# J M Healthcare Limited

# JM Healthcare

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|

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

# Summary of findings

## Overall summary

J.M. Healthcare provides personal care and support to approximately sixty three people in and around Ivybridge, Kingsbridge, Salcombe and Newton Abbott. At the time of our inspection a team of thirty six staff were operating from the main office in Ivybridge.

The service is required to have a registered manager in post. At the time of our inspection there was not a registered manager in post. 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 manager had been working in the service since May 2016. An application for the post of registered manager had not been submitted to the commission.

Staffing levels were being monitored and recruitment was still in place. Staff told us, "It's been a difficult few months but things seem to be getting better now" and "We have all had to do extra to cover the gaps." The service used a mobile phone based call monitoring system to ensure all planned care visits were provided each day. Contracted hours were being met but there were times when staff were late for calls or did not arrive. Staff were expected to call the office if there were delays. One staff member said, "Sometimes we can't get through, it can be a problem." The inspector noted that on the day of the inspection engineers were visiting the service to arrange installation of an extra line into the office to improve communication channels. Comments from people during a recent survey included concerns that staff had been late for calls or had arrived on the wrong day.

We have made a recommendation for the service to improve its communication system.

Care plans were in place but in most instances information was dated. For example, one file had an assessment from 2015 but no other evidence of reviews having taken place. Assessments from service commissioners were in place on two files seen but they were dated from 2012 and 2013. In one instance when visiting a person's home the folder contained the original commissioner's assessment from 2012. The most recent agency assessment was dated August 2015. There was no evidence of reviews taking place recording any changes in the person's needs. The person told us they had been admitted to hospital since the latest assessment but there was no information to show care needs had changed or were being responded to.

Risk assessments were in place on all files seen. They covered areas of personal care, diet, health and safety, although where risk had been identified there was a brief overview but no plan of action to show how the risk would be managed. In one instance a stair lift had been fitted recently but the person's risk assessment had not been updated to show the level of risk to the person using it.

Medicines were not always being recorded in people's homes. Some records showed there were gaps where it could not be confirmed if a medicine had been administered. In other records staff were using letters from

the index at the bottom of the medicine record. For example (D) which denoted dispensed, however on other days the staff member signed their signature to denote it had been administered. Staff told us (d) stood for medicines left for the person to take themselves after the carer had left the service. Some medicine records had recently been audited. One showed staff being prompted to sign for all medicines given. However there were still gaps where staff were not always signing. This meant people had the potential to be at risk because staff did not know if the medicine had been administered or not.

There were weekly meetings between the manager and directors to review the operational issues. The meetings looked at the use of staff hours and field managers had been designated eighty per cent of their time to work as a carer and twenty per cent for senior responsibility. This included carrying out reviews, updating assessment and care plans, audits including medicines and staff supervision. Field workers told us they did not have enough time to carry out responsibilities associated with their senior capacity. This was confirmed when looking at gaps in reviews, assessments and supervisory roles.

Recruitment systems had been reviewed and developed to ensure staff were suitable and safe to support people in their own homes. Necessary pre-employment checks had been completed.

All new staff received a basic office induction looking at health and safety issues, safeguarding, moving and handling as well as familiarisation of policies and procedures. Records showed recently recruited staff had received probationary supervision including spot checks and first review.

The service had used the care certificate induction standards for newly appointed staff. However none had yet completed the programme. The training record showed all staff had access to a range of training suitable for their development in a caring role. The training was dated and monitored so that all certificates were in date and where training updates were necessary staff were made aware of them.

There were systems in place to record safeguarding concerns, accidents and incidents and take necessary action as required. Staff had received safeguarding training and understood their responsibilities to report any unsafe care or abusive practices.

The management team had systems in place to measure the service's performance and look at ways of developing the quality of service they provided. There were processes in place to seek people's views on the service and monitor the quality of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end 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**

The service was not always safe. Medicine management was not always being monitored to make sure medicines were being administered as prescribed.

Staff were not always being provided with enough information to manage risks.

People were protected by ensuring safe recruitment procedures were in place.

### Is the service effective?

**Good**

The service was generally effective. People were involved in their care and support however this was not always recorded.

Staff had access to training events and procedures were in place for the induction training of new members of staff.

People were supported to access other healthcare professionals as they needed.

### Is the service caring?

**Good**

The service was caring. Staff were kind, compassionate and understood people's individual care needs.

