J.C.Michael Groups Ltd

J.C Michael Groups Ltd Bexley

Inspection report

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Date of inspection visit:
31 May 2018

Date of publication:
18 June 2020

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

We undertook an announced inspection on 31 May 2018 of JC Michael Groups Ltd Bexley.

JC Michael Groups Ltd Bexley is registered to provide the regulated activity personal care and provides personal care, housework and assistance with medicines in people's homes.

At the time of the inspection, the service was providing care and supporting 83 people and had 34 care workers working for them.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The business manager told us an application had been submitted to the CQC and this was still in progress.

At our last inspection on 5 October 2017, the service did not meet Regulations 9, 12 ,13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans were not kept up to date and there was no clear guidance on how people's care needs should be met, risks to people were not identified and managed, procedures for reporting safeguarding concerns were not always being followed appropriately and there were no effective quality assurance systems in place to monitor the service.

The service was rated Inadequate in well led and a warning notice was issued against the service. A focused inspection took place on the 4 January 2018 and we found the service had addressed the issues and met the warning notice we served. The rating for well led was improved to requires improvement. However, the provider had not sustained improvements in terms of the quality monitoring that were observed at our last inspection.

During this inspection, we found the service took sufficient action to meet Regulation 13. There were safeguarding and whistleblowing procedures in place. Training records confirmed that staff had received safeguarding training and were aware of how they would recognise abuse and what to do if the service did not act upon concerns. Accidents and incidents were recorded. Records showed any necessary action had been taken by management staff in response to the incidents. Records showed statutory notifications were completed and sent to CQC when required.

However, the service failed to take action to address the concerns identified in relation to Regulations 9 and 12. In addition to this, additional breaches of regulations were also identified.

People experienced a lack of consistency in the care they received. Care workers turned up late and people were not aware of which care worker was coming to support them.

Risks assessments were in place however risks to people were not identified and managed appropriately.

Arrangements in place to manage people's medicines were not sufficient to ensure people received their medicines safely and as prescribed.

Staff told us they received regular training and were supported in their roles. Appropriate checks were carried out when staff were recruited. However, people using the service and relatives told us they felt the care workers were not sufficiently trained to provide the care and support people needed.

Some people spoke positively about the care workers, however we found instances where people experienced a lack of consistency in the care demonstrated by staff and there were instances where people were not treated with dignity and respect.

Procedures were in place for receiving and responding to complaints. Formal complaints received had been responded to and resolved, however, people and relatives did not always feel listened to when they contacted the office to raise concerns.

Some action has been taken by the provider to assess and monitor the quality of service being provided. A business manager had been appointed to ensure the office was managed effectively. An action plan was in place and some measures had been taken to make improvements.

Staff we spoke with had an understanding of the principles of the Mental Capacity Act 2005 (MCA). Care plans contained information about the person's mental state and cognition. People were supported with their nutritional and hydration needs.

Staff told us that they received up to date information about the service and had an opportunity to share good practice and any concerns they had at team meetings. Staff spoke positively about working for the service.

We have made one recommendation about reviewing the effectiveness of current systems in relation to measuring staff performance.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

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

The service was not safe. Risk assessments did not clearly reflect the risks to people or how to manage these which put people at risk of avoidable harm.

There was a lack of consistency in the level of care being received by people as there were not always sufficient and competent staff deployed to meet people's needs.

Arrangements for managing people's medicines were not sufficient to ensure people received their medicines as prescribed. The administration and prompting of medicines to show people had received their prescribed medicines had not been recorded accurately

There were effective recruitment and selection procedures in place to ensure people were not at risk of being supported by people who were unsuitable.

Is the service effective?

Requires Improvement

Aspects of the service were not effective. Care workers received regular training however people using the service felt care workers were not sufficiently trained.

There were arrangements in place to obtain, and act in accordance with the consent of people using the service.

People's health care needs were detailed in their care plans.

Is the service caring?

Requires Improvement

There were aspects of the service which were not caring. There was a lack of consistency in the caring approach of staff.

There were instances where people's dignity and privacy was not respected and maintained.

Some positive caring relationships had developed between people using the service and staff.

Is the service responsive?

Requires Improvement

There were aspects of the service which were not responsive.

Care plans were not easy to follow and in different formats. It was unclear which care plans accurately represented people's needs.

There were procedures in place for receiving and responding to complaints.

Is the service well-led?

