Genuine Carers Limited

Genuine Carers - Kirklees

Inspection report

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Date of inspection visit:
24 April 2023
27 April 2023

Date of publication:
29 August 2023

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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, 32 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
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people and providers must have regard to it.

Right Support
Staff had been trained and were assessed as competent to administer medication. People were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice, although records required improvement.

Right Care
Risks assessments were not always consistently recorded to ensure safe practice. The management team and staff understood people's care needs. Staff understood how to protect people from poor care and abuse.

Right Culture
Feedback we received was positive around the care people received.

At this inspection we saw minor improvements in the service people received. Feedback from people and relatives was more positive, although people still reported experiencing missed calls. The management team did not have sufficient oversight of this. Office staff over-relied on people reporting late or missed calls and were not proactive in responding to electronic call monitoring, which identified when care tasks did not appear to have taken place.

Quality systems remained ineffective as systems of audit were not routinely carried out. There was little evidence of oversight of the service in key areas.

People and relatives were consistently asked for their feedback through telephone calls, spot checks and

satisfaction surveys. However, concerning responses in relation to a recent satisfaction survey had not been acted on.

People said they received suitable support with their medication needs. Improvements were needed to records to demonstrate the safe management of medicines. Risks to people were fully understood by the management team and staff were reasonably confident. However, this information was not always included in risk assessments we looked at.

People and relatives said they were mostly satisfied with their call times and staff stayed for the full duration of the call. They provided positive feedback about the caring nature of staff who they said understood their care needs.

Some improvements had been made since our last inspection. Suitable travel time had been allocated between calls, consent was being recorded and mental capacity assessments had been put in place.

Formal staff support was not detailed in records we looked at, although staff said they were given plenty of time to cover what they needed and felt well supported.

People largely felt safe with this service. Records relating to safeguarding investigations showed these events had been looked at. Healthcare partners were clearly involved in people's care as referrals were made because staff identified concerns and the management team acted on these needs. People said staff were good at identifying when they were unwell and acted on this.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 6 June 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found some improvements had been made, although the provider remained in breach of regulation.

Why we inspected
We carried out an announced inspection of this service on 16 March 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve 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.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

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 inadequate to requires improvement. This is based on the findings at 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 have identified a breach of regulation in relation to the management and oversight of the service.

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 'Requires improvement'. However, we are keeping the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over 2 consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, 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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service 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 2 inspectors on 24 April 2023 and 1 inspector on 27 April 2023. On 26 April 2023 an Expert-by-Experience made telephone calls to people and their representatives to gather their feedback. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

At the time of our inspection there were 2 registered managers in post. Following our inspection, we were notified that 1 registered manager had left their role.

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

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.

We used all this information to plan our inspection.

During the Inspection
We spoke with 4 people who received a service and 9 relatives of other people who received a service.

We spoke with the nominated individual, 2 registered managers, a care manager, a registered operations manager and 3 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 4 people's care records, as well as medication records. We looked at the recruitment of 3 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.

Requires Improvement

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 inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment;

At our last inspection, the provider was in breach of Regulation 18 of the Health and Social Care Act (2008), Regulated Activities 2018, as there were not enough staff on duty to ensure people's support was provided in a timely way.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18. However, concerns remained about the oversight of this process. Please see our findings under the well-led key question.

• There were sufficient numbers of staff. However, the monitoring of calls was not robust.
• We spoke with 3 relatives who said they had recently experienced missed calls. Records we looked at before and during our inspection showed other instances where care calls were missed. Whilst this was the case, there was no evidence that people came to harm as a result.
• Office based staff were not proactive when electronic monitoring software showed care calls and specific tasks were not completed. The care manager said these checks were conducted every 2 to 3 hours. Whilst some of these issues were a result of care workers not logging into calls correctly, this was not known at the time the alert appeared on electronic call monitoring. A person said, "The office could manage better. A couple of times I have cancelled calls, I spoke to the manager and I was told it was on the system. The carers then turned up. They need to be more proactive." Following our inspection, the provider introduced new call monitoring software and told us they were carrying out weekly checks to monitor call times. The provider expected this would help provide greater oversight.
• Where people had been assessed as needing 2 care workers, relatives we spoke with confirmed 2 staff attended these calls. People and relatives confirmed they were usually supported by a settled staff team.
• Feedback from service users and relatives was generally positive about call times and duration. Feedback included, "Yes, (staff) arrive when expected. They let me know when they are running late and stay for the duration" and "They more or less stay for the duration."
• Safe recruitment practices were being followed.

