

Miracle Centre Limited

# Miracle Care Centre CHC

## Inspection report

Carnon Building  
Wilson Way, Pool  
Redruth  
TR15 3RS

Tel: 07904161282  
Website: [www.miraclecarecentre.co.uk](http://www.miraclecarecentre.co.uk)

Date of inspection visit:  
22 June 2023  
23 June 2023

Date of publication:  
09 October 2023

## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

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

Miracle Care is a domiciliary care agency providing personal care to people. The service provides support to older people and some younger people with a learning disability. At the time of our inspection there were 30 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

### People's experience of using this service and what we found

Relatives did not all think their family member was safe whilst receiving support from Miracle Care. Staff did not all understand how to report an accident or incident and the registered manager had not understood when to share safeguarding concerns externally. Risks relating to people's health and care needs had not always been recorded in a risk assessment.

Most people received their medicines as prescribed, however medicines management was not always safe.

People did not always receive care from consistent staff members at a consistent time each day. This compromised the quality of their care.

People's care plans did not always contain sufficient information about people's needs, preferences and routines. The care people received did not always reflect their preferences and choices. Relatives did not have access to information about what care had been provided to their family member.

People did not always receive food and drink in a way that they preferred.

Assessments of people's capacity had not been completed in line with the principles of Mental Capacity Act 2005 (MCA).

Staff had completed training but professionals and relatives raised concerns about the training and support staff received.

Staff meeting minutes did not show staff were encouraged to share ideas, raise concerns or discuss people's support needs.

Staff did not always understand people's cultural needs and relatives and staff reported that sometimes there was a language barrier which had a negative impact on people's experiences.

The registered manager had not ensured the service followed best practice. Checks of the service had not identified the failings found during the inspection.

People received care from staff who were calm and kind. Staff and some relatives said the registered manager was approachable.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

#### Right Support:

The model of care did not maximise people's choice, control and independence. It did not always focus on people's strengths or promote what they could do. This meant people did not always have a fulfilling and meaningful everyday life.

There was limited guidance available on how to support people who were experiencing periods of distress.

#### Right Care:

People's care plans were not holistic. They did not reflect their range of needs and meant staff did not have full information about people when supporting them.

There was little information about people's aspirations and what they needed to enjoy a good quality of life.

There was no clear plan to ensure people were given the opportunity to actively engage and try new activities.

#### Right Culture:

The service did not reflect the ethos of Right support, right care, right culture. Staff had not received support or training to understand best practice in learning disability services.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

#### Why we inspected

We undertook this inspection to provide a rating for this previously unrated service.

#### Enforcement and Recommendations

We have identified breaches in relation to safe care and treatment, staffing, consent, person centred care, and how the service is managed.

Please see the action we have told the provider to take at the end of this report. We issued a warning notice to the provider telling them the date by which they were required to make improvements.

#### Follow up

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



## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### 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** ●

# Miracle Care Centre CHC

## Detailed findings

### Background to this inspection

#### The inspection

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

#### Inspection team

The inspection was carried out by 1 inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

#### Service and service type

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

#### Registered Manager

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

At the time of our inspection there was a registered manager in post.

#### Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because the service is small and we wanted to be sure there would be people at home and in the office to speak with us.

Inspection activity started on 20 June 2023 and ended on 23 June 2023. We visited the location's office on 23 June 2023.

#### 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. We used all this information to plan our inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

#### During the inspection

We visited 3 people and spoke with 2 of them and 4 relatives. We spoke to 4 staff including the registered manager. We also spoke with 1 person, 10 relatives, 5 staff and 4 professionals by phone. We reviewed a range of information including 2 people's care plans and risk assessments, 3 medicines records (MARs) and a range of records relating to the management of the service such as meeting minutes and audits.



# Is the service safe?

## Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Several relatives told us they did not think their family member was safe whilst being supported by the service. Examples of staff leaving a person's door unlocked or people slipping off their bed and chair whilst receiving care, were given. Following the inspection, the registered manager told us they had investigated the concerns but were unable to substantiate them. The local authority spoke to 2 relatives who confirmed the concerns they had raised.
- Some people became upset, anxious or emotional at times. However, there was not always detailed guidance about the best way to support them at these times.
- A safeguarding allegation had not been shared with the local authority, which meant there was no external assurance that the person remained safe.

