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JK Caring for You

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place 29 January 2018 and 22 February 2018 and was announced.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older people, younger adults, people with dementia, learning disabilities or autistic spectrum disorder, people with mental health conditions, a physical disability and sensory impairment. At the time of our inspection 79 people were using the service.

Not everyone using JK Caring for You may receive a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; for example, help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The provider of JK Caring for You is registered as an 'Individual'. Individuals register in their own name with the Care Quality Commission. They are not required to have a registered manager in place because they are directly responsible for carrying on and managing the regulated activity of 'personal care'. As the 'registered person' they have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection we had rated the service provided as Good. Following this inspection we have changed this rating to Requires Improvement.

People's medicines were not managed safely. There was a lack of clear guidance for staff to follow with regards to what medicines people were prescribed and the support they needed. Records were not always completed fully or accurately.

Although the provider had systems in place to monitor the provision of the service, these had not ensured the quality and safety of care provided was consistently meeting people's needs.

People were not supported to receive timely care and staff were often late for people's care calls, which impacted on them and their families. People were not always informed when care staff were running late for their care calls and did not know who would be arriving.

Staff had received training in infection control practices but people gave mixed feedback on staff's hygiene and cleanliness when they supported them.

When people raised complaints these were addressed and resolved. However, people did not feel the service was always responsive in addressing any verbal concerns they raised.

Although people had care plans in place there was sometimes a lack of focus on people's own preferences and wishes in relation to how they would like their care delivered. However, where staff had built

relationships with people they had got to know their preferences and wishes which helped them to provide person centred care.

People felt communication could be improved from managers and office staff when care staff were going to be late for their care calls. People had difficulty getting through to the office and did not always have their telephone calls returned. They did not always find staff at the office helpful when they telephoned them.

The provider took action when safety or safeguarding incidents happened. Where necessary the provider worked with the person, their relatives and outside agencies in investigating incidents and ensuring the person was kept safe. Where poor staff practice was identified, disciplinary action was taken. The provider understood their responsibilities under the duty of candour.

The provider had systems in place to help safeguard people from abuse. Staff had received training in and understood how to protect people and keep them safe from avoidable harm and abuse. Risks associated with people's care had been assessed and plans were in place to help minimise these risks.

People's care needs were assessed and staff that provided people's care had received training to meet their needs. People were complimentary about the skills of their "regular" carers but did not feel all staff had the skills to meet their needs.

People's consent was sought by staff before they helped them with any care or support. The provider worked with other health and social care professionals as required to help them to deliver effective care and support to people.

People were able to build positive relationships with the care staff they saw often. The provider aimed to keep care staff within their own localities to help people receive a consistency of care. People were treated with kindness, respect and dignity by the care staff that supported them.

We found two breaches of the regulations relating to safe care and treatment and good governance. You can see what action we have told the provider to take at the back of the full 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?

The service was not always safe.

People's medicines were not managed safely. People did not always receive their care calls on time and were not always informed that care staff would be late. People were supported by staff who were trained to protect people from avoidable harm and abuse. Risks to people's safety were identified and measures were in place to help reduce these risks.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff had received training but this was not always wholly effective in ensuring all staff had the skills they needed. The provider worked with other agencies to help ensure care delivered was effective and people had access to healthcare. People's consent was sought prior to care being delivered.

Requires Improvement ●

Is the service caring?

The service was caring.

People received care from staff that treated them kindly. Staff kept people involved in their own care whilst they supported them. Staff promoted and respected people's dignity and privacy.

Good ●

Is the service responsive?

The service was not always responsive.

People had opportunities to raise their concerns but did not feel the provider was responsive in addressing these. Where complaints were made these were investigated and responded to. People felt that the care they received met their needs but they did not always feel involved in reviewing or updating their care plans.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

People and relatives thought the culture and communication at the service needed improving. Although the provider had systems to monitor the quality of the service provided, this was not always effective in identifying where improvement was

Requires Improvement ●

needed.

JK Caring for You

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 was announced. We gave the service two days' notice of the inspection because we needed to confirm which people we could contact for their experiences of the service. We also needed to be certain the provider would be available.

