Genuine Carers Limited

Genuine Carers - Kirklees

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Genuine Carers – Kirklees is a domiciliary care agency which provides personal care to people in their own homes. At the time of our inspection, 31 people were receiving a 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.

People's experience of using this service and what we found
People and relatives experience of the care provided significantly varied. Some people and relatives were enthusiastic about the service, whilst others had poor experiences. Some people and relatives said they had experienced missed calls. We received mixed feedback about the timeliness of calls and records did not show call times were reliable. The provider did not have adequate oversight of the service people received. Recruitment records were not sufficiently robust.

Systems to assess, monitor and review the quality of the service were not adequate. The provider did not have systems in place to check people received a suitable service. Insufficient action had been taken to ensure confidentiality was maintained. Spot checks of care packages were increased following our inspection.

Staff understood their safeguarding responsibilities, although recording of safeguarding incidents was not robust.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; however, the systems in the service did not support this practice. There was an absence of mental capacity assessments and consent to care records as these had not been carried out. These records were created following our inspection.

We were not assured the management of medicines was safe. Some of the feedback we received indicated medicines had not been administered on some occasions. Medication records were not being robustly reviewed. Staff were trained in administering medicines and had their competency checked.

Risks to people were routinely being assessed and staff were aware of risks to people. With one exception, people and relatives consistently told us staff always wore their PPE.

With one exception, which the provider addressed, we found people received support to access healthcare services when they needed this. Staff assisted people in the preparation of meals and received training in food hygiene. Staff received formal support through meetings, supervision and appraisals.

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

Rating at last inspection
The last rating for this service was good (published 2 May 2019).

Why we inspected
The inspection was prompted in part due to concerns received about missed calls, the culture within the service and maintaining confidentiality. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

The provider has taken action since the inspection which they expect will improve the service quality. However, we need to see these systems are effective and sustained over an extended period.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

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

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

We have identified breaches in relation to the reliability and punctuality of visits to people's homes, the safe management of medicines, recording consent and mental capacity, plus systems to ensure oversight and quality of care provided.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Genuine Carers - Kirklees

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
This inspection was carried out by one inspector. Following our visit to the provider's office, an Expert-by-Experience made phone calls to people and their representatives to gather feedback about their experience of the care they received. 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.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

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

Inspection activity started on 14 March 2022 and ended on 5 May 2022. We visited the location's office on 16 March 2022.

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

from Healthwatch, the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the Inspection
We spoke with four people who received a service and eight relatives of people who received a service.

We spoke with the nominated individual, two operations managers, the registered manager, a care coordinator and four care workers. The nominated individual was responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records, as well as medication records. We looked at the recruitment of four staff members as well as records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at further quality assurance and training records.

Inadequate

Is the service safe?

Our findings

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

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

Staffing and recruitment
• The service people received varied in its reliability and recruitment procedures were not robust.
• People's experience of the attendance, timeliness and consistency of staffing varied widely.
• We were contacted by a relative shortly after we visited the provider's office. We were told that two calls had been missed in March 2022 and the person affected had gone without personal care and a meal or snack.
• Other relatives told us, "This morning, they didn't arrive for the 9am call until 10.10am. A few months ago, nobody turned up at the weekend at all and we just got left", "There has been a missed call recently, although I can't remember exactly when that was. It has happened before" and "They (staff) can be anything from 45 minutes early, to 45 minutes late."
• In an email response to us dated February 2022, the nominated individual said, 'Often the carers swap shifts between themselves last minute, and management are not always aware'. However, the provider used an electronic system intended to flag when calls were more than 60 minutes late. There was limited evidence of active monitoring of calls and this was demonstrated in the provider not identifying missed calls on occasions.
• We looked at call times for one week in March 2022. This showed 789 occasions when call times were recorded. Over 300 instances were seen where the call time was recorded as either over an hour early or an hour late.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service people received was not reliable.

• Other feedback we received was more positive, indicating that staff turned up on time, with consistent staff carrying out visits and staying for the full duration.
• Following our inspection, the provider told us they were introducing more robust call monitoring and systems to ensure people's care needs were met.
• We looked at recruitment records for two staff members and found concerns.
• Two staff had not completed their education and work histories and this had not been followed up by the provider. Document checklists had not been signed off to confirm all relevant checks had been completed.