Inadequate

There were aspects of the service which were not well led. There was no registered manager in post.

There were no effective systems in place to monitor the quality of the service. The services failed to sustain improvements in terms of the quality monitoring.

People and relatives spoke positively about some aspects of the service but overall did not feel the service was well managed.

Some measures had been put in place to make improvements. An action plan was received after the inspection detailing action the service would take in response to the issues identified.

People and relatives spoke positively about some aspects of the service but overall did not feel the service was well managed.

Staff were supported by management and told us they were approachable if they had any concerns.

J.C Michael Groups Ltd Bexley

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 provide a rating for the service under the Care Act 2014.

This inspection was carried out by two inspectors who were supported by two experts 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. The provider was given 48 hours' notice of the inspection because the location provides a domiciliary care service and we wanted to make sure staff would be available for our inspection.

Before we visited the service, we checked the information we held about the service and the service provider including notifications of incidents affecting the safety and well-being of people. The provider had completed a PIR as they advised they had not received a request but would ensure this was completed. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 16 people using the service and 14 relatives. We also spoke with the business manager, office manager acting manager, two care co-dinators and five care workers. We reviewed seven people's care plans, five staff files, training records and records relating to the management of the service such as audits, policies and procedures.

Inadequate

Is the service safe?

Our findings

People using the service and relatives told us they felt safe with their care workers. People told us "Yes because my regular carer is a treasure", "Oh yes perfectly safe, she [regular care worker] is a very nice person, she is friendly", "Yes I do feel safe, I am really happy with her [care worker]. I know I can trust her" and "Absolutely safe, I like their good manners."

Relatives also told us "It is safe, at this time, it is very good", "Yes safe, everything is fine we are happy with the service" and "Yes definitely [safe]. I see her regularly [care worker], [person] is very happy with the carer." Despite these positive comments we found that the service was not always safe.

At our inspection on 5 October 2017, risks to people had not been identified or appropriately assessed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was received from the provider detailing what actions would be taken to meet this regulation. However, at this inspection, we found insufficient action had been taken to meet the regulation. Risk assessments were in place however we found risks to people were still not being identified and appropriately assessed.

For example, one person's care plan stated there were at risk of falls but there was no further information detailed and no risk assessment in place to indicate what support the person may need.

Another person's care plan stated they were registered blind however there was no information which identified or assessed any risk in relation to this or any detail of the specific support the person would need from staff.

The care plan of another person stated the person had diabetes, however there was no information about this condition, any possible symptoms the person may display and guidance on what staff should do in the event the person suffered a hypoglycaemic or hyperglycaemic episode. The care plan also stated the person was at risk of skin breakdown and infection, however there was no further information or guidance for staff to help minimise the risk of potential pressure sores.

There was limited information about the safe practice and risks associated with using equipment and appropriate moving and handling techniques required by care workers. For example, in one persons' care plan it stated the person mobilised with a Zimmer frame indoors and wheelchair outside. The care plan also stated the person needed support getting out of their wheelchair and walked slowly around their home. However, there were no details of the actual support needed, how many staff were needed to provide this and no mobility risk assessment identifying risks and providing guidance for staff on the appropriate moving and handling techniques to minimise the risk and keep the person safe from harm.

In another person's care plan, the risk assessment form stated the person had shoulder pain and arthritis in

the legs. However, in the section headed 'any requirements aids/equipment' it only stated 'S' which means 'support and assistance required', however there was no further information which detailed what this support was. The risk assessment also stated the 'person sleeps on sofa, painful shoulder' and stated 'S' which indicated the person needed some support, however again there was no information detailing what support was needed.

Although there was some information available about risks to people using the service, risk assessments did not clearly identify and reflect the potential risks to people or how these should be managed which could result in people receiving unsafe care. We also found that risk assessments were difficult to follow as they were handwritten and were not legible at times.

The above evidence demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some arrangements in place to manage peoples' medicines. People told us "I have confidence in them about this, I am happy with that" and "They make sure I have my medication I am very happy with this." Relatives told us "Yes, when I see the dosette the box it is correct. They bathe [person] and give medication I am happy" and "It is going along fine; the carer does watch it to make sure [person] takes it."