We visited the office location on 29 January 2018 and 22 February 2018. The inspection was carried out by one inspector and one expert-by-experience, who conducted telephone interviews with people and staff. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to our inspection we reviewed information held about the service. We looked at our own system to see if we had received any concerns or compliments about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We contacted commissioning teams and representatives from the local authority and Healthwatch for their views about the service. Where we received feedback, we used this information to help us plan our inspection of the service.

We made a total of 33 telephone calls to people and relatives and spoke at length with seven people who used the service and ten relatives. We looked at seven care records, including medicine records. We also viewed five staff recruitment records and records relating to how the service was managed. We spoke with 10 staff which included care staff, care managers, logistics manager and the provider.

Is the service safe?

Our findings

We looked at how the provider ensured the proper and safe use and management of medicines and how staff helped people to take their medicine. We found that staff did not always administer people's medicines in accordance with the provider's medicines policy or in line with current legislation. We also found that the provider had not ensured instruction for staff was clear and unambiguous with regards to the support people needed with their medicines. One care manager told us the care co-ordinators kept people's medicines support under review and they monitored what medicines they were prescribed. However, we saw no evidence of people's medicines in the records we viewed on the first day of our inspection. People's care records did not contain any information about what medicines they needed to take.

Staff did not always administer medicines in accordance with prescriber's or provider's instructions. We were told by a staff member that they and other staff left one person's medicines in a pot for them to take after staff had left. This was a direct opposite to their medicines care plan which stated that staff must ensure they saw this person take their medicine. One staff member told us they advised one person on when they should take their medicine. They told us they had spoken with the person and informed them that they did not need to take it every day if they did not want to. We viewed this person's medicines record which showed this medicine was prescribed to be taken twice a day. The provider had not ensured that people's medicines were being administered as they had been prescribed, which placed people at risk of harm.

The provider had not ensured that information about people's medicines was clear or accurate regarding the support they needed from staff. We saw people's care plans did not always give the same information that was on their care call planner. The care call planner informs staff of the support a person needs at each of their care calls. One person's care plan stated they were able to manage their own medicine and therefore did not require any assistance from staff. However, their care call planner stated that staff were to, "apply any creams as prescribed and assist with the administration of medication." We also saw there was a lack of information provided about who had responsibility for monitoring or ordering stocks of medicines for people. We viewed one record where a staff member had written that a person's medicine had run out so they had started to use another similar medicine. We spoke with a care manager about this. They informed us that this person's GP had confirmed this was acceptable practice. Staff were to inform the person's family if their medicine stocks were low and the family would re-order them. Sometimes the new medicines did not arrive before the existing medicine ran out. However, this information or the GP's verbal instructions were not recorded anywhere within the person's care plan or medicine records. This placed people at risk of harm because instruction was not available or made clear to staff.

People's care records did not contain information about what medicines people were prescribed, what they were for, the dosage required or their side effects. We spoke with one staff member about how they found the information they needed about what medicines one person needed to take. They told us, "I just give [person] the tablets that are in the dosset box." A dosset box is used to separate medicines into individual compartments for different times of the day, for each day of the week. No information was provided on people's 'as required' medicines, such as pain relief. Because there was a lack of this information, staff did not have instruction on what the medicine was for, what dose of medicine should be given, the minimum

time between doses and the maximum dose to be given. This placed people at risk of harm.

People's medicine administration records contained gaps in recording, and used abbreviations which were not identifiable. We saw staff signatures were missing from some people's medicine records and daily records did not confirm whether these people had received their medicines. Where medicine administration records are not accurately completed the provider cannot be assured that people received their medicines as prescribed.

Staff did not receive information on what topical medicines were for or where they should apply them. Where people were prescribed medicine patches, there was no application chart to monitor where the patches were applied. One staff member told us they applied a medicine patch for a person they supported. The provider confirmed this information was not recorded in the person's care plan. We received differing feedback from managers about the application of this patch. Instruction had been given by the person's GP about rotating the application site, but this was contrary to the manufacturer's instructions. The verbal instruction given by the GP had not been followed up with any written confirmation and had not been recorded within the person's medicine records. Because this instruction from the GP had not been recorded, there was a risk the person's medicine patch may not be applied as prescribed. Managers confirmed they did not use patch application site charts because staff recorded where the medicine patch had been placed in the person's daily record. We checked this person's daily record and could not see this information.

