Kris Carers Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Kris Carers is a domiciliary care agency, providing personal care to people living in their own homes. At the time of our inspection, 90 people were using the service. They all received support with personal care.

People's experience of using this service and what we found
People were not always kept safe from the risk of abuse. Care plans did not provide guidance on people's physical and mental health needs. This lack of guidance can impact staff's ability to keep people safe. Health care professionals were contacted when people were unwell, however there was not always a written record of their involvement and advice. P People's medicines were not supported safely. There were enough staff, however staff were not always recruited safely. This was because they had started working with people before their background had been checked. Poor quality recording and analysis meant lessons were not always learnt when things went wrong. People were kept safe from the spread of infection.

People were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible and in their best interests. Systems in the service did not support good practice. People received enough to eat and drink. Staff had received training to complete their role, however some feedback and findings suggested this training was not sufficient to enable effective care.

The oversight of the service meant people may not always receive kind and caring support. This is because the registered manager did not always respond to safeguarding allegations, and staff had begun work before their background had been checked. However, people and relatives spoke highly of individual staff kindness.

Care plans provided detail on people's life history and beliefs. No one at the service was currently at the end of their life, however pro-active discussions had not occurred to discuss people's end of life wishes if their health deteriorated.

The governance and oversight at the service was poor quality. In June 2022, the local authority audited the service and found concerns. These concerns were ongoing at this inspection. When we raised specific examples to the registered manager, a lack of action had been taken a week later. This poor oversight and action taken when risks were raised, left people at ongoing risk of poor-quality care.

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

Rating at last inspection
The last rating for this service was good (published 18 November 2021)

Why we inspected

The inspection was prompted due to concerns we had received from the local ambulance service. We had also received an allegation that a person had been moved without using suitable equipment and had been force fed by staff. The local authority safeguarding team had investigated this allegation and found the provider's response to this allegation was poor quality. Due to this, a decision was made for us to complete a focused inspection and examine the safety and governance at the service. While completing the focused inspection, we identified some further concerns at the service. We therefore decided to widen our inspection scope and complete a fully comprehensive inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of the report. These sections describe what breaches of regulation have occurred. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

At this inspection, we have identified breaches in relation to safe care, safeguarding, fit and proper persons deployed, consent, and governance.

Full information about CQC's regulatory response can be found at the end of the 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Kris Carers Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was completed by one inspector. An Expert by Experience also made phone calls to people and relatives to gather their feedback. 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.

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

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure someone would be in the office to support our inspection.

We visited the office location on 11, 12 and 26 October 2022. We made phone calls to people, relatives and staff on the 12 and 25 October 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

What we did during the inspection
We spoke with two people who used the service and six relatives about their experience of the care provided. We spoke with seven members of staff. The registered manager was informed about each of our inspection days but was unable to attend the office location. We therefore requested evidence of their audits were made available for us.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

● Our inspection was prompted by a concern from the local authority safeguarding team. The safeguarding team had received an allegation that person was physically abused. They were concerned that the registered manager had not taken sufficient action after this allegation was made.

● Due to the above concern, the local authority had therefore made recommendations to the registered manager that the alleged perpetrators should be suspended from duty while full investigation and retraining of these staff occurred. When we inspected the service, we found the registered manager had not followed this local authority advice and the staff had remained working with people at the service without further suspension and training occurring. The failure to respond to an allegation of abuse, or take action directly specified by the local authority safeguarding team; had left people at the service at risk of abuse.

● During the inspection, a relative informed us of an incident where a person's care calls were not re-started after they had gone to a hospital appointment. Staff informed us that the person had managed by eating snacks by their bed for three days. This neglectful care put the person at substantial risk of harm. The Local authority safeguarding team advised that the service have since put in place actions to reduce the risk of missed calls happening in future.

The lack of action to protect people meant people remaining at risk of abuse. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff had received training in how to report allegations of abuse. They told us they were confident in reporting concerns to their management team.

● People and relatives at the service told us that they felt safe.