People and their families were involved in their care and were asked about their preferences and choices.

Staff supported and encouraged people to maintain their independence.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive. People's needs were not being reviewed or changes recorded to support staff.

Staff were respectful of people's rights and privacy.

People and their relatives told us they knew how to complain and would be happy to speak with managers if they had any

concerns.

## Is the service well-led?

**Requires Improvement**

The service was not always well led. There was no registered manager in post and no application had been made to the commission. A manager had commenced work at the agency in May 2016.

Staff were supported by their manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with their manager.

Systems were in place to monitor how the service operated.

# JM Healthcare

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 October 2016. The service received short notice in advance of the inspection. This was in accordance with our current methodology for inspecting domiciliary care services. The inspection was carried out by one inspector.

Before the inspection we reviewed information held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we visited three people who received a service from the agency. Following the inspection we spoke with three people who used the service, two relatives, six members of care staff and the manager.

We received comments from one professional associated with the service. We also inspected a range of records. These included three care plans, three staff files, three recruitment records, training records, surveys, meeting minutes and the services policies and procedures.

Requires Improvement

# Is the service safe?

## Our findings

People we spoke with told us they generally felt safe while they or their relatives were receiving care and support from J.M.Healthcare. People's comments included; "Staff are generally good at what they do. Sometimes they are late or don't arrive together (double rounds)," "I don't know what we would do without them (staff)" and "They (staff) all know what they are doing. We don't have any worries." Three people told us there had been late and missed calls during recent months but that 'it was getting better'.

Risk assessment plans included areas of personal care, health and safety including lifting equipment, environmental medicines and diet. The records were in place on all files seen, however where risk had been identified there was little evidence about how it was going to be managed and the risk mitigated. For example statements included 'at risk of falls'. Another person was at risk of accessing medicines. This was noted on the person file at their home but had not been recorded on their risk assessment. This meant staff did not have enough information to make sure people were being protected and were safe.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Medicine management was not always being monitored to make sure medicines were being administered as prescribed. Some records showed there were gaps where it could not be confirmed if a medicine had been administered. In other records, staff were using letters from the index at the bottom of the medicine record. For example (D) which denoted dispensed, however on other days the staff member signed their signature to denote it had been administered. Staff told us (d) stood for medicines left for the person to take themselves after the carer had left the service. This was not a safe way of administering medicines because of the risk of the medicines getting mixed up, or for them to be available to other people living in the house or visitors. Some medicine records had recently been audited. One showed staff being prompted to sign for all medicines given. However there were still gaps where staff were not always signing. This meant people had the potential to be at risk because staff did not know if the medicine had been administered or not.

Staff were responsible for applying a pain relief patch once a week for a person. The MAR chart was not always clear. Some days the index to showed it had been' refused' or 'not required'. This occurred on a regular basis but there was no evidence to show what action staff had taken to alert a healthcare professional about this. This meant the person might not be receiving the correct level of analgesia as prescribed.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The manager immediately updated the services medicine policy. The revised policy reflected current good practice for dispensing medicines in the community for domiciliary services. However, we were not able to measure its effectiveness due to the recent introduction.

The manager told us there was an on-going recruitment process due to gaps in staffing levels in recent months. Staff told us they were working as a team to make sure contracted hours were being met. To

achieve this, all levels of staff had been providing care hours. One staff member told us, "Things are starting to settle down and we are starting to focus on all the paperwork." The main office had a 'white board' used to monitor each geographical area, call times and staff members. It identified when people were in hospital or on holiday. Staff were responsible for contacting the office by phone if there were delays. However, some staff said they could not always get through. The manager told us there had been a problem with the telephone line affecting communication. Engineers were at the office to establish another line which would alleviate some of the issues. A professional told us, "There are regular problems getting through to the office. It can be a real problem." A person using the service told us, "Times are getting better now but it has been a problem when staff arrive at different times." In order to address this issue the manager had reviewed each area to make sure staff had the time to arrive at the same time when providing double calls.

Senior staff were available each day and the on call system operated outside normal office hours. People told us they had the phone numbers available to them and felt safe knowing there was someone to speak with should they need to. However, some people told us, "It can be difficult to get through sometimes" and "The waiting can be bad especially when you are trying to find out what's going on."

It is recommended the service seeks and implements effective communication systems suitable for the purpose they are being used.

