Katie Moore

JK Caring for You

Inspection report

Lasyard House
Underhill Street
Bridgnorth
Shropshire
WV16 4BB

Tel: 01746862422
Website: www.jkforyou.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place 15 November 2018 and was announced.

We had previously carried out an announced comprehensive inspection of this service on 29 January and 22 February 2018. Two breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the safe management of people's medicines and governance practices.

This focused inspection, 15 November 2018, was prompted by a high volume of concerns and complaints shared with us by people using the service, their relatives and the local authority. These complaints were in relation to the safety and governance of the service. We also checked the provider had followed their action plan and to confirm whether they now met legal requirements. This report only covers our findings in relation to the key questions of safe and well-led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for JK Caring for You on our website at www.cqc.org.uk.

During this focused inspection four breaches of legal requirements were found. These breaches were in relation to the safe care and treatment of people, protecting people from abuse, staffing and governance. We found serious shortfalls in the management of risk, insufficient staffing levels and leadership and governance. The overall rating for this service has deteriorated from 'Requires Improvement' to 'Inadequate' and the service is therefore placed in 'special measures'. The overall rating for this service is Inadequate which means it will be in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

JK Caring for You is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It is registered to provide 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 61 people were using the service.

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

JK Caring is required to have a registered manager in post. They were present for our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive their medicines as prescribed. Where visits had been missed or were late, people had not received their medicines, which put them at risk of harm. Records relating to people's medicine were not always clear, accurate, complete or up to date. Staff did not always record when they had administered people's medicines. This placed people at serious risk of not receiving their medicines as prescribed.

People were placed at serious risk because the provider had not ensured people always received safe care and support. People did not always receive their planned care calls and staff were frequently late to people's homes.

The provider had not ensured sufficient plans had been put in place when considering how to reduce the potential risk of pressure sores. Information about one person's capacity to make their own decisions was contradictory, meaning they may not be involved in decisions about risk. This could impact on people's freedom, choice and control.

The provider had not ensured one person was protected against the risk of potential or on-going abuse as staff had not followed local safeguarding procedures.

The provider had not ensured there were sufficient staff to meet people's needs safely. People experienced late and missed calls and were not told when staff would be late. This placed people at serious risk of avoidable harm because their care needs were not always safely met.

We found there was a lack of management oversight and the systems and processes in place had not ensured that people received their care visits or medicines as planned and this had placed some people at risk of avoidable harm. The provider's action plan from our previous inspection, although instigated, had been ineffective in mitigating risks and breaches.

People and staff were not always given the information they needed and there was a lack of communication.

Complaints from people, relatives and external healthcare professionals had been responded to but had not been used to drive improvement within the service. The provider received a high volume of complaints

about missed and late calls and people not having their calls returned. This information had not been used to drive the required improvement to the service.

You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found that action had not been taken to improve safety. People were placed at serious risk of harm because their medicines were not managed safely, risk was not always managed and people were not always safeguarded against the risk of potential and on-going abuse. There were not sufficient staff to ensure people received their care calls when they needed them.

Is the service well-led?

Inadequate

We found action had not been taken to improve the key question of well-led. Although improved procedures had been put in place since our last inspection these were not monitored or followed by staff. Previous areas of concern identified at our last inspection continued to be found. Information from complaints and feedback about the service had not driven improvements.

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 was planned to check 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.

We undertook an announced focused inspection of JK Caring for You on 15 November 2018. This inspection was prompted by a high volume of concerns and complaints shared with us by people using the service, their relatives and the local authority. These complaints were in relation to the safety and governance of the service. We also checked the provider had followed their action plan and to confirm whether they now met legal requirements following our previous inspection on 29 January and 22 February 2018.

The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led? This is because of the concerns we received and the service not meeting some legal requirements. We did not inspect the remaining Key Questions. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The inspection was undertaken by two inspectors and one 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.

Prior to our inspection we asked the provider to notify people who used the service we would contact them and to ensure they consented to us contacting them. This was to gain their feedback and experiences of the care and support provided. We gave the provider notice of the inspection site visit to their office to be sure someone would be in.

Inspection activity started on 13 November 2018 and ended on 16 November 2018. It included speaking with people, their relatives and staff. We visited the office location on 15 November 2018 to see the registered manager, office and care staff; and to review care records and policies and procedures. During our inspection we spoke with 13 people and five relatives.

After our inspection the provider sent us their response to the concerns we identified and their action plan.

