Cera Homecare Limited

Cera Hammersmith

Inspection report

Unit 22.2
Coda Studios, 189 Munster Road
London
SW6 6AW

Date of inspection visit:
22 November 2022
24 November 2022

Date of publication:
18 January 2023

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
Cera Hammersmith is a domiciliary care agency. The service provides personal care to older people and people with physical disabilities. At the time of our inspection there were 259 people using the service.

Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

People's experience of using this service and what we found
The service did not have enough staff to safely meet people's needs. Many people we spoke with told us that calls were often late which could cause uncertainty. Some staff had unmanageable rotas, which meant they struggled to attend calls on time. The provider acknowledged they did not have enough staff and were taking appropriate steps to improve recruitment.

People told us they were treated with respect by their care workers and felt safe when care workers visited. There were suitable measures in place to safeguard people from abuse. Staff were competent in moving and handling and people had suitable risk management plans in place. Medicines were safely managed with appropriate oversight of these by supervisors.

The provider did not operate electronic call monitoring systems effectively in a way that meant they could adequately monitor the safe delivery of care. The provider was moving to a new electronic recording system which was set up to allow more effective monitoring, but this was not in place at the time of our inspection.

Care workers told us they were often busy and could struggle to attend calls, but that they felt well supported and listened to by managers. People received regular monitoring visits and calls, but often reported difficulty in reaching the office if they had an issue they needed to discuss.

The service had systems in place to ensure there was learning from when things had gone wrong.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection:
The last rating for this service was good (published 20 May 2020).

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

Enforcement
We have found a breach in relation to how the service monitors the quality and delivery of care.
Please see the action we have told the provider to take at the end of the full version 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.

Cera Hammersmith

Detailed findings

Background to this inspection

Inspection team
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 four 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
This service is a domiciliary care agency. It provides personal care to people living in their own homes. This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. However, the branch manager had started the process of becoming the registered manager.

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 held about the service, including complaints and notifications of serious incidents the provider is required to tell us about. We spoke with the contracts and complaints team at the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all of this information to plan our inspection.

During the inspection
Inspection activity started on 22nd November and ended on 1st December 2022. We visited the location's office/service location on 22nd and 24th November.
We spoke with the branch manager, two regional directors and the ECM officer. We made calls to 37 people who used the service and 14 of their family members and 8 care workers.

We looked at records of care and support for 17 people who used the service and records of recruitment, training and supervision for 8 care workers. We reviewed information relating to the management of the service including team meetings, overviews of training and audit and records of complaints, safeguarding and incidents. We reviewed records of electronic call monitoring for 259 people.

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 we have rated this key question 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

- There were not enough staff to safely meet people's needs. Care workers often had impossible rotas, with a high number of visits per day and no time to travel between calls which were frequently far apart. Some staff told us this caused problems for them, particularly when they needed to provide extra cover. A staff member told us "It's really difficult, there's never time" and "I know for my colleagues they really struggle; we need travel time. This needs to be fixed otherwise it makes life messy."
- People often experienced late visits as a result of staff shortages. Half the people we spoke with told us they had experienced late visits which could cause them problems. Comments from people included "They are short staffed, we have got used to it by now", "They are regularly late but it is not the carers fault", and "Today they arrived very late…I thought no one was coming at all."
- The provider had identified staffing levels as a high priority and gave us examples of what they were doing to address the situation. This included arranging for a dedicated recruitment worker to support the branch, expediting the recruitment process and attending recruitment fairs. We saw examples of additional staff who were beginning to become available as a result of these measures. The provider told us they had a non-refusal contract with the local authority, which had resulted in them having to provide care to more people than they could manage with their current staffing levels.
- Staff were recruited safely. Care workers had appropriate checks carried out before they started work. This included verifying staff identities and obtaining suitable references and evidence of the right to work in the UK. Care workers had checks with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk from abuse

- People were safeguarded from the risk of abuse. The provider operated a suitable safeguarding policy. Staff had received training in safeguarding adults and understood their responsibilities to report potential abuse. Staff we spoke with were confident that managers would take appropriate action in response to any concerns they may have.
- The provider took appropriate action when abuse was suspected. This included taking immediate actions to safeguard people and to report suspected abuse to the local authorities. Where appropriate, the provider carried out a suitable investigation and took appropriate steps as a result.
- People felt safe with their care workers. Comments i9ncluded "I do feel safe", "The regulars I call my crew, they are outstanding" and "I can see their faces and I know I can trust them."

Assessing risk, safety monitoring and management

● The provider carried out suitable assessments of risks to people's wellbeing. This included assessing risks in key areas such as mobility, falls, skin integrity and the condition of people's homes. There were suitable risk management plans to promote people's safety. In some instances plans lacked personalised details on the signs that people's health conditions such as diabetes may be deteriorating.