Where responsibility for people's medicine administration was shared between a relative and care staff, people's care records did not reflect this. The provider confirmed that one person's relative managed their medicine. They told us that if the person's relative was not present then care staff would be expected to administer their medicine. However, there was nothing in the person's care plan or medicine administration record to indicate what medicines care staff would need to administer. The provider also confirmed that care staff had been "secondary administering" one of this person's medicines when their relative had left the medicine out of its packaging for staff. The provider and managers were not aware this practice had been taking place. The provider told us after the inspection, "Secondary dispensing (administration) is not ever acceptable and our medication training clearly states that this is not correct procedure. The whole team have been alerted to this situation and reminded of the procedure."

We discussed our concerns with the provider and asked them to take immediate action to address some of the issues identified. The provider acknowledged what we had found and that they needed to make significant improvement to the safe management of people's medicines. Some improvement had started to be made when we visited for our second day. Since our inspection the provider has provided us with further information and informed us they are taking steps to improve medicines management.

People's medicines were not safely managed and this is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection people had told us care staff often turned up late for their care calls. At the time of that inspection the provider was trialling a new computer system which would alert managers if care staff were late to care calls. This computer system was now embedded within the service delivery but people continued to tell us care staff turned up late for their care calls.

At this inspection people told us care staff were often late for their care calls, and they were not always informed. They told us this was worse at weekends. One person told us, "I stopped my evening call as it was more trouble than it was worth. The girls (care staff) were late and not interested. They would be rushing in and out too quickly. The times have settled a bit in the week, but the weekends are a misery. Sometimes

they are one to two hours late and they don't let you know. We have to ring them; it's not good enough. We complained, and they did find a regular one, but if she's off it goes back to lateness and not knowing who is coming." One relative said, "Times, that's a laugh. The mornings aren't too bad, but tea time and evening call can be awful. They [care staff] can come at any time. The Sunday tea time call which should've been 5pm got later and later sometimes at 7pm so I cancelled it. They are terrible at letting us know, we get no phone calls, and I usually have to ring them."

Relatives told us that staff being late had an impact on people's and their lives. One relative told us they had to support their family member to bed because the care staff were so late on one occasion. They told us they could not get hold of anyone from the service to find out where they were. They told us the care staff eventually turned up but said, "I could've waited and saved my energy if I had known." Another relative told us, "It is bad sometimes. One day someone comes in the morning and then no one comes at all. Then some days it's the evening call that it happens. I have spoken to the company and they say they have no staff. We have sat here for hours waiting in an evening so that [person's name] can get a meal. If they don't come I have to do it. It happens sometimes that I am serving, and then they arrive. If only they would tell us. Like today they are normally here by 10 and it's now 10.40am." One relative felt the service did not have the office staff they needed. They said, "I think it's the office that can't cope with the volume of work. I know the girls (care staff) tell the office if they are running late, but the office staff doesn't pass it on."

We spoke with the provider about what people had told us about the punctuality of care calls. They acknowledged that there was often a high staff absence at weekends where staff would have short notice illness. They confirmed that because of this, people experienced late care calls most weekends. We also were aware that disciplinary action had been taken against some staff who were not providing safe care. The provider felt this had also impacted on the service as a whole. If the service experienced high levels of staff absence or if staff were running late for care calls, the office staff and managers were able to provide care and support to people. The service used a computer system to monitor staff attendance at care calls. This would alert managers if a care staff had not 'signed in' at the person's home. Care staff and managers told us that the expectation was that if care calls were late by 15 to 30 minutes the office staff or a manager would notify the person. However, managers told us that, despite receiving these alerts, if they were covering care calls they were unable to telephone people to inform them care staff were delayed. The provider also told us they were actively recruiting for new staff and some new staff had started work recently.