However, in people's care plans, we found instances where information was unclear as to what support people needed with their medicines and there was confusion between prompting medicines and assisting and administration. For example, in one care plan, it stated the person 'self-medicates' but then then went on to state, 'sometimes needs assistance in the morning'. However, there was no further information which detailed what assistance was needed and why. The risk assessment for one person, detailed that the person was able to manage their medicines however needed staff to remind them. However, there was no information which detailed what staff should do if the person did not take their medicines or refused to do so. In another care plan, it stated medicines were to be prompted however Medicines Administration Record (MAR) charts were completed for November and December 2017 for this person which indicated that staff had administered these.

We reviewed the MAR sheets for four people and found there were unexplained gaps for each person. For example, one MAR sheet showed there were gaps between the 22/1/2018 and 12/2/18 but there were no details of the reasons why. Another MAR sheet showed unexplained gaps for the 21 and 28 January 2018.

Records showed some checks of MAR sheets had been conducted by management staff. We were provided copies of medicines audits dated 1/11/2017, 15/2/2018, 22/2/2018 and 16/4/2018. The audits showed that some gaps had been identified and the relevant staff were to be contacted to explain the gaps. However, the audits were ineffective as there was no further information as to whether staff had been contacted and what further action had been taken and the gaps remained unexplained. The audit dated 1/11/2017 audited two MAR sheets covering January 2018 and concluded that the areas were met and there were no issues. However, when we reviewed the MAR Sheets we identified 13 gaps for this period which were not explained. The date of the audit was also inaccurate as it was dated 1//11/2017 but the MAR sheets audited were from the 1/1/2018 – 29/1/2018.

Staff had received medicines training and policies and procedures were in place. However, medicines competency assessments were not in place to ensure staff were assessed as competent to support people with their medicines.

The above evidence shows the arrangements in place to manage people's medicines were not sufficient to

ensure people received their medicines safely and as prescribed. The administration and prompting of medicines to show people had received their prescribed medicines had not been recorded accurately.

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

The service did not have an effective system to ensure there were sufficient numbers of suitable staff to meet people's needs safely and in a timely manner.

Feedback from some people and relatives told us staff turned up on time. They told us "She [care worker] generally is on time, she rings to let me know if she is going to be late" and "She [care worker] arrives on time, together we arrange the time for the next day." Relatives told us "She [care worker] comes at 8am, most of the time, but if she is late, she will always let us know" and "If the carer is late they call me, then, they come within 10 minutes."

However, the majority of feedback from people and relatives was that staff were arriving late for their visits. People told us "They come at different times" and "There have been occasions, when the carer was very late, I rang them, they didn't let me know, the carer was running very late." Relatives told us "I don't know what time they are due to arrive", "It's problems with the timing of visits, I can't do things, I don't know when they are coming. They once came at 7am and gave me a shock" and "My relative doesn't know what time they are coming, they do not inform them, if they are going to be late."

People experienced a lack of consistency in the care they received and were not aware of which staff member was coming to support them as they were not routinely informed. We asked people using the service and relatives whether they had the same care workers on a regular basis and received varying feedback from people. Some people told us "I mainly have one carer", "Same carer every morning, she is a lovely person" and "Same carer comes in the morning and another carer in the evening."

However, the majority of feedback from people relatives was that staff were not consistent and they were not aware of who was coming to support them with their care. People told us "I don't always feel that safe that I have a key safe and there are lots of different people all the time. It makes me feel uncomfortable" and "I do feel safe generally but it's the uncertainty of it all that I don't like and all the different people."

Relatives told us "We are not notified about new carers. The communication is not great", "Previously it was often the same lady but over recent weeks my concern is that it is different people and we just don't know who to expect. Recognising the person is so important for my [relative] who has dementia and so all these different people affects them". "It's absolutely atrocious care they provide. The timekeeping is terrible" and "They don't ever let [person] know if they are running late and quite often we think they may not be coming."

Some people and relatives also voiced their concerns about staff using the key safe to let themselves into people's homes especially when people were not aware of which staff member was due to attend. One person told us "My main carer has been off sick for a while and it's all gone wrong since then. It's supposed to be twice a day visits but they are often late or occasionally they don't turn up. I sit there waiting for somebody to turn up to wash and dress me. One day nobody came until 7pm in the evening. I was waiting all day. It frightened me when they did come in that late as they used the key safe and just came in."

One relative told us of an instance in which a staff member had no knowledge of using a key safe. They told us "He [care worker] said he didn't know how to work the key safe. They should ensure the carers know this before sending them out. He didn't know what to do and didn't look at the care plan. I feel very nervous

leaving [person]. Sometimes they don't get to [person] until gone 10am and until 2pm at lunch. A couple of times [person] has tried to start lunch on their own as they haven't turned up and that's not safe."