Inadequate

Is the service safe?

Our findings

At our previous inspection, we found the service was not consistently safe and had rated the safety of the service as requires improvement. The provider was in breach of regulation because they had not ensured people's medicines were managed safely at all times. At this inspection, we found a continuing breach of legal requirements because people's medicines were still not managed safely. We also found further breaches of legal requirements because people did not always receive their care calls on time, people were not safeguarded against on-going abuse and risk was not always managed to keep people safe.

The provider had failed to ensure people received their prescribed medicines safely. One person told us care staff had not given them their medicine during a recent care call. They told us, "One missed lot wouldn't matter." This person went on to tell us the care staff on this day had told them their care call was 15 minutes despite them having a planned 30-minute care call. They said they felt their care call was rushed and this was why they did not receive their medicine. This placed the person at risk of serious harm as care staff did not ensure they received their medicine as prescribed.

We found information in people's care and medicines records was contradictory and not always clear about the support people needed and the medicines they were prescribed. One person's records we viewed gave contradictory or unclear information across four records about their medicines and who had responsibility for administering them to the person. The records did not include detail about the person's topical medicine, what it was used for or where it was to be applied. The records did not give clear instruction on who was responsible for administering one of this person's medicines, yet staff had signed the medicine administration record to say they had administered it. This placed service users at risk of not receiving their medicines as prescribed because information was not clear about who had responsibility for the person's medicine

Medicine administration records (MARs) lacked detailed information. The side effects, the dose of medicine people were prescribed, how often they needed their medicine and how the medicine was to be administered was not available to care staff. This placed people at risk of harm because care staff may not understand the effects of the medicine they administer or how to administer them safely.

The provider did not have protocols in place for when people were prescribed 'as needed' or time sensitive medicines. There was also no information provided to staff on why the person may need these types of medicine. As needed and time sensitive medicine could be pain relief, antibiotics or inhalers and will be administered only when the person needs them or within a specific timeframe. Where people were prescribed 'one or two tablets', care staff did not record how many they had given. This is important as people are placed at risk of overdose if they exceed their prescribed amount of medicine. Where people were prescribed topical medicine, there was no information on where and why they needed these creams. This placed people at risk of harm because instruction was not available or made clear to staff.

The provider had not fully assessed and mitigated the risks to the health and safety of people. One person told us a care staff had not changed their wet incontinence pad and one relative told us when care staff were

late, their family member was often left in a wet bed. This increased their risk of developing sore skin and skin breakdown. Where one person had reduced mobility, the risk of damage to their skin was not sufficiently assessed to show how the risk was to be mitigated. This person had been assessed as at risk of pressure sores. There was little information on the measures in place to reduce the risk of this person experiencing skin breakdown, other than for staff to monitor and report changes in their skin. No information was given on what pressure relieving equipment had been considered or used to minimise risk. This placed people at a serious risk of skin breakdown and sores.

We found contradictory information on one person's capacity within their care records. Their plan of care stated they did not "give informed consent as is disabled". Their plan of care later stated the person was "able to communicate needs and wants and wishes". This placed this person at risk of not being involved in decisions about risk, which may impact on their freedom, choice and control.

These issues constitute a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured there were sufficient staff to keep people safe. Twelve people told us they had experienced missed and late calls. One person told us, "I phoned the office to say I had been missed and the office staff did not know who I was. It's just one call a day I have, if they turn up." They went on to tell us, "I have been missed but I still have to pay." Another person told us, "The staff don't come on time, they are always late. Sometimes the staff are one hour late, sometimes two hours late. I had personal care this morning at 9.45am and my next visit is due 12 noon." People were kept waiting, without being informed, for their care calls. One person told us care staff were often late and sometimes up to one and a half hours late. They had been left wet, in bed, due to care staff being late. After our inspection, the provider informed us, "It is also not true that the service charges people for missed calls. These charges and charges for very late calls are reversed on people's invoices." The provider sent us copies of invoices where charges for missed and "very" late calls had been refunded to people. However, these invoices confirmed that service users continued to receive late care calls, along with shortened and missed calls. This placed vulnerable people at risk of avoidable harm due to a lack of sufficient care staff to meet their needs.

Since our previous inspection we had received a high volume of complaints from people, relatives and whistleblower information informing us of missed calls, late calls and care staff rushing calls. Commissioners from the local authorities have reported concerns to us regarding the poor timeliness of care calls, including the high instances of missed calls. Data shows the provider has made some improvement recently, with the support of the local authority. However, people continue to experience late, missed and rushed care calls. This places people at serious risk of harm.