Using medicines safely

At our last inspection, feedback we received and records we looked at meant we were not assured that people received their medicines as prescribed.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12. However, we had concerns about the governance of the medication process. We have referred to this under the well-led key question.

• Medicines were mostly managed safely.
• Medication records we looked at showed medication being administered to people. A relative told us staff administered their family member's medication and noted that staff applied cream for this person as needed.
• A person received their medication covertly, although records showing involvement from relevant medical professionals were not in place. A registered manager told us they would look into this and ensure instructions for which medicines could be administered covertly were clearly recorded.
• The registered managers told us it was not always safe to administer 1 person's medication. Whilst this person's care plan indirectly referred to the issues affecting this person, it did not clearly state when staff should or should not administer their medication. A staff member who confirmed they attended this person's care call was unaware of these circumstances.
• A person's dietary needs were not recorded in detail as reference to how much thickener they needed to reduce the risk of choking was missing.

There was no evidence of anyone coming to harm as a result of the above. We have reported our concerns regarding oversight of medication processes under the well-led key question.

Assessing risk, safety monitoring and management

• Risks to people's care were not sufficiently detailed to ensure clear guidance was available to staff.
• A person's behavioural support needs were not recorded in sufficient detail. In addition, the gender of staff needed to safely support this person was not recorded.
• Another person had repositioning needs to protect their skin integrity, but information around how often this assistance was needed was missing. There were no pressure wound concerns at this inspection.
• A person's dietary needs were not recorded in detail as reference to how much thickener they needed to reduce the risk of choking was missing. We asked the management team to add this detail.
• The registered managers knew people's care needs and risks and how these were to be managed. We found staff demonstrated a sufficient understanding of people's care needs.

Learning lessons when things go wrong
• Concerns identified at our last inspection had largely not been acted on. However, since our last inspection, distance between calls and suitable estimated travel time was suitably built into call schedules and had recently been reviewed.

Systems and processes to safeguard people from the risk of abuse
• People and relatives felt confident in the staff providing their care.
• The majority of staff were able to describe appropriate action to protect people from the risk of harm. Staff told us they would report concerns to the management team.
• Records showing how the provider responded to safeguarding alerts was seen during this inspection, although other records could not be accessed due to a third party data breach in March 2023. We refer to this under the well-led key question.

Preventing and controlling infection
• Infection prevention and control was suitably managed.
• Positive feedback was provided by people and their representatives around infection prevention and

control. They told us, "They (staff) wear PPE. They dispose on the way out in the bins" and "They wear foot covering, masks and gloves."
• During spot checks, staff were observed to ensure they were wearing PPE correctly.
• Staff told us there was always enough PPE available to them, so they never ran out.

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 as requires improvement. At this inspection the rating for this key question has remained 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

At our last inspection, we found records of people's mental capacity and consent were not in place.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17. However, further improvements were still needed regarding the recording of capacity and consent. We have commented on this under our well-led key question.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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

• At our last inspection, the provider was unable to demonstrate they had obtained people's consent to care and mental capacity was not assessed and recorded.
• At this inspection, people had a mental capacity assessment, although this was a general assessment and not specific to key decisions and recording of both was not consistent.
• A person's medication assessment indicated they knew and understood their medication needs. However, consent for medication was signed by a relative. Another person was receiving their medication covertly, although there was no mental capacity assessment specifically for this and their medication assessment stated a best interest decision was not in place.
• We have referred to this under our well-led key question.

Staff support: induction, training, skills and experience
• Staff received formal support, although the recording of this required improvement.

• We looked at examples of recorded supervision sessions which contained little meaningful detail of discussions around current issues and staff development. However, staff we spoke with said these were lengthy conversations which left them feeling well supported.
• Feedback from people and relatives showed staff appeared to be well trained and knew people's care needs and preferences. However, a person said, "The new carers are often not briefed about my care. I can explain things, so I talk them through it."
• We saw new staff were given opportunities to shadow experienced workers as part of their induction. Training records showed staff were mostly up-to-date with their training needs. Where specialist support was required, further training had been delivered to help ensure staff were competent.