● There were suitable measures to ensure that people were supported to make transfers safety. People had personalised moving and handling plans which outlined the number of staff required to carry out particular tasks. Care workers received practical training in moving and handling, including how to operate a hoist safely. Comments from people included "They are very knowledgeable" and "Very occasionally we have had someone new who didn't know what to do, but everyone else has been perfect."

Using medicines safely

● Medicines were safely managed. The provider had suitable processes for assessing people's medicines needs and ensured that an appropriate care plan was in place. Care staff received the right training to support people safely with their medicines.

● Staff maintained suitable records of medicines support and administration. This included completing medicines administration recording (MAR chart). MAR charts contained appropriation information on people's medicines including timings and details of any allergies that staff needed to know.

● There were suitable processes for checking medicines records. MAR charts were reviewed by an auditor who detected any omissions and anomalies and arranged for appropriate action to be taken to support staff where necessary. The provider told us they intended to introduce an electronic medicines records as part of their migration to a new system which would allow records to be reviewed in real time in future.

Preventing and controlling infection

● There were suitable measures to prevent and control infection. Care workers received training on infection prevention and received regular updates on what was considered best practice.

● Care workers used appropriate personal protective equipment to protect people from infection. Quotes from people included "They do wear PPE, especially now", and "They do wear PPE, and have left a supply here just in case they forget."

Learning lessons when things go wrong

● There were suitable processes for learning lessons when things had gone wrong. Staff understood their responsibilities to report incidents and accidents. Managers maintained a suitable record of what had happened, investigated incidents and took appropriate action to prevent a recurrence.

● Managers worked to ensure that there was learning across the service when things had gone wrong. Team meetings were used to highlight recent case studies of incidents had occurred and to promote discussion about what staff needed to do to prevent a recurrence.

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 we have rated this key question 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.

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

- Systems were not always operated effectively to understand quality and risk. The provider operated an electronic call monitoring (ECM) system to monitor the delivery of care. However, in practice staff recorded calls less than a quarter of the time. A high number of calls were manually recorded as being delivered on time, even when this could not have been the case due to staff not having enough time to travel to calls. This meant that it was not possible to effectively monitor the delivery of care and assess whether calls were delivered within a safe timeframe. The service operated a full time ECM officer who contacted staff who had not logged in to ensure they had not arrived, however this did not serve as a robust system to prove that care was delivered as planned.

This constituted a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider told us they were working with staff to improve the use of the ECM system, and we saw examples of communications to staff outlining management expectations for logging in. The provider were moving to a new system which provide better evidence of when care and medication had been delivered. However, there had not been improvement at the time of the inspection.
- The service did not have a registered manager. However, a new branch manager had been appointed, who had started the process of registering with the care quality commission.

Working in partnership with others; Continuous learning and improving care

- The service was transitioning to an improved, electronic care planning system. This meant that logs and medicines records would be completed electronically using mobile handsets and could be monitored in real time. Staff had received training on how to use the system and we saw examples of new style care plans which were being put in place to support this.
- The service had systems in place to ensure continuous learning. This included discussing recent events with staff teams and ensuring staff were kept informed of changes to the service.
- The service worked in partnership with the local authority to monitor the service and identify areas for development.

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

● The provider engaged with people who used the service. This included through regular spot checks and quality monitoring calls. Comments from people included "Someone from the office has rung to check if I am alright" and "[a manager] has called and spoken to me several times."

● People sometimes were not able to contact the office. We received mixed comments from people about the responsiveness of the office. Comments ranged from "I just phone the office and talk to someone", "they are very polite when you ring them" to "The office rarely pick up the phone" and "I have left messages and they don't get answered either."

● Care workers told us they felt well supported by their managers, notwithstanding the issues with travel time and busy rotas some staff had raised. Comments from staff included "I get support but I would appreciate more liaison, I can get hold of them, but at the weekend it may be a little more difficult", "The new manager is very good" and "I can always get hold of a manager if I want to speak to anyone."

● The provider monitored the performance of staff through auditing and spot checks. Audits of care records were completed regularly and identified any issues with daily recording. Care workers told us they received effective feedback from managers. Spot checks were carried out regularly with staff in people's homes and these were used to assess the skills and knowledge of care workers. Sometimes spot checks were not carried out at the most effective time to observe personal care and medicines management, which the provider identified as an area for development.

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 duty of candour. There was a suitable process in place for ensuring that safety events were appropriately investigated and findings shared with families and the local authority.

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 effectively operate systems for assessing, monitoring and improving the quality and safety of the services provided 17(2)(a)