This contributed to a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff we spoke with told us they would be confident raising any safeguarding concerns they had.

Assessing risk, safety monitoring and management

- Some people had risks to their health, such as diabetes, weight loss or using a catheter, but there was no guidance provided to staff about how to help reduce the risks to people.
- People were not always supported to take positive risks. A relative told us at times, due to a lack of guidance, staff restricted 1 person's freedom by stopping them doing things in order to keep them safe.

This contributed to the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

- Staff were not all clear about how to report an accident or incident.
- Relatives described certain incidents that had happened which had not been recorded or investigated.

This contributed to the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- When the registered manager was aware of an incident or concern, this was reviewed and any changes or learning was shared with staff.



### Preventing and controlling infection

- Some people and relatives were positive about how well staff cleaned people's homes, but others raised concerns about cleanliness and hygiene practices. Relatives gave examples of staff not changing gloves between care tasks, not washing flannels after personal care and allowing urine to drip on the floor from a urine bottle.

This contributed to the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Using medicines safely

- One person had their medicines covertly (hidden in food or drink), however there was no information about which medicines were safe to give with which food or drink.
- Some people were prescribed medicines to be taken 'as required' (PRN); there was not always clear information about when staff should administer these medicines.
- One person sometimes asked staff to give them a painkiller. This was not on their records and so staff did not record times when they had given the painkiller to the person. This meant if the person requested another one, staff would not have been able to advise them of the time of the previous dose.

This contributed to the breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's care plans gave some information about how they preferred to take their medicines.
- Staff had received medicines training and assessments of staff competence to administer medicines had been completed.
- Staff recorded when they administered or prompted people to take their medicines.

### Staffing and recruitment

- People did not always have consistent staff providing their calls. This meant people did not get to know staff well and staff did not always understand people's routines and preferences. One person's care plan stated that new faces could bother them and their relative told us they had asked for a consistent staff team. However, their rota showed they had been supported by 24 different staff members over 4 weeks. Relatives told us this meant staff were not always experienced in supporting the person and therefore the quality of care reduced. Other relatives told us, "They send a lot of different carers and it doesn't work for someone with my family member's needs" and "My relative sees a lot of different staff and what they really need is consistency".
- Some relatives reported that calls were on time and for the correct amount of time but others reported their calls were regularly late and sometimes staff did not stay long enough.
- Staff did not always receive sufficient days off to enable them to rest. Three staff members had worked for 16, 19 and 25 days consecutively. This meant their ability to provide safe care and support may have been compromised.
- Suitable recruitment practices were in place and records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service.

# 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.

This is the first inspection for this newly registered service. This key question has been rated requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- A record of staff training showed they were up to date with training, however a professional raised concerns about the level of training and knowledge staff had. The professionals had to provide part of the care for 1 person as the Miracle Care staff did not have sufficient skills or experience. They told us this person currently required 2 staff because the Miracle Care staff were not experienced enough to work alone. This resulted in the person being overly restricted. The relative of a different person told us, "The staff aren't trained to cope, and it just hasn't worked at all."
- Staff helped some people manage their catheter. Guidance was available detailing the needs of 1 person who used a catheter, but not for another person. Staff had received online training but during the inspection the provider told us they had not recorded any assessments of staff competence to provide catheter care. Following the inspection, they provided evidence of competency assessments for 5 staff members which were dated prior to the inspection. However, this did not evidence that all staff providing catheter care had received the correct training and competency assessments
- Staff completed shadow shifts with experienced staff before they supported someone on their own. However, when the person had a learning disability or had more complex support needs, records of shadow shifts did not show they had been tailored to ensure they covered everything the staff member needed to know to support the person effectively.
- There were procedures in place for spot checks of staff practice. However there was no record to show these had been completed for all staff.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us the training they had undertaken was useful and helped them support people.

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.