Supporting people to eat and drink enough to maintain a balanced diet
• Most people's care plans described their preferences around dietary needs, although 1 care plan gave minimal information about a person having diabetes. Care workers explained district nurses were responsible for managing this, but this was not recorded in the person's care plan. The nutrition and hydration care plan stated 'create and encourage to follow a heathy diabetes diet plan', although this hadn't been produced as a care plan with guidance.
• We spoke with 2 relatives, who said staff who supported them did not know how to cook 'English food'. We have asked the provider to investigate this. However, most people were happy with this assistance, with a person saying, "They (staff) are good at hygiene and some are good at cooking. They will go above and beyond."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Feedback we received about staff responsiveness to signs of ill health was very positive.
• Feedback from people and relatives included, "Yes, (staff) would know if I am unwell. The first thing (staff) always asks, is if I am alright. (Staff member) would call the doctor. One day (staff member) called 999 and waited until the ambulance came" and "Yes, the regular care worker has spotted I am unwell lots of times. I was not feeling well, so they came with test kits and the next day I found I had COVID-19."
• During our inspection, we saw a number of examples where staff and the management team worked together to ensure people received the healthcare support they needed.
• Where external support was needed, the management team were actively using a range of professional contacts to help people get the assistance they needed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Relatives spoke well of the support they received from a registered manager when their care needs were being assessed at the start of their care package. A relative said, "They (staff) understand my care needs and how I like things done."
• People's communication and sensory needs were assessed in accordance with best practice.

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 inadequate. At this inspection the rating for this key question has remained 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.

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

At our last inspection the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as previous breaches of regulation were not met and further breaches were found.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• At our last inspection, the service people received was not reliable as records did not show calls were punctual and feedback demonstrated calls had been missed. At this inspection, people continued to report instances of missed calls which the provider was unable to demonstrate oversight of, partly due to the way office staff were recording these events. Insufficient monitoring of calls times remained a concern.
• Examples were seen where some care workers had copied electronic care notes entries made by other staff and pasted them for calls they carried out. This meant an accurate and person-centred record had not been made. Disciplinary action had been taken against 2 staff members, but we saw examples of other staff copying daily notes which had not been identified or acted on.
• We were told by the care manager that care notes were expected to be audited monthly. We saw 2 examples where care records had not been audited since August 2022 and other gaps were seen.
• In response to concerns including missed calls and staff performance, disciplinary action was taken against several staff. However, the provider had little oversight of this and was not able to produce records to support the action they said they would take.
• In March 2023, the provider notified CQC that a data breach had occurred, and that information could no longer be accessed, including safeguarding records, call time audits, complaints and accidents and incidents. The provider had not taken steps to ensure suitable back-up systems were in place to recover lost data.
• The 'registered operations manager' produced a quarterly quality report, but this was not detailed in showing which records had been checked and did not provide detailed action plans.
• Concerns remained around the recording of risk management processes and medication management.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Continuous learning and improving care
• Opportunities to learn and develop the service were not always taken.
• The provider operated 'sister' services which had been affected by an external data breach, but a registered manager told us they had not worked together to share ideas around how to manage the loss of this information. Following our inspection, the provider shared evidence to show these discussions had taken place. However, the registered manager was not aware of this.
• A satisfaction survey had been sent out in March 2023. Whilst the majority of feedback was positive, some relatives raised concerns about aspects of their service which had not been followed up to ensure people received a safe service.
• We received mixed feedback from people and relatives about their understanding around how to make a complaint about their service.
• The registered managers showed good knowledge of people's care needs. However, care plans did not always reflect this information. This had not been identified by the provider as care plan audits had not been completed regularly. The nominated individual told us they had asked their management team to oversee these and other checks. However, at this inspection, the nominated individual could still not show us evidence of the checks they personally carried out to assure themselves appropriate action had been taken. The service remained disorganised.
• Staff raised concerns about the leadership style of the nominated individual as they did not always feel their ideas were listened to.
• To help relieve pressures on staffing levels, the nominated individual had recruited new staff on sponsorship arrangements, which helped to ensure there were sufficient staffing levels to meet people's needs.

All of the above was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider remained unable to demonstrate oversight of key aspects of service delivery.

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

At our last inspection, feedback we received showed the provider did not always achieve good outcomes for people.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

• People, relatives and staff said that spot checks were carried out to help ensure quality standards were maintained. Staff we spoke with told us they received feedback about their performance following a spot check. Staff meetings were also taking place which staff felt able to contribute to.
• Despite our concerns about the leadership of this service, overall user satisfaction levels had improved since our last inspection. One person told us, "They (staff) are honest, genuine, caring, helpful and respectful. Nice people."

Working in partnership with others
• During our inspection, we found evidence the provider worked well with healthcare partners and connected people and relatives to this support.
• We overhead a registered manager having a telephone conversation with a relative who recently experienced a significant health event. The help provided by the registered manager was kind and supportive and looked at the assistance the relative's loved one needed.

• At our last inspection, we signposted the provider to a local registered manager's network. We spoke with a registered manager who said they had attended one of these meetings recently.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider remained unable to demonstrate oversight of key aspects of service delivery through robust quality assurance checks.

The enforcement action we took:

Warning notice