Assessing risk, safety monitoring and management

● Care plans did not always provide staff with clear guidance on how to support people's physical needs. For example, a person had a catheter however their care plan did not describe that staff needed to support this person's catheter care. There was therefore no detail on how often support was needed to change the catheter or how carers should support this catheter care safely. We raised this concern with the registered manage, when we returned a week later, we found the care plan had not been changed. This left the person at risk of receiving poor-quality catheter care.

●Care plans did not always provide clear guidance on how to support people's mental health needs. For example, staff explained that a person with dementia could become agitated towards care staff. As a result, two care staff supported this person instead of one. There was a lack of care plan guidance on how these two staff could support the person in the safest way. Including what actions were most effective in minimising the person's distress. This lack of guidance risks the two staff not providing the most appropriate

support to the person.

Using medicines safely

● Staff did not have guidance on when to administer 'as needed' medicines. For example, one person was prescribed two pain relieving medicines to be taken 'as needed'. There was no guidance on when each medicine would be required. There was also no guidance on taking these medicines together. If taken together, these two medicines could cause an overdose to the person due to the ingredients of the medicine. Not having clear 'as needed' medicine guidance in place, risks staff supporting as needed medicines unsafely.

● Staff did not have clear guidance on whether a person's medicine should be taken 'as needed' or should be taken regularly. This risks the person not being given their medicine as prescribed

● Staff did not record why 'as needed' medicines were given to a person. This was unsafe, as we can-not be sure that the medicine was given for the required reason.

● Topical creams were not recorded safely. Staff recorded that they applied creams to a person in their daily notes. However, there was no reference to these creams within medicine records or care plans. It was therefore not clear what cream the staff member was applying, or whether it was being applied for a suitable purpose or place on the person's body. We raised this concern with the registered manager. When we returned a week later, we found insufficient action had been taken to improve the recording of creams.

● Some people at the service required their medicine to be taken at a certain time period before food. Staff did not record what time this medicine was given in comparison to the person's meal. It was therefore not clear that this medicine requirement was safely met. We raised this concern with the registered manager, when we returned a week later, we found insufficient action had been taken.

● Staff recorded medicines as a single entry 'dosset box'. It is within the provider's policy to have a record of what actual medicines were given to a person at each care visit. Not following this recording standard, meant office staff would not be sure what medicine had been administered to a person. This makes is difficult for office staff to assess the safety of medicine administration.

● Staff had received medicine training. However, the poor recording of medicines showed this training was not enough to enable safe practice.

Care plans were not always good quality and medicines were managed unsafely. These concerns are a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We reviewed four staff members recruitment files. We identified that one had started a month before their Disclosure and Barring Service (DBS) had been checked. The other three staff had started work five months before their DBS had been checked. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. By not checking a staff members DBS history before starting to work with people, puts people at risk of receiving care and support from unsuitable staff.

● We identified the provider did not keep up to date records on staff's right to work in the UK. For example, one staff member's right to work in the UK permit had expired while they were employed at the service. The provider had not checked that this right to work had been renewed until we raised it as a concern. The poor oversight of staff's right to work, risked the provider continuing to employ staff who were not allowed to work in the UK.

Staff were not always safely recruited. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to support people. Records suggested and people fed-back; that the majority of calls were on time.

Learning lessons when things go wrong
● Staff did not keep clear records on the care that had been provided to a person. For example, a staff member wrote 'shouting, so left'. This did not describe what had distressed the person, what attempts had been made to resolve the person's distress or whether the person's needs had been met at the visit. The failure to record what occurs at a care visit, risks improvements not being made to a person's care.
● Before the inspection, we received concerns from visiting professionals that the notes carers kept were sometimes difficult to read. This had impacted the visiting professional's ability to support the person. During the inspection, a person also told us that they were unable to read the carers handwriting. We saw some carers notes were too difficult to read. The registered manager was informed of this concern and completed an action plan to improve this.