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

- Assessments that had been completed of people's capacity did not follow the principles of the MCA. They did not show that information was communicated to people in a way they could understand. The decision being made was not clear and the questions asked as part of the assessment would not have provided clear evidence about whether the person had capacity or not.
- One person's care plan stated staff should fortify their food but do this covertly. There was no mental capacity assessment to evidence whether they could make decisions about their food for themselves.
- A section on people's care plans for them to consent to their care, or for a best interests decision to be recorded, had not been completed.

This was a breach of regulation 11 (Need for consent) 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;  
Supporting people to live healthier lives, access healthcare services and support

- People's care plans were not always tailored to reflect their needs and preferences. One person had dentures, but their care plan did not mention these. We reviewed 2 people's care plans which were similar rather than reflecting their individual preferences.
- People's care plans did not provide comprehensive information about the support people needed with their oral care.
- When people needed encouragement to accept care, there was little guidance available to staff detailing the best way to encourage the person. Relatives gave examples of people not being showered or washed frequently as they did not receive the right encouragement. A relative commented, "My family member needs to have a shower, but they don't encourage them, so they don't."
- The care plans and support for people with a learning disability did not meet the principles of right support, right care, right culture.

This contributed to the breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the provider told us they had implemented new guidance in relation to encouraging people to accept the care they needed.
- When staff supported people regularly, people and relatives told us they understood people's needs and routines.

Supporting people to eat and drink enough to maintain a balanced diet

- Relatives raised concerns that staff did not always cook or present meals as people would expect and therefore their family members were no longer eating much.
- One person's care plan stated that how much they ate and drank needed to be monitored. However no further information was provided about how much the person needed to eat or drink to stay healthy or who was responsible for monitoring this.
- People were given choices about what they ate.

Staff working with other agencies to provide consistent, effective, timely care

- Staff and the service worked with other professionals to improve the care and support being provided to people.

# 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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- People were not always offered choices. For example, there was little evidence of one person being offered a shower, even though their care plan required staff to ask. The person's family confirmed they did not get offered a shower regularly.
- Some professionals and relatives raised concerns that communication with staff whose first language was not English, was not always effective. They felt staff were keen to agree even when they had possibly not understood what was being requested. This meant there was a risk that people would not receive their care as they preferred.

This contributed to the breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- One person requested female only staff. Initially the provider had been unable to provide this but following the inspection confirmed they had recruited more female staff to comply with the person's wishes.
- Following the inspection, the provider told us they had invested in further training to support staff to increase their English language skills.
- People's care plans included some information about how to communicate effectively with them.

Respecting and promoting people's privacy, dignity and independence

- People had not been supported to maintain and develop their independence. People's care plans did not include guidance on how to encourage or support people to do things for themselves.
- One person's care plan stated that they liked to be involved in their care and to complete light domestic tasks around the home. The person's family said this did not happen and records of the support provided showed the person had not been supported or encouraged to participate in these tasks.

This contributed to the breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us their privacy and dignity were respected by most staff.

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

- People and relatives were complimentary about individual staff, saying they were kind, polite and respectful. Comments included, "They are as good as gold" and "The carers we have treat my relative with

respect and they like interacting with them too."

- A professional told us they were impressed at how staff had built a trusting relationship with 1 person through being calm and patient.
- A relative reported that their family member's anxiety had been reduced because of the care they were receiving.

# Is the service responsive?

## Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

- People's calls were not always planned for the same time each day, the times rota'd for staff to complete 1 person's morning call ranged from 7.50 am to 9.45am; another person's ranged from 8am to 10.15am. This meant they were unable to plan their day around their calls.
- People's care plans were not always accurate and did not provide staff with enough information to enable them to meet people's needs. For example, the care plan of an individual who was deaf said they had good hearing in both ears.
- A professional told us that when staff started working with a particular person, there was not enough information available to the staff to guide them on how to support the person's needs. Another person told us, "The carer I have at the moment doesn't understand what I need."
- People had not all seen their care plan. Relatives' comments included, "No one has been out to do a care plan" and "I haven't seen or discussed a care plan."
- Some people with a learning disability were supported throughout each day. However, their care plans did not describe any hopes or aspirations they had, or how staff could support them to increase their skills.