We received some feedback that the office staff had responded to some concerns raised by people and relatives about care workers timekeeping. They told us "My regular carer is on time but not the others, I never knew what time they were coming. At 11am I was sitting in my house waiting for the carer, I rang and said I was going to leave [the service] they changed back to my old carer and she is on time" and "Previously we didn't know who was coming or what time they were coming. We talked to the office two weeks ago and they have addressed this. In the last few weeks we have a regular carer."

The service used an electronic call monitoring system (ECM) to monitor calls and staff timekeeping. The system would flag up an alert if a member of staff had not logged a call. Office staff told us they would then call the care worker to find out why they were late however there were no notes recorded on the ECM system that this action had been taken and explanations provided of why people had not received their call at the scheduled time.

We reviewed monitoring reports for the 29, 30 and 31 May 2018 and we found there were many late calls and the office staff had not followed them up to establish why they were late. The monitoring report also showed that care workers were not staying the allocated time their visits required. For example, on the 30 May, the report showed a planned visit from 10am until 10.45, however the entry showed staff arrived at 10.42 and finished at 10.51, which is less than 10 minutes for a 45 minute call. Another entry showed a planned visit from 10am until 11am, however the report showed the staff arrived at 10.10 and finished the call at 10.30, which is 20 minutes for a one hour visit.

On the actual day of the inspection, on the 31 May, the report showed a planned visit from 12.30 until 13.00, however staff arrived at 12.23 and finished at 12.40, which meant only 17 minutes were attended for a 30 minute call. Another entry showed a planned visit for 8.30 to 9.15, however the report showed the staff member attended at 8.29 and finished at 8.56 which is 27 minutes for a 45 minute call.

We raised this with the management staff who were unable to tell us why the calls were late and why staff were not staying their allotted times as required.

There were some entries that were blank and we asked what the reason for this was. The acting manager told us those entries represented staff who did not have a phone to log in and out calls. This meant the service were unable to establish whether these calls had been attended to or not and what times the care workers had arrived and left.

There were no audits conducted to assess the timekeeping of care workers to ensure people received their care in a timely manner or any records checked to assess whether the times recorded by care workers were accurate.

Daily records of the care and support provided by staff were completed each day. However, we received feedback that these were being completed before the care had been provided and the times when staff started and finished were not being accurately recorded.

One person told us "They [staff] write in the folder before they have done anything and make up the times. Nobody has been through the care plan or been to see how things are going. None of the carers look at the care plan. They haven't a clue."

Relatives told us "I lay everything out ready for them to help [person] and I leave the book ready for them to fill in. What I don't understand is that they fill the book out with the times they arrive, the times they leave and what they have done before they even start doing anything, for example she [care worker] did this again this bank holiday Monday. Instead of her getting up and getting on with helping [person] she arrived and immediately wrote in the book '… Assisted with shower, creamed legs….and left [person] comfortable with wife' before she had even started. They fill in the book as if they have finished. What if [person] was to fall or something happened during the visit. It just isn't right."

Another relative told us "They should be here for an hour in the morning and they were here for 30 minutes but logged 50 minutes. The other visit should be half an hour and its usually about seven minutes but they write 30 minutes and they log incorrect times. They will sometimes leave the daily logs and fill it in the next day; just making it up."

The above evidence demonstrates the service did not have an effective system to ensure the effective deployment of staff to keep people safe and meet their needs in a timely manner which resulted in a lack of consistency and continuity with people's care.

The above evidence demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 5 October 2017, the provider's procedures for reporting safeguarding concerns to the local authority were not always being followed appropriately and not all staff were aware of what to do if their manager or head office had not acted upon concerns reported to them. These issues were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

An action plan was received from the provider to show what actions would be taken to meet this regulation. During this inspection, we found the provider has taken sufficient action to meet the regulation.

There were safeguarding and whistleblowing procedures in place. Training records confirmed that staff had received safeguarding training. When speaking with staff they were aware of how they would recognise abuse and what to do if the service did not act upon concerns. They told us "We need to protect vulnerable adults from harm and abuse. I will report it to my manager. If they don't do anything, I will whistleblow. I can also contact the social services and the Police" and "Safeguarding is about abuse, strange marks on the body and neglect. You have to be very vigilant. I will contact the manager straight away. I can also call social services and CQC."