There was a log reporting missed visits which the manager had introduced and told us about in information we asked about the service before we visited. The log showed there had been six missed visits since April 2016. The missed visits in October had been caused by a system error which was identified and quickly rectified.

People were supported by dedicated teams and there were suitable arrangements in place to cover any staff absence. Staff told us that the service manager and area field managers undertook some care shifts especially if there were staff absences at short notice due to staff sickness.

The way the service recruited people had been reviewed to ensure procedures were safe. Three staff files confirmed that checks had been undertaken with regard to disclosure and barring checks (DBS). The service had checked potential new staff member's employment histories by requesting references and verifying those references before the person was employed.

Where accidents had occurred they had been reported to the service's managers and documented in the service's accident records. Accidents had been fully investigated and evaluated.

Staff understood their role in protecting people from avoidable harm. All staff had received training on the safeguarding of adults. For most it was in date and for others the manager told us they had approached the local authority to update staff on current good practice in safeguarding people. Staff could explain how they would respond to any incident of suspected abuse. Staff said they would immediately report any concern to their manager who, they were confident, would take appropriate actions to protect the person. Staff understood the role of the local authority in the safeguarding of vulnerable adults.

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Good

# Is the service effective?

## Our findings

People received care from staff who they felt confident had the necessary knowledge and skills to meet their needs. People and their relatives spoke well of staff, comments included: "We tend to get the same girls. They know what they are doing" and "If one of them (staff) are new there is always a more senior carer with them."

Some staff had worked for the agency for a number of years. They told us they were being supported by the manager and they supported newer members of staff being introduced to their role. There had been a number of new staff recruited since April 2016. Records showed they had completed an induction programme in line with the Care Certificate framework which replaced the Common Induction Standards with effect from 1 April 2015. However, none had yet completed the care certificate standards. Staff told us they completed the initial office based training where they were made aware of the expectations of their role. Staff shadowed more experienced staff on initial home visits until they felt confident to support a person on their own. Following completion of the probation period staff received a 'spot check' and a formal supervision where they discussed their role and if it was progressing to a suitable standard.

Staff were supported in their roles by receiving supervisions. Staff told us most of them had received a formal supervision when they finished the probation period but had not received regular supervision since. Records showed a new supervision structure. This showed staff would receive a three month supervision session with an annual appraisal. To date the record shows eight staff had received supervision and two staff had received annual appraisal. A field manager told us senior staff had a number of delegated staff to supervise and it was an on-going programme. However, they told us there were constraints in the time available to them to carry out supervision and appraisals due to the limited number of hours allocated for this task.

Training records showed staff received training in subjects including, safeguarding adults, moving and handling, Food hygiene and health and safety. Where people they supported required specialist clinical input staff had received training from a health professional. A member of staff we spoke with said, "I have good access to training I am actually in the process of doing my NVQ 3 in health and social care. If a service user needs specific care needs for example catheter care, dementia, diabetes or any other complex care I would receive training on this from my field manager."

People told us care plans had been developed with them or a family member which demonstrated that they were in agreement with how care staff would provide their support. However, they were not always signing to evidence they were in agreement with their plan of care. We spoke with the registered manager about this who agreed to address the issue immediately. People told us that staff always asked for permission before providing care or support. People's comments in relation to consent included, "They (staff) always ask for my consent before they help me", "Yes, and write everything in a book" and "Yes, they always ask."

It is recommended the service puts systems in place for people to agree to their planning documentation.

The Mental Capacity Act (MCA) provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make specific decisions for themselves. Managers and staff understood the requirements of this act and what this meant on a day to day basis when seeking people's consent to their care.

People's consent was sought for agreement to care and treatment to be delivered and for medicines to be administered or prompted. Records identified where the person had capacity to sign the agreement. Where they did not have capacity to agree the form refers the assessor to refer for a best interest meeting with the local authority.

Records showed J.M. Healthcare worked with other health and social care services to ensure people's care needs were met. There was evidence of staff receiving guidance from an occupational therapist who provided guidance about the use of equipment supporting a person using the service.

Good

# Is the service caring?

## Our findings

People were generally positive about the staff that supported them and said they were treated with consideration and respect. People we spoke with complimented J.M. Healthcare staff on the caring approach to the support provided. People told us, "Caring and patient" and "They (staff) are very patient and caring, but they can be rushed sometimes."