As part of the local authority's Integrated Care Services (ICS), the service provided care to people at short notice to avoid hospital admission. The provider told us that when the ICS Team organised people's care packages they would often inform people they could have a specific time for their care call. They felt this meant that people's expectations were different to what the service could deliver. They were currently working with the ICS Team to improve on this. The provider acknowledged however, that concerns about care staff lateness were not entirely due to this reason.

People and relatives told us they did not always know which care staff would be coming to their home. Some people told us this was not an issue, but others did and told us they did not like not knowing who would be supporting them. One person said, "I have different ones (staff), I don't know who is coming and this can be a problem at times as I like to know who is going to walk through my door." Another person said, "I get different ones (staff) all the time. They are all pretty good. I don't get a list of who's coming, but I don't have a problem with it."

One person told us they felt staff were rushed and task focused. They said, "They do what they have to do then leave. I am really not sure how long they are supposed to stay. They never sit and chat."

People gave us mixed views about whether they felt safe with the staff that supported them. People and relatives spoke about their "regular" carers and that it was with them that they felt most safe. One relative said, "They keep [person's name] safe especially when getting them out of bed. They treat them very well." However, one person did not feel safe when staff supported them in the shower. They said, "When I stand up from the shower seat my walker must be by the door, otherwise I am frightened I may slip. Not all the staff think about this and I have to tell them. Some staff are better than others at thinking about things like slipping. I am not convinced they are all aware of my safety needs." One relative told us that unless their family member's care was provided by their "regular" carer they did not feel they were always safe. They told us, "I usually make sure I am around in that situation."

The provider had systems in place for ensuring staff protected people against the risk of abuse or discrimination. This included staff training to enable them to treat people fairly and in a safe manner. Although staff we spoke with were able to tell us about their responsibilities for keeping people safe within their own homes, what people had told us did not confirm that staff always put this into practice. The provider notified us when incidents came to their attention which had compromised people's safety. They notified and worked with the local authority safeguarding and social work teams as appropriate to ensure people were kept safe once they had been made aware. People and their relatives were kept informed by managers, who told us they made sure outcomes were shared. Where staff practice had been an issue we saw that disciplinary action was taken against staff, and training and supervision increased as necessary.

Risk assessments were in place which identified the risks associated with people's care. Where risk was identified a care plan was in place which informed staff on how to support the person safely. However, with regards to people's medicines we found the assessment of risk had not been fully considered. Where people were at risk of skin breakdown care staff were instructed to monitor and report any concerns. Instruction was given on mobility equipment to be used to keep people safe. Some risk assessments were generic and did not give much detail but staff understood what people were at risk of when they supported them. One staff member told us they knew that if a person had limited mobility they needed to check their skin to make sure it was intact. They told us they also made sure people were safe when they were in bed and checked the security of their homes as they were leaving. Staff told us communication within the service was good with regards to managing risk. Managers shared information such as changes in people's needs or risk with staff, which enabled them to keep up to date. Care staff told us this information was shared through text messaging and emails. Staff received training in using any equipment that was needed to help reduce risk to people and help them to stay safe.

The provider had a contingency plan in place which was used in the event of exceptionally poor weather. Following heavy snow in December 2017 the provider confirmed they had carried out their "snow plan". By liaising with people, relatives, staff and the local authority the majority of care calls were completed. Contact was maintained with people, care calls were prioritised and four by four vehicles were used to help staff reach the most affected areas. Where care calls were not completed the provider told us people had confirmed they were fine or relatives had provided the care for that day.

People and relatives confirmed that care staff wore gloves and aprons when they supported them. However, three told us they felt some staff did not have good hygiene practices. One relative told us care staff had left soiled incontinence pads in a bag, in their relative's bedroom overnight. One person told us, "I do think some of the hygiene of some (staff) leaves a lot to be desired. Some of them won't wear gloves, they say they upset their skin, and they don't even wash their hands, even after creaming my legs. It really isn't nice." Staff we spoke with told us they received training in how to prevent and control the spread of infection. They confirmed they were able to access protective clothing and that people had stocks of gloves and aprons in their own homes for staff to use. They confirmed there was no restriction on the amount of gloves and

aprons they could use. The provider has systems in place designed to ensure people were protected by the prevention and control of infection. We saw that managers carried out regular 'spot checks' on care staff and part of these included observing that infection control procedures were followed.