Accidents and incidents were recorded. Records showed any necessary action had been taken by management staff in response to the incidents. Records showed statutory notifications were completed and sent to CQC when required.

There were effective recruitment and selection procedures in place to ensure people were safe and not at risk of being supported by staff that were unsuitable. We looked at the recruitment records for five members of staff and found appropriate background checks had been completed. These included checking employment histories, proof of identify and right to work in the UK. Satisfactory references were obtained and enhanced criminal record checks had been undertaken to ensure staff were of good character.

The service had an infection control policy and records showed staff had received training in infection control. Staff were aware of infection control measures and said they had access to gloves and aprons. People told us that staff observed hygienic practices when providing care, however they told us some staff

did not wear aprons. When speaking to staff they told us they had access to protective clothing which was available in the office to collect.

Requires Improvement

Is the service effective?

Our findings

We asked people and their relatives about the care workers and if they felt they had enough knowledge and skills to provide the care and support they needed. We received mixed feedback from people and relatives about this.

Some people and relatives spoke positively about staff. People told us "They are good". "I definitely think so, [skilled and experienced]", "She [care worker] was new when she came to me, she is good. She always asks if there is anything else she can do", "They are. I ask them to do anything and they are willing to do it" and "Yes, they get on with things and know what they are doing. They help me and wash me."

Relatives told us "Yes I do, my relative is very satisfied with the main carer, she is very good" and "They all seem to know what they are doing".

However, some people and relatives did not feel staff were competent to carry out their roles. They told us "The new carers don't always know what to do", "The new carers do not shadow experienced staff and are not properly introduced, my relative has to show the carers what to do", "I don't think there is any evidence that they have training" and "If I was running this business I would certainly give them a lot more training. I don't feel confident that they are highly trained. They have to be told everything."

We looked at five staff files and found staff had received supervision and annual appraisals to monitor their performance. Records showed staff had received an induction. The service had implemented the Care Certificate which staff had achieved. The Care Certificate is the benchmark that has been set for the induction standard for people working in care. Training records showed that care workers had completed training in areas that helped them to provide the support people needed and included safeguarding, medicines management and moving and handling.

Staff confirmed they received regular training which included practical moving and handling sessions. A staff member told us "The training is good. Manual handling. We have to go to the Head Office. They show us how to do it and use the slide sheets. It's quite interesting."

Records showed that some spot checks had been conducted to monitor staff performance however records showed these were not conducted on a regular basis. For example, in one person's care plan, the last spot check was conducted on the 23/11/17. The spot check showed the staff member was not wearing an identification badge as it had expired however there were no further details documented to show any action taken by the manager. Some people's care plans contained no information about spot checks being undertaken.

Feedback from people and relatives demonstrated that the training provided to care workers had not been fully understood or consistently applied by staff in their behaviours and best practice when providing care and support for people using the service. The performance of staff had not been assessed effectively to ensure staff were competent enough to provide the level of careand support to meet people's needs.

We recommend the service review their existing systems including spot checks to measure the effectiveness of the training provided to care workers and ensure staff performance and their competence is assessed so any shortfalls in their performance are promptly identified and addressed.

People's needs were assessed by office staff with people and their relative's participation where appropriate. A service user needs assessment was completed and this was used to form a care plan based on the needs identified.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We reviewed whether the service was working within the principles of the MCA. We noted that care plans contained some information about the person's mental state and cognition. Where people were unable to give verbal consent, records showed the person's next of kin (where appropriate) and healthcare professionals were involved to get information about the person's preferences, care and support and decisions were made in the person's best interests.

People and relatives told us staff asked for their consent before undertaking care. They told us "Yes they ask and I tell them what I want" and "They ask before doing things."

Records showed that staff had received MCA training. When speaking with staff, they were aware of the importance of obtaining people's consent regarding their care, support and treatment and if people needed support with decisions, then family and relevant healthcare professionals would need to be involved.

Care plans contained information about people's medical history. We received positive feedback from people and relatives which showed staff supported them to access healthcare professionals in accordance with their needs. People told us "My carer came with me to the doctors, waited for me and took me back home", "I wasn't well, she got me to bed and gave me flannel, she rang my relative They are looking after me. They call the doctor if needed", "Yes, my regular carer, when I have to go to the hospital, makes sure she comes early to shower me and makes sure I am ready for the ambulance people" and "One of the carers I think, probably did save my life as she picked up that I wasn't well and she called for an ambulance. It turned out that I had [medical condition] and got treated in hospital."