Using medicines safely
• Medicines were not safely managed.
• Medication records were not being reviewed and medication audits were not fully effective. This meant there was a risk that people were not receiving their medicines as prescribed.
• We received mixed feedback about the management of medicines from people and their relatives. One

person told us, "They (staff) did miss my medication once last week and I did complain to [registered manager]." A relative told us staff had not recorded the administration of medicines on two consecutive nights and that some new staff were not aware that tablets for their family member had to be crushed. A further relative said that creams were not consistently been recorded as applied and that prescriber instructions around the minimum time needed between the administration of medicines was not always followed due to irregular call times. The same person was found with medicines in their bed.
• Medication records which were signed as audited showed gaps, which had not been identified through the audit. It wasn't clear if these discrepancies had been followed up.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we were not assured that people received their medicines as prescribed.

• Staff received medication training and had their competency checked. Following our inspection, all staff were retrained in medicines management.

Systems and processes to safeguard people from the risk of abuse
• Safeguarding incidents were not being consistently recorded.
• We looked at the safeguarding log and found incidents we reported to the provider prior to our inspection were not recorded. Incidents where missed calls had occurred had not been recorded as safeguarding incidents.
• One relative spoke about concerns raised by a visiting professional and a member of Genuine Carers staff who both expressed concerns about personal care not being provided. This was not recorded on the safeguarding log.
• We received mixed feedback about people feeling safe. One relative was concerned about their key safe not being left secure by staff. However, another relative said, "If it's [staff name] or [staff name] doing the call, I know [relative] is in safe hands."
• Following our inspection, the provider has reviewed how they record safeguarding incidents.

Assessing risk, safety monitoring and management
• Risks to people were routinely assessed, but not consistently kept up-to-date.
• Most people said relevant risk assessments were in place when their care package started. However, one relative said their care records, including risk assessments, were missing for the first two weeks of their service being provided.
• We looked at one person's risk assessment for falls after an incident in September 2021. Their falls risk assessment was updated at the end of October 2021, although a member of staff told us this person did not receive a service for three of those weeks in between. The most recent risk assessment for the same person did not reflect they were using a specific piece of equipment for their mobility needs. The registered manager updated this record during our inspection.
• One person told us, "They did a full risk assessment and went through my care needs when they first started. It gave me confidence."

Preventing and controlling infection
• Suitable infection control steps were usually being followed.
• However, one relative told us they witnessed a care worker using the same gloves during personal care whilst giving a person their medicines. The provider took appropriate action in response to this feedback.
• Other relatives consistently commented positively about staff using PPE correctly. Feedback included, "I like (staff) to wear their face masks and gloves and they do this always" and "They always wear their full PPE and take it away with them."

Learning lessons when things go wrong
• There was limited evidence of lessons learned prior to our inspection.
• The provider had not identified areas where improvements were needed as systems to monitor performance were absent.

Requires Improvement

Is the service effective?

Our findings

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

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

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

• Care was being provided for people who were unable to give their consent to this as they lacked capacity to do so. The provider was unable to produce records to show they had assessed people's capacity and completed best interest decisions as needed for those people. Consent to care was also not recorded.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records of people's mental capacity and consent were not in place.

• Following our inspection, an operations manager created mental capacity assessments which they shared with us.
• Staff we spoke with had received training in the MCA and could describe how they offered choice to people.

Staff support: induction, training, skills and experience
• Induction records had not been created, although staff were receiving ongoing support through training and supervision.
• The registered manager told us there was no recorded overview of the staff induction provided as this was given verbally. The nominated individual showed the registered manager a form to use for this, but the registered manager said they had never seen it. Staff confirmed they received a suitable induction.
• The staff training matrix showed high completion levels. Training was also provided in specialist subjects, such as epilepsy awareness, Parkinson's disease and use of percutaneous endoscopic gastrostomy (PEG) to ensure people received adequate nutrition.

• One person told us, "They (staff) seem well trained for the job and when they are new, they soon get the hang of the work that needs to be done."
• Ongoing staff support was being provided through supervision and appraisals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The provider and staff worked with healthcare services to meet people's needs. This was also evident in care records we looked at.
• However, an incident in January 2022 showed that a care worker had not responded to serious concerns about a person's health. The provider responded to these concerns and said they would provide additional training.