The manager and senior staff had reviewed which staff supported people in their homes. In most instances there was continuity of staff visiting people. However, due to absence through sickness or staff leaving there had been variations in staff supporting people. Comments included, "Having the same staff is important to us because they are coming into our home. It has got better recently though." Staff told us, "We have had to just fill in the gaps but we make sure people are getting the care they need." There was nothing to suggest people were not receiving the care and support they needed.

Staff understood the importance of making sure a person's privacy and dignity was upheld. A person told us, "They (staff) are very good at making sure doors are closed when they are supporting me." A staff member told us, "We (staff) often work in pairs and always make sure they (the person) are safe but have privacy when we provide personal care. When we use hoists and things like that we make sure they (the person) are always covered up for their dignity."

Staff spoke about the people they supported fondly. Staff and managers knew people well and demonstrated during their conversations with us, a clear understanding of both people's care needs and individual preferences. For example, what people liked to eat and what time they would like to go to bed. Staff told us they enjoyed their role and aimed to care for people as they would for their own relatives. Staff comments included; "It's a good job. I like it very much now I have the hours I want and I work with the same people" and "I am really enjoying this job. It's a job I wasn't sure I would like, but I love caring for clients. I get a lot of job satisfaction out of it."

In recent months rotas showed people were not always supported by the same care staff. As highlighted in the safe domain of this report, it was due to a significant staff change. At the time of this inspection there was evidence in rotas that visit schedules and records showed more continuity in people being supported by the same care staff. People told us, "We were getting a lot of different faces through the door, but things have got a lot better and the girls are familiar now" and "I know who is coming through that door which is important to us." Staff told us, "It has been difficult and we still have some blips, but on the whole things are much more settled and we can deliver care and support to people who know the staff well."

People told us their care staff always responded to small changes in their care needs and one person commented, "Every day can be different. Some days I can do more than others. They (Staff) know me well and respect the times when I need more support. There is no fuss; they just get on with it."

A number of staff told us what they would do if a person they were supporting became unwell. This included reporting to the field manager but that if it was an urgent issue they would use the contact details for the

person GP or emergency services. Staff told us that if a person was unwell and they needed to stay longer they would let the main office know so that managers would contact their other clients to inform them of any delay. Some people confirmed this is what happened but others said they had not always been informed a call would be late. When we spoke of this with the manager they told us that they tried to make sure people were always informed but acknowledged there had been occasions when this had not always been communicated. They told us current work to increase telephone lines to the office would improve the level of communication.

Requires Improvement

# Is the service responsive?

## Our findings

There were initial assessments in place as well as care assessment records. The records we observed were not person centred. This was because the information focused on tasks. For example one recorded, "risk of falling, impaired vision." Another recorded "times of lunch" and what time a person would like to go to bed. The care plans did not contain more personalised information about people's backgrounds and personal histories. This type of information could help care staff engage meaningfully with people and gain an understanding of the life events which have helped shape them. This was particularly important for people living with dementia and other conditions which might affect their cognitive abilities and memory. We discussed this with the manager who agreed action was necessary to extend information and for it to be written in a 'person centred' way.

Some of the information was dated. For example two assessment plans were from August 2015. There had been no update since then. One person had a health assessment from 2012 in their home file which was when the service commenced. Where the assessment asked for a review date there were no recorded dates. None of the files seen had evidence of review records in place. A professional we spoke with told us they had great difficulty in obtaining review information when requested from the managers. They told us, "There are a number of us who ask for information about a person but we either have to keep asking before we finally get it or we don't receive it at all." A staff member provided an example of a person who had a hospital admission in the last twelve months. Following discharge there was no evidence of review to establish if there was a change of need. This meant people's needs were not being reviewed and the support may not be at the correct level.

This was a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us they generally found the service was flexible and responsive in changing the times of their visits when required. For example, where appointments had been arranged and conflicted with home visit times. The rotas were planned in advance but reviewed daily with field manager meetings identifying where there were changes which needed to be responded to. Field managers told us they thought the meetings were essential. They said, "Keeps us on top of what's going on as there are changes every day" and "We use any updates to share with the staff and families if we need to." The manager and field managers told us they recognised the service was taking steps to improve how it communicated with people and other professionals. This included improving the telephone system.