People were supported with their nutritional and hydration needs. Areas in which people needed support with their food and drink were highlighted in their care plans. People and relatives spoke positively about the support they received with their nutritional and hydration needs and staff supported people with any specific requirements. People told us "They make me my meals", "She [care worker] offers it to me, puts a meal in the microwave, puts out a dessert. She does it very well" and "She gets my breakfast laid out for me and makes me a cup of tea. I have gluten free cereal every day."

Relatives told us "Sometimes she [care worker] helps with meals. We have shown her what to do as we are vegan, she [care worker] respects this", "They do get their breakfast for them. [Person] does choose it but has the same every day", "They only come to do us a meal. We choose the frozen meal we want and they heat it in the microwave and they ask what drink we want. They go as soon as they have cooked it and we clear up ourselves. They are quite pleasant."

Requires Improvement

Is the service caring?

Our findings

People and relatives spoke positively about the way they were looked after. People told us "Yes they are caring and kind", "She [care worker] is a very nice person, she is friendly", "She gets on with me and I get with her, she is brilliant", "She is a very lovely girl she is very kind, she is good with my family too" and "They are good carers and do all that I ask of them."

Relatives told us "Yes at the moment the carer is a very nice girl", "All quite good, [care worker] is nice, kind and caring and consistent with her timing" and "My [relative] says they are very happy with the main carer."

We received some good feedback and examples from people and relatives which indicated there were positive caring relationships between them and staff. They told us "He [care worker] is good, it's a good relationship. It's nice to have someone in your home I am comfortable with" and "Yes definitely caring. She [care worker] does make [person] laugh it is therapeutic, I like that they are both in stitches (laughing)."

People and relatives told us their privacy and dignity was maintained and respected. People told us "They pretty much respect me", "Never been rude to me, they have been polite", "Yes, they don't open the window or door, until I am dressed", "They do, I am a very private person, I am happy with how they wash and shower me", "I said I didn't want a male carer, they have never sent a male carer" and "The gentleman carer I have is quite polite and thoughtful. I need help with washing and getting dressed and undressed and he is very thorough when he washes me."

Relatives told us "Yes, they do respect privacy", "She [care worker] is polite and very nice to my relative" and "My relative likes the door to be closed, the carer knows to do this."

Staff were able to tell us how they maintained people's privacy and dignity. They told us "I will tell them what I am doing and cover them to keep their privacy", "You keep them covered where you can. It's their dignity", "I close the door. I will talk to them as I am supporting them and always make sure we laugh and talk together."

However, we found there were instances in which staff were not caring and people's privacy and dignity had not been respected and maintained.

One person told us, "I use a stair lift and was upstairs using the toilet. The carer was downstairs and called out that she was going. I said, 'So you are going and leaving me upstairs on the toilet' There is a real lack of caring. If they could train their carers to be more kind and polite then that would be a start."

Relatives told us "They are too busy. They don't sit and have a chat. They just rush in and out. They don't really talk to [person]. [Person] is a proper gentleman and for example he likes a proper shave and I don't think they like that he wants a proper shave. They are overly busy."

Another relative told us "It's absolutely atrocious care they provide. It makes you not want to have them

around. [Person] isn't just a piece of meat. Initially there were 2 male carers, one of them ruled the roost and was telling us what to do and what time he would be coming in. He had a very rude attitude and even threw [person's] dirty pads and dirty pyjamas all over the carpet. You just couldn't make it up. [Person] has some dementia and it's been so stressful to see their decline and to watch these people coming in and not really care."

People and relatives also told us that some staff did not communicate with people and staff would talk amongst themselves in their own language. They told us "They are very young and don't say much. One of them doesn't say a word", "Some have a heavy accent and [person] is 86 and doesn't necessarily understand all they say and so it's hard for her. She tells me that she gets the 'gist' of it" and "They will speak in their own language to each other which makes us feel uncomfortable as it's clear they are saying things they don't want us to understand" and "[Person] likes to talk to the carers but some don't talk at all. [Person] has said to them, 'Why don't you talk?' There are a couple who shout sometimes as they are quite bossy but [person] has found a way of dealing with that. They say, 'Why are you shouting?' or they shout back and they don't like that, it seems to work."