Supporting people to eat and drink enough to maintain a balanced diet
• Staff supported people with nutritional needs.
• Staff received training in food hygiene which helped them understand these responsibilities.
• Staff said they looked at care records to understand people's dietary needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Before packages of care started, an assessment of the person's needs was carried out to ensure a service could be provided.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There was an absence of systems to ensure sufficient oversight of the service.
• We asked how the provider measured its performance in areas of the business, such as number of missed calls, duration of calls and punctuality. It was evident these checks were not taking place. This meant the provider did not know how effective the quality of care was that people received. It also meant the provider did not know where additional support was needed as it had not identified its own shortfalls.
• Where paper care records were coming back into the office, these were scanned, but no one took responsibility for checking these and whether they matched electronic records.
• The nominated individual was visiting the service several times a week. However, they did not produce any evidence of checks they were completing to ensure the quality of care was being provided to the required standard.
• Concerns we identified around robustly recording safeguarding incidents, medication management, capacity and consent had not been identified by the provider prior to our inspection.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems to ensure sufficient oversight were not adequate.

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 provider was not always fulfilling its duty of candour responsibility.
• Prior to our inspection, we asked the provider to submit statutory notifications for events which were not reported to us. We met with the registered manager to discuss this. Shortly after this inspection, a relative made us aware of a missed call where the person's care needs were not met. We had to prompt the provider to submit a safeguarding alert which was received two weeks after the missed call.
• Shortly before our inspection, we were made aware of a breach of confidentiality when a new member of staff attended a partner meeting, despite their recruitment checks having not been fully completed. These discussions included sensitive information.
• We identified the provider was using a social media platform to communicate key updates between staff concerning people's needs. However, this included the names of people being cared for. The nominated individual investigated these concerns in February 2022 and assured us this was dealt with. However, we still saw a named person on this social media platform when we inspected. The social media site was not a secure way of sharing information. Since our inspection, the provider has taken steps to remove all sensitive

information and identify people differently using codes.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not fulfil their legal responsibilities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The service did not always achieve good outcomes for people.
• One relative told us, "Some (staff) are very good, some are not. I don't know whether that is down to training or personality. They can be very different."
• Whilst some staff were committed to meeting people's care needs, feedback we received from people and relatives indicated this was not always the case. Some staff had failed to recognise the importance of their roles and ensuring people received a service.
• One relative told us, "There was a call recently where [relative] was left in bed as [staff member] said they had to take their kids to school."
• A relative told us, "When I realised that no lunch visit had happened today, I called Genuine Carers office which diverted to voicemail and I was unable to leave a message as it said the mailbox was full. I then attempted to ring [registered manager] to be greeted with the same message about the mailbox being full. These calls were made within office hours."
• One relative said they experienced a missed call and raised a complaint about this, although there was no record of this on the complaints log we were provided.

The concerns identified above meant this was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not always achieve good outcomes for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• We received mixed feedback about people and relatives involvement in planning care.
• One relative said, "[Relative] does need a care plan review as [person's] needs have changed a lot, but it hasn't been offered."
• Some of the feedback we received demonstrated there were positive aspects to the service provided. One person said, "I asked for females only right from the start and they have always adhered to that." Relatives commented, "My [relative] does speak some English, but prefers Urdu, so the (staff) use that which makes [relative] feel comfortable in their own home" and "They (staff) even know to remove their shoes or wear shoe covers when they come into our home" (as part of religious beliefs).

Continuous learning and improving care
• The management team told us they wanted to make improvements to the service.
• We looked at spot checks carried out. An operations manager told us these were completed for all staff every three months or sooner if concerned were identified. These were designed to make improvements to the service provided as well as identifying positive practice. Following our inspection, the provider committed to an increased number of spot checks.
• The provider responded to concerns raised in a satisfaction survey to provide assurances through the action they had taken. Surveys had also been completed for staff and showed positive feedback.
• Following our inspection, the provider explained the improvements they were making to the service. However, these improvements need to be embedded and sustained.

Working in partnership with others

• The registered manager was working in partnership with other agencies.
• We saw care records which demonstrated the registered manager was working with other professionals, such as social workers and commissioners.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Feedback we received and records we looked at meant we were not assured that people received their medicines as prescribed.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service people received was not reliable as records did not show calls were punctual and feedback demonstrated calls had been missed. The culture within the service meant that good outcomes were not always achieved for people.

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 Management oversight was not evident over key aspects of the service. This demonstrated that systems to assess, monitor and improve the service were not sufficiently robust. Mental capacity assessments and recording of consent were not in place,

The enforcement action we took:

Warning notice