We viewed computer records which showed on one recent date there were six planned care calls not delivered. Although the system had an alert facility, the registered manager, senior care co-ordinator, business deputy and provider were not aware these care calls had been missed. Despite our concern these care calls had been missed, the registered manager could not provide evidence to confirm these care calls had taken place. We viewed the care records of two of the people who had not received their care call and found one person had dementia and one person needed a named medication administering to ensure their ongoing health. Following our inspection, the provider confirmed one person had not received their care call and had been missed. The other person had received their care call two hours late. The provider also confirmed the other people did receive their care calls, but staff had failed to record this. This placed people at risk of not receiving safe and agreed care and placed them at serious risk of avoidable harm.

In response to the concerns we raised and after our inspection, the provider told us, "For those who have

received a missed call, we are formally apologizing to (all) who have been affected by this transition period and for us not reaching targets as quickly as anticipated. No client should have been missed and all who are in our safety team throughout the improvement period are either dismissed or have received a warning. They are aware of the disciplinary procedure and what will happen if they do not make the immediate changes required in order to protect our service users."

These issues constitute a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered persons had not acted to redress an allegation of abuse or take the necessary steps to ensure the abuse was not continued. Where an allegation of abuse had been raised for one person, we found the registered persons had not followed a safeguarding plan which had been put into place by the local authority. An earlier concern had been raised by the person's relative and was subject to a safeguarding enquiry by the person's local authority. The safeguarding plan contained recommendations from other health professionals to protect the person from potential harm. Despite the registered person's working with the local authority to implement the safeguarding plan, they had not ensured this plan was followed by staff and recommendations followed. This placed the person at risk of continued abuse."

The provider had failed to ensure one person was safeguarded from continued abuse. The local authority had raised concerns with the registered manager that this person's safeguarding plan was not being followed by staff. The local authority substantiated the allegation of abuse. They found the risk to this person had not been reduced because staff had not adhered to the recommendations in the safeguarding plan. The registered persons had failed to redress the concerns and take necessary steps to ensure the alleged abuse was not continued. The registered manager told us they were not aware this concern was a safeguarding, despite it progressing through the safeguarding process. The registered manager told us there was no evidence of lessons learnt or reviewing the incident to ensure this situation did not reoccur for another person. After our inspection, the provider sent us an "information guide" which was part of a staff training guide, which had been updated in response to this incident. This placed people at risk of harm because systems and processes were not operated effectively or followed to prevent continued abuse.

These issues constitute a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of the spread of infection. People and relatives told us staff wore gloves and aprons where needed. However, one relative told us, "I feel the (care) staff we meet are often dirty themselves." They went on to tell us some staff had dirty nails and others did not wear gloves when they provided support. Staff told us they had received training in infection control and always had gloves and aprons available to them when they supported people. Care staff underwent 'spot checks' where their practice was observed. Part of this spot check was to ensure infection control procedures were followed.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, we found the service was not consistently well-led and had rated this key question as requires improvement. The provider was in breach of regulation because they had not ensured governance and quality systems which were in place improved the quality and safety of care provided. At this inspection, we found the provider had failed to make improvements and a continued to be in breach of legal requirements. This was because new procedures which had been put into place had not been implemented effectively, care records continued to be completed poorly and people continued to find communication with office staff difficult. We also found further improvement was required to ensure feedback about the service was used to drive improvement.

The provider had failed to monitor progress of their action plan and had not acted where progress was not achieved as expected. Following our previous inspection, we asked the provider to complete an action plan to tell us how they intended to make the improvements required. The registered manager confirmed this action plan had been completed and new procedures had been introduced. However, we found these actions and new procedures, which had been introduced, had not been monitored to ensure they were implemented effectively and followed by all staff. We looked at people's care records to ensure the actions had been embedded and monitored and found these new procedures were not implemented by staff. We looked at a new procedure for staff to follow when there was no record of a person having received their last prescribed medicine. The new procedure meant care staff had to contact office staff "immediately" if there was a recording gap. This was so the previous care staff could be contacted to ascertain whether they had administered the medicine. When we viewed medicine administration records, we found multiple gaps in recording which had not been followed up. This showed the new procedure was not being followed by staff or managers. This failure to monitor the implementation and effectiveness of the action plan placed people at risk of continued unsafe care.