One relative told us a care worker was speaking to someone else using a telephone earpiece whilst supporting a person with their care. They told also us "One of the first things they also do is plug their phones into our socket to charge up their phones. They all do it and they don't ask whether its ok."

The above evidence demonstrates a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some arrangements in place to ensure people were involved in expressing their views and being involved with the planning of care. Records showed that review of care meetings had been conducted with people in which aspects of their care was discussed.

When speaking to people and relatives, they confirmed they had a review, some however stated they had not or the reviews were not as regular which could indicate that some people's needs were not being identified and met when they changed or that some people were not being involved in decisions about their care.

Care support plans included information about people's religious and cultural preferences. Staff showed awareness of equality and diversity. They told us "You treat everyone equally whatever your race, gender and age", "Not to discriminate against anyone, there is no difference, we are equal" and "We are all equal and there should be no discrimination."

Requires Improvement

Is the service responsive?

Our findings

At our inspection on 5 October 2017, care plans were not always well organised, easy to read and complete. Care plans did not always accurately reflect people's current needs and the support they required from staff. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was received from the provider detailing what actions would be taken to meet this regulation. However, at this inspection, we found insufficient action had been taken to meet the regulation and care plans were not easy to follow and did not always accurately reflect people's current needs and the support they required from staff.

For example, for one person we noted their medicines were listed and staff were to prompt the medicines however MAR sheets were completed for November and December 2017. The care plan did not detail why MAR charts were introduced and then stopped after December 2017. We asked the office manager about this who told us it was because the person was very ill in November and December and could not self-administer then. The person was better in January 2018 and then the family administered the medicines, however the care plan had not been updated to reflect this.

At the last inspection, the service implemented a new electronic care planning system which would mean all care plans would be transferred to the new system and would be electronically held. However, during this inspection, we found not all care plans had been transferred to the new system, some care plans were submitted to us using a paper format, some were printed off the new care planning system. Some care plans were in the old format and did not include the service's new name and used the old name. We were presented with three files which contained a care plan breakdown. We asked to see the care plans and were advised by the office manager that they were the care plans. However, the acting manager told us they were not the care plans and printed off the actual care plans from the electronic system.

It was not clear which care plans were being used to reflect the actual care people required and due to the different formats being used risks to be people were also not being appropriately identified and managed. This placed people at risk of receiving unsafe and inappropriate care.

This is a continuing breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were policies and procedures for receiving and responding to complaints. Records showed that five complaints had been received and all had been responded to by management staff. Any follow up action was also implemented such as additional training or supervision for staff if needed in response to complaints received. For example, in response to a complaint made about a care worker completing their daily logs incorrectly, the care worker had been called in for supervision and additional training had been given in relation to record keeping.

Some people and relatives had expressed when they had raised concerns, these had been addressed. A person told us "I've had experiences where I've been put to bed at 8pm and then the morning carer hasn't turned up until 10.30am. I did complain and it hasn't happened since."

Inadequate

Is the service well-led?

Our findings

At our inspection on 5 October 2017, we found there was a lack of effective quality assurance systems in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enforcement action was taken and during our inspection 4 January 2018 we found the service had taken some action to meet the regulation. However, at this inspection we found the provider had not sustained improvements in terms of the quality monitoring that were observed at our last inspection.

We found there was a failure to take sufficient action to address the concerns identified in the last inspection on the 5 October 2017. In addition to this, additional concerns had been identified for improvement such as no checks done on ECM monitoring reports and staff timekeeping, no regular spot checks to assess staff behaviour and lack of robust medicines management.

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

Some action had been taken by the provider to monitor the service and ensure it was being managed effectively. There was no registered manager in place. However, we were advised an application had been submitted to the CQC and they were awaiting to hear from the CQC registrations team. This was being followed up by the provider to ensure they met their condition of registration to have a registered manager in place.

A business manager had been appointed to support the service and had been in post for over a month. The business manager told us he was aware there were issues with the service and had already started to take steps to ensure measures were in place to address the issues. For example, an operations audit had been completed on the 21 May 2018 which covered areas such as medicines management, call monitoring, care planning and risk assessments. Recommendations highlighted included the business manager to oversee all missed calls and ensure this was continuously reviewed, a service evaluation to be sent out to get current feedback from people and relatives and all care plans and risk assessment templates to be adopted into JC Michaels templates and the templates reviewed to provide a more robust care plan and risk assessment.