This contributes to a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Some people were supported with activities such as following interests, daily living tasks and socialising. A relative told us that if staff did not engage well with their family member, they would not have a good day. However, their care plan did not contain clear information about the things they liked to do, or what they might like to try in the future to broaden their experiences.
- There was no clear plan to ensure people with a learning disability were given the opportunity to actively engage and try new activities. A professional had asked staff to support a person to make a plan of what they wanted to do for each week. They told us the plan appeared to be the same every week and did not include opportunities to widen the person's social circles.

This contributed to the breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A professional told us 1 person had been going out more since they had received support from the service.

### 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.

- There was some information in people's care plans about how to communicate with them, but there was no clear detail about what formats people needed information sharing in.
- Professionals and relatives reported a communication barrier between some staff and people, meaning people could not have a chat with staff. People and relatives told us, "Language is definitely a problem with some of the carers, the one I have at the moment doesn't understand", "The carers don't chat or generally communicate with my relative. It's not good. Communication is poor", "Some of the carers turn up and don't say a word" and "Dad is deaf. I couldn't understand the carer at all so dad wouldn't ever be able to understand them."
- Relatives told us that sometimes staff spoke to each other in a language their relative didn't understand and that this could cause confusion for the person and make them feel excluded.

This contributed to the breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Improving care quality in response to complaints or concerns

- The registered manager told us they had not received many complaints; however, some relatives told us they had raised concerns and not had a response, or their concerns had not been resolved.



# 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.

This is the first inspection for this newly registered service. This key question has been rated 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.

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

- People were not always enabled to achieve good outcomes. The model of care did not maximise people's choice, control and independence. It did not always focus on people's strengths or promote what they could do.
- Information about visits to people and the care provided was only recorded on the service's app. Relatives did not have access to this so were unable to see when staff had been to see their family member or what care had been provided. This meant they were unable to identify any changes they thought might benefit their family member.
- Staff meetings were held regularly but minutes did not show that there was opportunity for staff to raise ideas or concerns about people's needs or preferences. They mostly noted the registered manager telling staff of the consequences of doing anything wrong. A staff member told us staff had been shouted at during some meetings.
- A staff member raised concerns that rather than receiving support to improve their work, staff got suspended from their work for making mistakes which meant they did not receive full pay.
- A professional told us they did not feel staff received enough support from the registered manager to fulfil their role. Relatives also raised concerns about the treatment of the staff members by the organisation.
- Staff meetings had been held as late as 9.30pm. This was particularly late for staff who started work early in the morning. The registered manager told us this had been staff choice; however, they had not offered an alternative that did not compromise staff rest time.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A relative told us the registered manager was approachable. "I know the manager and I'm happy to talk to the agency because they listen to me".

Continuous learning and improving care

- The service's quality assurance system were ineffective and had failed to ensure compliance with the requirements of the regulations. Checks of the service had not highlighted the failings identified via the inspection.
- Regular checks were made of records such as MARs and people's daily notes. However, there were no

checks of people's records to see if they had had enough to eat or drink, had been supported to go out or to wash according to their preferences.

- Relatives told us they received phone calls to check whether they were happy with the service. However, relatives and professionals told us concerns raised had not all been dealt with adequately and some concerns were ongoing.

This contributed to the breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The registered manager had not ensured staff had the necessary skills, knowledge and guidance to enable them to provide consistently good quality care.
- The registered manager did not have a clear understanding of their responsibilities to report safeguarding concerns. They had not notified the Commission of all significant events which had occurred, in line with their legal obligations.

This contributed to the breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they were supported by the registered manager and felt able to approach them for advice and guidance.
- The registered manager knew people and staff.

Working in partnership with others

- The service worked with key organisations to support care provision. However, some professionals told us communication with the service was not always effective.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

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  The provider had not ensured staff had the correct guidance and information available to provide person-centred care.
Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent  The provider had not ensured the service met the principles of the Mental Capacity Act 2005 (MCA).
Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The provider had not ensured people were safe when using the service.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  The provider had not ensured people received support from consistent staff who had the right skills and experience.

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 17 HSCA RA Regulations 2014 Good governance  The provider had not ensured the service met best practice and that failings had been identified and acted upon.

### **The enforcement action we took:**

Requirement notice