Staff told us they were aware of the importance of completing daily records following each visit. Those we viewed in two of the homes we visited were up to date and accurately reflected the care that had been provided. These records were returned to the office every two months. Those in the main office were in loose leaf folders. It was difficult to view them in date order as sheets had been place in various areas of the file. This meant an audit of a person's records would be difficult to identify any themes or trends which might require a response. We discussed this with the manager who agreed to organise the records in a way which would support staff.

People told us their carer's were always respectful." People described the actions staff consistently took to protect their privacy and dignity while providing personal care. Relatives confirmed staff routinely protected people's privacy and dignity while providing care. Staff clearly understood the importance of protecting a person's privacy and dignity.

Details of the service's complaints processes were included within the written literature at people's homes. People told us they understood how to report any concerns or complaints about the service. Records showed that complaints had been fully investigated and appropriate action had been taken to resolve the issues. J.M. Healthcare had also received compliments and thank you cards from people who used the service and their relatives.  They all reflected the appreciation of relatives and families for the care and support delivered.

Requires Improvement

# Is the service well-led?

## Our findings

The service is required to have a registered manager in post. At the time of our inspection there was not a registered manager in post. A manager had been in post since May 2016 although no application had yet been received by the Care Quality Commission.

People had mixed opinions about how the service was being run. Comments included, "There have been a lot of changes but things are settling down now", "I think getting in touch with the office can be a problem. It is frustrating," "Overall we are satisfied with the service. The manager visits us from time to time." Staff told us, "We are getting better support than we had a while ago," "I think things are getting better but it was difficult. We (staff) were all having to pick up more hours."

The service used an information technology (IT) system to report and record assessments and reviews. However the current system was licenced only for two users at any one time. This meant that if more than two field managers wanted to use the system at the same time it was not possible. This limited the time available for recording assessments and reviews. The manager told us they had discussed this issue with the registered providers in order to improve the resources available to them. There had been no decision made at the time of this inspection. This meant working directives and limited resources posed restrictions on senior staff having the time to complete contemporaneous records of the care and treatment to the service user.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There had been changes to the management structure in the service and there were clear lines of responsibility and accountability. The manager was responsible for the day to day operational oversight of the service. There was a current review taking place of all operational systems in the service. There were weekly meetings taking place between the directors of the service and the manager. The manager reported activity and development of the service at these meetings. However, senior staff told us the directive to divide their working hours into 20% for senior work including supervision, assessment and review and 80% for care duties was not appropriate. They said this was because they needed more time to carry out senior role responsibilities. The safe section of this report identifies the potential impact of limiting senior staff hours in respect of maintaining reviews, supervision and assessment information.

There were systems in place to gain the views of people using the service. The most recent survey from October 2016 asked people using the service their views on staff supporting them and their satisfaction with the service. The results were varied and showed most people had found the service had improved, but it also gave examples of where there had been staffing issues resulting in late or missed calls. People's comments included, "Generally very good, but occasions, particularly on a Sunday when no one arrived," and "Frequently late. Often one person arriving for double up."

The manager told us they were currently using the feedback to identify gaps in the service and how to

respond to them. For example after reviewing each geographical area and determining where staff were travelling from, changes had been made. Staff were now working in local areas so there was less time to travel. A staff member told us, "It's a lot better now that I am working locally. It works much better."

The manager underlined the importance of developing the service by asking for and listening to people's views including family and advocates about how the service was run so that any areas for improvement would be identified and considered to enable the service to continually improve.

Staff told us they felt well supported by the manager and senior staff. A staff member told us, "We do feel supported by (manager's name) and field managers. We now get more information and our rotas are being delivered earlier than ever so it's good for planning."

The auditing process was on-going. Most policies had been reviewed recently and the medicine policy update was carried out after this inspection visit when issues had been raised with the manager. This demonstrated the manager was prepared to make the changes needed to make the service safe, effective, caring, responsive and well led. The manager and senior staff told us they were committed to developing the service and provide a high quality care and support for people using it.

Staff meetings were being held regularly. The manager told us this was important due to all the changes which had occurred in the running of the service. Staff told us these were useful and gave them an opportunity to exchange any ideas for the development of the service.

People's personal confidential information was held in locked facilities suitable for storing records and personal information. Only senior office staff had access to records and personal information relating to people using the service and staff.

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<br><br>Reviews of peoples care and support were not always taking place. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Medicines were not always being recorded when administered. Staff were not seeking professional advice when people regularly refused their medication. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Records did not always include information about how risks were being managed. Senior staff did not always have the resources to carry out their role. |