Is the service effective?

Our findings

People and relatives told us that on the whole they thought staff carried out their roles effectively when they arrived at their homes. One person said, "I think they know what they are doing. I get two carers each time as I need support to stand. I use a standing aide and they are competent with it. I feel confident they know what they are doing." One relative told us, "All are good and know just how to look after [person's name]. We do have excellent ones during the week. The others are good and we all get on well and they include me too. You have to give newer staff time to adjust and they do."

Some people felt staff required further training in specific areas such as using continence aids and supporting people with their mobility. One person said, "Some of them don't know what to do. I don't think they train them well enough before they come. They know nothing about you or your needs." One relative told us, "[Person's name] is very hands on and will help the staff. Although I do feel staff should at least know the basics like how to turn them over in bed. How can they change an incontinence pad if they don't know this skill?" Another relative told us care staff often did not know how to support their family member with their continence aid. They said, "I feel they (care staff) should have the basic skills to look after the people they take on their books."

Staff told us they received the training they felt they needed and that it was specific to people's individual needs. Staff had access to a range of training deemed by the provider as required in order to meet the needs of people. Despite this, we had found that training, such as medicines, had not been wholly effective in ensuring all staff had the skills they needed to manage people's medicines. We spoke with the provider about how they monitored staff practice to ensure staff were able to deliver effective care. They told us and we saw evidence that through people's feedback and observation of staff practice, managers had already identified areas of improvements for some staff. These improvements were on-going but they told us they had seen improvement in staff skills and knowledge recently.

There was a structured induction and training programme in place for all staff, which was delivered by the provider's in-house tutor. Staff received 'on the job' training when they first started working for the service and worked alongside more experienced staff to learn how to support people. They were supported to complete their Care Certificate. The Care Certificate is a set of standards that social care and health workers must adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. One staff member told us, "Training is important. It shows the client that we know what we are doing and helps them to trust us."

Prior to care commencing the person was visited either at home or hospital to talk about the support they needed. The provider also worked with the local authority to deliver care at short notice to people who need support to avoid hospital admission. In this instance the provider relied on the local authority's initial assessment to start providing care. Staff told us that a manager or care coordinator would accompany staff on the first care call to complete further assessment and develop the provider's own plan of care. The provider liaised with a range of community health and social care professionals, such as social workers, GPs, physiotherapists and occupational therapists. This helped to ensure the support provided achieved positive

outcomes for people and they had access to any equipment or aids they needed. We saw the provider was working with one person's social worker to help manage and improve the effectiveness of care staff could deliver. This person had very specific needs and together they were working to improve outcomes for this person. Another person was to trial a bed sensor pad. This person required 24 hour support but did not want care staff in their bedroom at night. The use of the sensor allowed staff to stay in the next room. The provider had confirmed that further assistive technology was being looked at following a referral to the community health services. One staff member said, "We offer everyone the same level of care. Everyone is an individual regardless of their background. We have to treat them fairly and make sure all their needs are met."

The service supported people to maintain their general health and wellbeing. If needed, office staff would contact a GP or district nurse on someone's behalf. One care staff member told us they had recently requested the district nurse to be contacted as they had concerns about a person's skin condition.

Support workers provided support to ensure people ate and drank enough. Where people required support, this was detailed in their care plans for staff to follow. Staff told us they offered choice to people and prepared meals in line with their preferences.

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. Where people lack mental capacity to make 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 MCA. Where people live in their own homes, applications to deprive a person of their liberty must be authorised by the Court of Protection. The provider confirmed that at the time of our inspection that each person they supported had capacity to make decisions relating to their own care. They confirmed no one was being deprived of their liberty and there were no authorisations under the Court of Protection. The provider understood the process they must follow if a person was assessed as not having capacity and best interest's decisions had to be made. They told us that they would involve the family, GP and local authority as appropriate.