We also received an action plan following the inspection which showed us additional action the business manager advised they will be taking. This included medicines competency assessments for staff, all care plans and risk assessments to be uploaded onto the electronic system to ensure consistency in content and format, spot checks to be undertaken to assess and monitor staff behaviours and regular monitoring checks on the ECM system. The action plan also highlighted and the business manager confirmed they will be reviewing and taking disciplinary action for consistent late or missed visits by care workers, not completing their times accurately in daily logs and not staying their allocated times per visits. The office staff were also to undergo refresher training to improve their quality of communication.

There were some arrangements in place to seek feedback from people using the service and their relatives.

Postal questionnaires had been sent out and received in November 2017. We reviewed eleven questionnaires and found people provided positive feedback about their care workers. Comments included "I am very happy with my carer and wish her to continue. She is very good at her job", "[Care worker] is excellent and I enjoy her presence" and "Please let [care workers] know that the job they are doing is superb."

Negative feedback was provided about the office management and staff who covered visits. Comments included 'Service is poorly organised. Never know if or when carer is coming. Not informed when carer changes or times they are coming. Some carers are very good. Others are indifferent and not very caring' and 'Can [staff] come at the same time every day as it disturbs my sleep pattern.'

Records showed the questionnaires had been analysed to identified areas of improvement which the business manager confirmed would be acted upon. We will check this at our next visit

Telephone monitoring was also conducted on 21 May 2018 and 30 May 2018. We reviewed 10 questionnaires. The questionnaires covered areas such as timekeeping, staff behaviour, office management and whether staff respected people and offered choices. Some questionnaires included positive comments and people were satisfied with their care especially with their main carers. Comments included '[Staff] member is fantastic and I am very happy', '[Staff member] is new to [person] but brilliant, very happy stays her time, we absolutely love her. Always on time, patient and caring' and '[Staff member] was an amazing carer who had a great relationship with [person].'

However, there was also negative feedback about the office management and staff who covered visits. The comments included 'The office are not very organised. Feel like the covers are not done very well', 'When main carer is off the cover can be very late. The office doesn't call back', 'The main carer does not work weekends and I have to do with new faces' and '[Staff member] is not very good, doesn't write leave time in book and comes late in the morning.'

The business manager told us that these would be reviewed and negative feedback would be followed up. The business manager told us that they would ensure all the measures proposed were acted upon immediately and improvements would be made. He also told us that any good practice within their services would be shared so people received a consistent level of care from the provider organisation.

We received mixed feedback from people and relatives when asked whether they considered the management and office staff to be approachable and easy to contact.

They told us "No need to ring them, never had a problem with this agency", "The girls on the switchboard are very good", "The [office] are as nice as they can be" and "The office are very good when I speak on the phone and do what I ask."

However, some people told us "I have been on the phone when they didn't turn up, I rang [office] she was very apologetic", "They listen and they say they are very sorry, but never ring you back and don't address the issue raised" and "Communication from the office is dreadful, that's the biggest issue. They are okay, when you ring to ask which carer is coming and when, you have to push them, i.e. ask them to ring you back, they don't do this."

Records showed there were staff meetings where staff received up to date information and had an

opportunity to share good practice and any other concerns. Staff told us "They give us updates and we can ask questions and advise on what to do", "It is open and you are able to say what you want" and "They give us feedback about clients and tell us what we need to do."

Care workers spoke positively about working for the service and the management. They told us "Its fine. It's good", "I am enjoying the job", "It is good. I enjoy the care work. I have regular clients. It's okay" and "They are okay to work with."

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 It was not clear which care plans were being used to reflect the actual care people required. This placed people at risk of receiving unsafe and inappropriate care Regulation 9 (1) (a) (b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The current systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people. Regulation 17(1) (2) (a) (e)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There insufficient numbers of suitable staff deployed to keep people safe and meet their needs. Regulation 18 (1)

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 10 HSCA RA Regulations 2014 Dignity and respect There were instances where people were not treated with respect. Regulation 10 (1)

The enforcement action we took:

A warning notice has been served.

The provider is required to become compliant with Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 20 July 2018

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not identified and managed appropriately. People were at risk of not receiving their medication safely and the administration and prompting of medicines to show people had received their prescribed medicines had not been recorded accurately. Regulation 12 (1) (2) (a) (g)

The enforcement action we took:

A warning notice has been served.

The provider is required to become compliant with Regulation 12 (1) (2) (a) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 20 July 2018