Preventing and controlling infection
● Staff had received training in infection control.
● People told us that staff wore suitable personal protective equipment.
● The provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. No one at the service was receiving care due to a court of protection application.

We checked whether the service was working within the principles of the MCA.

- People were not always supported to make their own choices. One person's care plan described that they can make an unwise choice to eat high sugar foods, however fully understood the consequences of this diet. The care plan guided staff to throw away the person's sugary food, and staff confirmed that they do this. The mental capacity act states that people have a right to make unwise choices, so throwing away the person's food is restrictive practice. We raised this concern with the registered manager. When we returned a week later, no changes had been made to the person's care planning. This put the person at prolonged risk of restrictive care practices.
- Staff were guided to support a person in pairs. This was due to the person's mental health diagnosis and agitation towards care staff. Staff did not have clear guidance on how to support this person's personal care in the least restrictive way. This risked staff not supporting the person in their best interests.
- The registered manager had completed one mental capacity assessment. This was poor quality, as it showed the person could not retain or weigh up information but summarised that they could make a decision on receiving care. This does not follow the principles of a mental capacity assessment, if a person cannot retain or weigh up information given to them – they are unable to make a decision.

People's consent was not always gained in line with the mental capacity act. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●Care plans did not always use national tools. For example, the local authority had advised the registered manager that people at risk of skin integrity should have an associated Waterlow assessment. This is a national tool that assesses people's risk of skin breakdown. We saw that this was not in place as expected for one person at risk of skin damage.
● Care plans described people's social histories and belief systems. However, they lacked guidance on people's physical and mental health needs. The lack of holistic guidance for staff risks care not being delivered in line with current standards.

Staff support: induction, training, skills and experience
● People and relatives mostly spoke highly of staff training. Despite this we received some mixed feedback, one relative explained that staff did not always demonstrate the patience needed when supporting a person's mental health needs. Another relative explained that staff did not always read the guidance for meal-time support. This feedback suggests that while training was provided, some staff may need further skill improvement.
● Staff spoke highly of the training and induction programme offered to them.
● Training records showed staff had received different types of training to complete their role effectively. For example, how to support a person to move safely.

Supporting people to eat and drink enough to maintain a balanced diet
● People were provided with enough to eat and drink. Staff kept records on when people were provided with food and drink
● These records suggest people ate and drank enough.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● External health professional guidance was not clearly followed by staff. For example, external health professionals had given guidance on what angle a person should lie down in. This was to ensure their skin did not breakdown. Staff kept daily notes of how they supported the person to reposition. However, these notes did not clearly reflect the guidance that had been given. So, we could not be assured that effective repositioning support was being provided.
● While it was not always clear that health guidance was followed, People told us that staff were quick to recognise when external professionals should be contacted. One person said, "Experienced carers will alert me to things and they will suggest I contact the GP."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The poor-quality oversight of the service, meant we were not assured that people would be cared for in a kind way. We have written in the safe section of this report, that staff had begun work before their background had been checked, and that the manager had not taken sufficient action after receiving an allegation of abuse. This poor quality oversight has left people at risk of receiving care from unkind staff.
- While the oversight of the service was poor, people mostly told us that staff were kind to them. One person said "Always a smile on their face and they want to help. So, I don't feel alone in the world anymore."
- Care plans had clear guidance on people's life history, religion and belief systems. This detail allows carers to support people in a way that respects their diversity.
- Staff had received training on equality and diversity. There was also an equality and diversity policy in place for staff to follow.

Supporting people to express their views and be involved in making decisions about their care

- People explained that they were consulted when their care plan was written, which allowed them to make some decisions about their care.
- People told us that staff ask their consent before engaging in care tasks. A relative said, "They bring food to her and say do you want this? They also ask if she wants a shower."