People told us that staff asked for their consent prior to supporting them. Staff we spoke with understood their roles and responsibilities in regards to gaining consent and what this meant or how it affected the way the person was to be cared for. One staff member said, "We always have to ask, is it ok to do this or do that. We can't make anyone do anything they don't want to." Staff told us if they had concerns about people's ability to give their consent they would contact their line manager. Although staff had received training in the MCA, we found their knowledge and understanding of how it would impact on people's lives and their practice was limited. We shared this with the provider. They told us after our visit that they had, "added a guidance sheet to remind and refresh carers of their responsibilities in between training. This is in the care plan."

Is the service caring?

Our findings

People and their relatives told us that their care staff were kind and caring. People felt that they had built good relationships with the care staff they saw regularly. One person said, "They [care staff] are kind and very easy to get along with. Each one is different, and we have some banter. I find some of them are very comfortable to be with. I can't fault them." One staff member spoke about the importance of building positive relationships with the people they supported. They said, "They (people) get to know me and I get to know their needs. They put their trust in us. They all say they prefer to see the same staff."

The provider told us that where possible they kept care staff working in the same localities to help ensure a consistency of care for people. The provider acknowledged that they sometimes struggled at weekends when there could be an increase in staff illness and this was reflected with people we spoke with. People confirmed they usually saw regular staff but did feel there was a noticeable difference when they did not know the care staff who supported them or if they were new. One person said, "They [care staff] are always polite, but if they are new to me I have to explain where things go and it all takes time. I think the older ones are more competent. The younger ones aren't quite as willing. On the whole they are alright."

People felt staff involved them in their own care when they supported them. One relative told us, "They [staff] have got to know my relative. They are all good and will include [person's name]. There is a good working relationship with most of them." Staff we spoke with demonstrated they understood people's individual personalities, needs and preferences. They understood the importance of making sure people had choices. All staff spoke about how they supported people with this, which included making sure people felt involved in any decisions. One staff member said, "We have to offer dignity and choice and we have to treat everyone fairly all the time."

The provider had identified people they supported that would be alone at the last Christmas holidays. They organised for food items to be collected to make up hampers and took these to people on Christmas Day. They also purchased Christmas meals for staff to cook for people. The provider told us they were also offered spaces at a local club for some people to go out and have Christmas lunch. Staff took and collected the people that went to this. The provider also told us they provided a free starter box to people. They told us, "We often arrive to a client who was discharged with inadequate supplies initially and with no bowl, flannel, soap, pads, incontinence disposal sacs and on assessment (first visit for ICS clients) as well as the usual PPE we offer this as a welcome gift." PPE is personal protective equipment care staff use, such as gloves and aprons.

People's rights to privacy and dignity were supported by staff, especially when being assisted with personal care. People told us that staff were considerate when helping them and never made them feel embarrassed. One person said, "They [staff] keep everything private, they even make the family wait outside and close the door if they are seeing to me." One relative said, "All the staff treat [person's name] with respect and dignity. They knock on the door and ask if they are ready to do something." Staff understood their role in supporting people to remain as independent as they could. One staff member said, "We have to provide a standard of care that helps people remain in their own homes."

Is the service responsive?

Our findings

People and their relatives told us that the service was not always responsive in addressing concerns they raised verbally. People said they would call the office if they had any problems and said office staff and managers would listen to their concerns, but they did not feel they were always resolved. One person said, "My relative has even spoken to the owners and although they say they will put things right and are very apologetic, nothing changes." One relative told us, "When I have complained about the fact we get no information regarding lateness, they always apologise but there is no change. The excuses they give are unbelievable and they usually blame the carers, but I am not so sure it is always sickness, I think sometimes it is co-ordination, or lack of it."

One relative told us that they had asked for a staff member not to care for their family member. They said, "I don't bother giving feedback as I feel it is a waste of time. I have asked several times that they don't send one particular member of staff, as they are unable to do the job but they keep sending them. It is every embarrassing, for both of us, having to turn [staff member] away at the door."

One person we spoke with told us they were not aware of what they could do if they had a concern or a complaint. They said, "I don't know the exact procedure for making a complaint and there is no information booklet to outline the process." Following our visit, the provider told us, "(The) complaints procedure is verbally discussed when a client starts on the welcome telephone call, guidance is on the front of the care folder and also a complete document is in the service user guide in the care plan with detailed actions of what to do and expect if a concern or complaint is raised. Also the compliments procedure is in there."

