which meant they could not respond effectively and safely.

Monitoring systems were not being used effectively to monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider followed safe recruitment procedures to help ensure new staff were suitable for the work they were undertaking. Staff recruitment records included completed application forms, references, identity checks and confirmation that Disclosure and Barring Service (DBS) checks had been carried out. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong

• The provider had systems in place to report safeguarding alerts and record incidents and accidents. There had only been two incidents in the last year and none in the month the new management team had taken over the service.
• However, we saw a review held for one person in September 2022, which indicated concerns regarding how the person's new care workers carried out some tasks and not always arriving on time for their scheduled visits.
• There was no evidence of any action the provider had taken to address the concerns or whether preventative measures were put in place to help prevent them happening again.
• When we asked to see evidence of when care workers were supposed to arrive compared to when they did arrive for this person in August 2022 and what action was taken to improve the situation, the nominated individual was unable to provide us with this information. This meant the provider had failed to identify the reason the care workers were not arriving on time and resolve this so care workers arrived as planned in line with the care plan.

As there was no investigation of the concerns raised, there had been no opportunity to learn lessons and help mitigate the same thing happening in the future. This was a further breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Medicines management was not always robust. The provider administered a prescribed emollient cream to one person but did not record this on a Topical Medicines Application Record (TMAR) which meant we could not be sure the cream was being applied as prescribed. A lack of records also meant there was no audit of staff applying the cream.
• In addition, emollient cream can transfer from a person's skin to fabric and cause a fire hazard. The provider did not have a risk assessment in place to help mitigate this happening.
• We discussed this with the nominated individual who said they would update their paperwork accordingly.

We recommend the provider consider current guidance on giving people topical medicines and take action to update their practice accordingly.

• The provider had a medicines policy and procedure in place with guidelines of how to administer medicines safely.
• At the time of the inspection, one person had topical cream administered but no one else was having medicines administered.

Assessing risk, safety monitoring and management

At our last inspection we recommended the provider consider current guidance on COVID-19 risk assessments and act to update their practice accordingly. We found the provider had made improvements in this area.
• The provider had systems and processes in place to help keep people safe including risk management plans to help reduce the risk of avoidable harm to people.
• People using the service and staff members had COVID-19 risk assessments in place. The provider had other risk assessments and risk mitigation plans. This included assessments for falls and diabetes which meant there were plans in place to help reduce risks and keep people safe.
• The provider also carried out an assessment of the person's home environment.
• The provider reviewed and updated risk assessments regularly to reflect people's needs.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

• We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse
• The provider had systems in place to help safeguard people from the risk of abuse, including procedures for safeguarding and whistle blowing. People and their relatives told us they felt safe with the care workers who supported them.
• Staff received safeguarding training to help ensure they had the skills and ability to recognise when people were at risk of being unsafe and they knew how to respond.
• The provider raised safeguarding concerns with the local authority as required and informed CQC. Safeguarding investigations included actions which helped the provider mitigate future risks and keep people safe.

Preventing and controlling infection
• The provider had policies and procedures to help prevent and control infection and staff had completed training in this area.
• People and relatives told us staff followed good hygiene practices and wore personal protective equipment (PPE) such as masks and gloves. The staff told us they had a good supply of PPE.
• People and staff had COVID-19 risk assessments and risk mitigation plans.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There were systems in place to monitor service delivery, but these were not always effective.
• Quality assurance systems, such as audits, were not being operated effectively as demonstrated by shortfalls highlighted during the inspection. For example, staff punctuality was an identified issue, but the provider did not have an effective monitoring system in place or an investigation process to analyse what went wrong and put in preventative measures.
• Additionally, audits of people's files had not identified staff were not recording the administration of a prescribed cream or risk assessed how flammable the cream was.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Notwithstanding the above, the provider undertook several checks and audits to help ensure continuous learning and improving care. These included completing audits each month for 10% of people using the service and two spot checks each month of how staff provided care in people's homes.
• The Managing Director and Nominated Individual did not have backgrounds in managing a domiciliary care service and were still learning the systems. However, they had employed an experienced manager who came into post after the inspection.
• Staff told us they had appropriate training for their roles, and they could ask for help when they needed it.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and relatives generally spoke positively about the overall the care provided and the care workers, but were not always happy about how the service was managed especially regarding communication. Comments included, "The manager is very co-operative", "I think they're terrific. All the carers have been helpful" and "Overall it is okay". One relative who thought communication could be better said, "If there is a problem like the carer not coming, they don't say in advance. I have told the office, but they are not responding to that." One person agreed and said, "In terms of management it is not well run. There is no advance notice of carers being late". Another person told us, "Overall the service is alright. If something

happens, they will phone me", but a second person said if there was a problem and they rang the office, very often the phone was not picked up.
• Most staff felt supported by the management team. One staff member said, "[The nominated individual] is very supportive. They guide me and help me out if I have any questions."

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
• The provider understood their responsibility around the duty of candour and of the requirement to notify appropriate agencies including CQC if things went wrong. They told us, "We must be open and honest if something goes wrong or there is a near miss. Try to rectify [the problem] and not hide [it]."
• The provider had policies and procedures in place to respond to incidents, safeguarding alerts and complaints and knew who to notify.
• People and their relatives knew who to contact if something went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• The provider contacted people using the service and their families for feedback about their experiences. Most people told us the new nominated individual had contacted them and introduced themselves.
• Team meetings were held to share information and give staff the opportunity to raise any issues.
• People's diverse needs were considered as part of the assessment process. For example, people's communication needs.
• Where appropriate, the provider had liaised with other relevant agencies such as the local authority. The nominated individual told us they planned to attend local authority care provider forums to help them keep up to date with best practice and share ideas with other forum members.

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 17 HSCA RA Regulations 2014 Good governance The provider did not always have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)