Respecting and promoting people's privacy, dignity and independence

- People explained that staff treated them with respect. One person explained that staff were mindful of their privacy and always asked permission to help shred the person's personal documents.
- Staff had received training in privacy and dignity. This training allows them to know how to treat people in a caring way.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans described people's social background and belief systems. However, the care plans lacked detail on people's mental and physical health needs. This lack of guidance can impact the ability of staff to provide personalised care for these differing needs.
- For example, one person's care plan guided staff to check a person's diabetic sugar levels during the care visit. However, there was no guidance on what safe sugar levels should be for this person. We raised this with the registered manager and the care plan was changed to state that external health professionals should check the person's sugar levels instead of care staff. However, we then spoke to a staff member who supported the person multiple times after care plan had been changed. They were unaware that changes had been made. There had been a lack of clear guidance on how to support a person's needs. Once the care plan detail had been changed, the staff member was not aware that a change had occurred. This means staff were not responsive to a person's needs.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The service was able to adjust their communication to ensure people understood the information given to them, for example using larger font in written documentation.
- Staff had received training in how to communicate with people.

Improving care quality in response to complaints or concerns

- People and relatives told us they were happy with the service and had not had to make any complaints
- The registered manager kept a log of complaints that had been received, and this log showed complaints had been recorded and responded to.

End of life care and support

- No one at the service required end of life support at the time of the inspection.
- We reviewed eight people's care plans and there was no evidence that pro-active discussions had been had about people's end of life wishes. It is important to have these discussions to ensure staff are prepared on how a person would like to be cared for, should a person's health deteriorate.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Poor governance meant improvements were not made when risks were raised to the provider. In June 2022, the local authority completed an audit at the service. The local authority identified concerns with care plans, staff recruitment, medicines and mental capacity assessments. When we completed this inspection in October 2022, the management team had not resolved the risks highlighted in the June audit.
- During the inspection, we emailed the registered manager with concerns that we had seen. When we returned a week later, limited action had been taken. Where action had been taken, it was ineffective at improving the care people received.
- The provider had clear policies on how to support medicines in a safe way. However, these medicine policies were not followed. The staff member responsible for auditing the medicines was also not aware of all of the policy requirements.
- Staff did not always record that they were late to a visit and the reason why. While people told us that calls were usually on time, this poor recording would impact trends being identified in an audit.

Poor quality governance and oversight at the service meant care was not high quality. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People were at risk of not having good outcomes. This is because staff were not given clear guidance on how to support them. During the inspection, we raised concerns with specific care plans that needed improvement. When we returned a week later, no effective changes had been made to the care planning for these people. This poor governance, left people at ongoing risk of poor outcomes.
- Feedback received from people and relatives was mostly positive. They spoke highly of the approach from care staff.

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

- People told us that they had no reason to make a complaint. One person said "If I was concerned, I would ring the office. The person in the office is very good. They want to do everything right and would come and check everything is alright."
- Where complaints were recorded, we saw they had been responded to.

● The provider has a legal duty to notify us when certain incidents occur (for example, serious injuries or safeguarding allegations). The registered manager had made the notifications as expected.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● People and staff were engaged with the running of the service. Surveys were sent out and the results analysed.
● People were involved with the writing of their care plans, so they could guide staff on how they would like to be supported.

Working in partnership with others
● Records showed us that referrals were made to health and social care professionals if needed. However, the guidance was not always clearly recorded in the care plans for staff to follow. For example, an external health professional explained that staff are not expected to check a person's diabetic blood sugar levels, however staff were guided to check sugar levels in the person's care plan. Poor quality governance had not identified this concern.

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 11 HSCA RA Regulations 2014 Need for consent People's consent was not always gained in line with the mental capacity act.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not kept safe from the risk of abuse

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Poor quality governance and oversight at the service meant care was not high quality.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans were not always good quality and medicines were managed unsafely.

The enforcement action we took:

We have sent the provider a warning notice. This gives a specific timeframe to make improvements. We will assess compliance with this at our next inspection.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Poor quality governance and oversight at the service meant care was not high quality.

The enforcement action we took:

We have sent the provider a warning notice. This gives a specific timeframe to make improvements. We will assess compliance with this at our next inspection.