The provider had failed to ensure people had accurate care plans in place and their care delivery was recorded effectively. At our previous inspection we identified people's care records were not always accurate, completed correctly or kept up to date. At this inspection we found the same concerns. One person's care plan stated they received four calls a day, although the lead co-ordinator advised us this person now only had one care call per day. The registered manager told us this was a care plan that required updating. We saw people had care records with no names on them or dates when assessments had taken place. One relative had also made a complaint when a different person's name had been written on their family member's care record. Medicine administration records continued to contain gaps in recording, which had not been followed up. Staff had scribbled out written entries and used correction fluid, which is against best practice. This placed people at risk because, when care records are not completed correctly, the provider cannot be assured people received their planned care and medicines as prescribed.

The provider had failed to ensure the systems in place to monitor medicine administration were effective. At our previous inspection we found quality systems were in place, but were not implemented effectively or monitored. At this inspection we found this was still the case. Completed medicine administration records (MARs) and daily logs were not returned to the provider office in a timely manner. One MAR was dated for

the period 28/7/18 to 31/8/18, but not received in the office until 15 October 2018. Although an audit had been completed on 15 October 2018, it had not identified a medicine had not been recorded as administered for eight days in August 2018, or that a patch application chart and body map had not been completed as per new procedures. The delay in records being audited means errors are not identified, which places people at risk. However, in this instance, despite the audit being completed, errors had still not been identified. We also saw "not to be audited" on some care records. The registered manager could not tell us why these records did not need auditing. After our inspection the provider told us they were, "prioritising auditing the newer records to check the new systems being implemented were reducing medicine errors". The registered manager told us they did not complete any formal audits or review completed audits or records and relied on the auditors to inform them of any errors. We saw in response to the auditor identifying issues with records they used a text message to remind staff of their responsibilities. After our inspection the provider told us issues were discussed with staff at supervision meetings and further training implemented. However, this practice continued with the auditor repeatedly reminding staff of the same responsibilities such as, using black pen and completing dates, times, names and signatures. These actions had not been effective in ensuring improvements were made and sustained. This lack of management oversight places the health, safety and wellbeing of people at serious risk of harm.

The provider had failed to implement systems which enabled people to communicate with them about their care. People and relatives told us they thought the culture and communication was poor from the office staff, this included managers. People told us they found it difficult to get in touch with office staff and when they did they did not always feel they were helpful. Two people felt they were often lied to about when their care call would happen when they telephoned to ask where care staff were. People also raised concerns that office staff did not return their calls when they left answer phone messages. This was important to them, as it was often when they had not received their planned care when they needed to speak to the office staff. One relative told us, "I have not spoken to the manager, if I leave a message on the answer machine no one gets back to me." This places people at risk of harm if they cannot contact office staff, when needed, to enquire about their care calls.

The provider had failed to consider or analyse people's views to drive improvement to the quality and safety of the service. Although the provider received complaints and feedback from people and relatives, this information had not been used to drive improvements in the service. Since our previous inspection we have received an increase in complaints. Local authorities have reported concerns to us regarding the volume of complaints they have received. The registered manager told us they had no action plan in place to make improvements based on service user's feedback. We viewed complaints the service had received and saw from June 2018, when the records started, to the end of October 2018 an average of 15 complaints were received each month. These complaints followed the same themes of people and relatives complaining of missed and late care calls, not being told when care staff would be late and not having their telephone calls returned by office staff. People had also completed a satisfaction survey in October 2018. Although there had been an improvement from the previous satisfaction survey in June 2018, the themes identified were similar to the complaints, with poor timekeeping and poor communication being uppermost. The registered manager told us they did not collate the satisfaction surveys and had not seen them; therefore, no action had been taken in response to these. After our inspection, the provider told us they contacted people who gave negative feedback to ask how the service could improve. Although the provider had gathered people's feedback and also used it in the creation of their action plan, we found it had not been effective in driving improvements to the quality and safety of the service

These issues constitute a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent to us statutory notifications, which are required by law, of specific events that occurred at the service. These may include incidents such as alleged abuse and serious injuries. These ensure that we are aware of important events and play a key role in our ongoing monitoring of services. However, the provider had failed to notify us of one allegation of abuse, which was substantiated. We discussed this with the registered manager who confirmed this notification had not been submitted. The provider had displayed the ratings from our previous inspection as required.