We spoke with the provider about how verbal concerns and complaints were addressed. The provider told us that if anyone wanted to make a formal complaint they would follow their complaints process. We saw evidence that where complaints had been made, action was taken in responding to and investigating them. One of the management team would speak with the complainant and keep them updated on actions they were taking and any outcome. The provider told us that if a verbal concern was raised, this was put onto a computer log and was discussed at the weekly management meeting, if it had not already been addressed. They confirmed that the expectation was that managers and office staff dealt with people's concerns as they arose. They were disappointed and not aware that people and relatives did not feel their verbal concerns were resolved to their satisfaction.

People and relatives felt that the care they received met their needs. One person said, "The job they do is good. Some will check if I need anything other than my legs creaming and stockings on. I really can't fault any of them." One relative told us they had worked with the care staff to establish a routine in the mornings which worked best for their family member. They said, "Doing it this way means [person's name] is not rushed and can enjoy their breakfast. I am really pleased with the care package. I think they are pretty amazing staff."

Whilst people had care plans in place, there was a lack of focus on what their own preferences and wishes were in relation to how they would like their care delivered. One person was not aware what their care plan

was for. They said, "I have a book they sign but I'm not sure what is in it." We found that the provider had not ensured people's care plans fully reflected their holistic and individual needs and did not fully demonstrate how person-centred care was to be delivered. We did see that some care plans contained considerably more detail than others and also gave information about the person as an individual. Staff we spoke with were able to tell us about the people they supported regularly and that they knew them as individuals. This helped them to deliver person centred care. One staff member told us they supported a person who had a visual impairment. They told us they had taken the time to sit and go through their care plan with them because the person had not known what it was for. Another staff member told us they supported one person to make their own decisions by offering simple choices. They told us this knowledge had come from working with this person rather than their care plan.

Not everyone we spoke with felt they were involved in reviewing their care plans. Care managers confirmed that people's care plans were reviewed at least every six months and that people were involved in this review. However, one person told us, "My care plan hasn't been reviewed since I started with them over three years ago. I think one of the senior carers is supposed to be coming round updating them."

People's communication needs were looked at as part of their care assessment. This highlighted if people wore glasses or hearing aids. Whilst no consideration had been given to recording where people may have specific accessible information needs, the provider told us they would provide information in different formats if this was requested or needed. All providers of NHS and publicly-funded adult social care must follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with health and social care services. The provider told us they were aware of the Accessible Information Standard. Following our inspection visit they informed us this was now included within their care plan. They told us this would, "allow the assessor to ensure the service user can access all detail and information in an appropriate format."

Is the service well-led?

Our findings

People and relatives gave us mixed views about the culture and communication within the service. People and relatives commented that they had difficulty in getting hold of anyone to speak with in the office. They told us they did not always know who they were talking with when they telephoned the office and felt not all the office staff were helpful. One relative told us that because of this they had not raised a significant concern they had. Whereas another relative told us the staff in the office were "all very nice and helpful".

People and relatives told us they often rang the office to ask where care staff were and if they were going to get a call. One relative said, "The office is not easy to get hold of. When staff don't turn up you can get the answer phone at the office. You leave a message, but they don't ring you back." Some people said their telephone calls were not returned and they felt communication was poor. The telephone may not be answered and not all were aware if there was an out of hour's number. One relative said, "I am not sure who to speak to. I do have the care number to ring but have rung at night time and it's difficult to get hold of them. I am not sure what happens when the office is closed as I have no other number." One staff member told us that people often complained to them about their telephone calls going unanswered and calls not being returned when they left a message. The provider acknowledged there had been problems with their telephone system and known issues with the answer phone not saving messages. They told us the service had grown but the telephone system did not "keep up" and this was probably the reason why people complained of telephone calls not being answered. The provider had arranged for their telephone system to be upgraded but following our feedback took more immediate action at the time of our inspection.

People and their relatives were asked to complete surveys about the quality of the service that was delivered. However, some felt that although they completed these they were not used to improve the service. One person said, "We occasionally get surveys but it's frustrating to fill in as I keep saying the same thing over and over and it doesn't change anyway." The provider told us they sent people and relatives surveys to complete quarterly. The surveys were anonymous but if someone had raised a specific concern, and had given their name then the provider or a manager would visit the person to talk about their concerns. The last survey had been completed in November 2017 where 15 out of 50 surveys had been returned. The provider had notified people and relatives of the outcome of this survey through a letter sent in January 2018. The provider confirmed that this survey had shown a drop, since the last survey, in people's satisfaction with the timeliness of care calls. They had shared, within this letter, their intentions for improving this drop in satisfaction.

The provider told us the survey had also identified that not all people and relatives knew who managers were and that communication was sometimes poor. They had created a "meet the team" leaflet which had been circulated to people to help them familiarise themselves with who managers were at the service. They told us, "We need to improve communication to make them (people) happier and on board with what we can deliver." Regarding the feedback they received from surveys, they said, "It is fine for people to tell us we're not doing something well and I want to make sure they know that."

Although the provider had systems in place to check people's medicines were managed safely these had not

identified the concerns we identified at this inspection. The provider had a medicines policy in place which all staff were trained in. Staff practice was monitored through training and observation of practice. People's medicines records were audited by managers and reviewed as part of care plan reviews. However, we identified that staff had not followed people's medicines care plans or the provider's medicines policy. We also found a lack of information and guidance on how staff were to support individual people and what medicines they needed support with. We viewed one person's medicine administration record which had been audited. We saw there were missing staff signatures where staff had not signed to say whether the person had received their medicine. There were also annotations which were not identifiable. The auditor had failed to address any of the errors and had signed the record off as accepted. The provider told us they would expect the gaps and annotations to have been addressed by the auditor and information on what they had done to address these errors and ensure medicine had been given. Once we had brought this to the provider's attention they asked a manager to ensure the errors were addressed.

The provider had systems in place to help them monitor the quality of service provided by their staff. The provider was responsible for the day to day management of the service and was supported by a team of managers and co-ordinators. Responsibilities were shared in ensuring audits were completed on care records, care plans were kept updated and staff practice was safe and met people's needs. However, as identified through our inspection these systems were not always effective in identifying areas for improvement. Care records kept at the office were not always up to date or complete. Managers told us the care records we viewed were up to date. We saw that one person had no risk assessment for falls or their mobility despite their care plan stating they were at risk of falls and were unable to mobilise independently. When we spoke with managers about this they told us this was kept on the computer. This was then printed off and placed in the person's care record. We identified that another person had incorrect medicines support information in their care plan. Again, managers showed us this had been updated but had not been put into the person's care records. People's care records must be kept accurate, complete and up to date to ensure staff are aware of people's needs and able to provide safe, person centred care. As a result of our findings the provider told us, "We need to be more robust. I will be checking these (care records) now until I'm satisfied."

This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they looked for opportunities to reward good staff practice. In the month before our visit the provider had introduced a "staff morale system" where they would award an "employee of the month". This would take into account staff's time keeping, spot checks and any compliments or feedback received from people about specific staff. The provider told us they were looking for the positives in staff and to help them realise that their work was appreciated.

Staff told us they were happy in their work, felt supported by managers and even though they worked in the community, they did not feel isolated. One staff member told us sometimes their calls were not returned if they phoned the office. When this happened, they told us they used the JK Caring for You "query email", which was responded to quickly.

The provider told us they were keen to support their local community. They were involved in an initiative between the local authority and a local housing group to support a volunteer group with a fortnightly respite session within the local community. The provider said, "It's assisting the community. It's somewhere I could see the need and we could see how it worked and have people who enjoy the activities. People who are part of the housing group and their carers can come and get some respite."

The provider was aware of their responsibilities and in keeping us up to date with specific events that have

happened at the service. These are called statutory notifications and are required by law to be submitted to us. These ensure that we are aware of important events and play a key role in our on-going monitoring of services. We saw the ratings from the previous inspection were displayed at the service and on their website.

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 not ensured the safe management of all medicines.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that governance and quality systems in place ensured the quality and safety of care provided.