White Dove Care Limited

# White Dove Care Ltd

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

The inspection of White Dove Care Ltd took place on 18 July 2018. We previously inspected the service on 7 August 2018, at that time we found the registered provider was not meeting the regulations relating to person centred care, consent, safe care and treatment, fit and proper persons employed and good governance. The registered provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to adults, on the day of our inspection nine people were receiving care and support from White Dove Care Ltd.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe. The registered manager and staff were aware of the action they should take if a person had a fall. Each of the care plans we saw contained a range of individualised risk assessments which included the actions taken to reduce identified risks. Where support was given to people in managing their medicines, this was safe.

Staff recruitment was safe and people told us staff were normally on time and staff did not miss their calls.

New staff received an induction when they commenced employment. Staff had completed training in a variety of topics and they received regular management supervision. This included field based observations of their practice.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff understood the requirements of the Mental Capacity Act 2005 and respected people's right to make their own decisions.

Care plans recorded people's dietary preferences and cultural requirements. People told us staff prepared food which met their individual tastes and cultural needs.

Everyone we spoke with told us staff treated them in a kind and caring manner. People told us staff communicated with them in their preferred language and respected their cultural preferences. Staff knew people well and ensured they supported people in a way which maintained their privacy and dignity. People had a care plan in place which was reviewed at regular intervals and was reflective of their needs, likes and preferences. We have made a recommendation about advance care planning for end of life care.

People told us they were satisfied with the service. They had regular contact with the registered manager and knew how to raise a concern if they were unhappy. Staff felt supported and listened to. The registered manager regularly monitored the performance of the organisation. The also ensured they obtained regular feedback from people who used the service and staff. We have made a recommendation about improving the organisations policies.

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

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People told us they felt safe.

Risk assessments were in place to reduce risk to people's safety and welfare.

Staff were recruited safely. People told us staff were normally on time and calls were not missed.

### Is the service effective?

Good

The service was effective.

Staff received ongoing training and management support.

Staff provided people with meals which met their personal and cultural preferences.

The registered manager and staff understood the requirements of the Mental Capacity Act 2005.

### Is the service caring?

Good

The service was caring.

Everyone we spoke with told us the staff were caring and kind.

People's privacy and dignity were maintained.

Staff respected people's individual cultural needs and preferences.

### Is the service responsive?

Good

The service was responsive.

People had a care plan in place which was reflective of their needs.

Care plans included the support people needed to enable them

to communicate effectively.

People knew how to complain if they were dissatisfied with any aspect of the service.

We have made a recommendation re end of life care planning.

## Is the service well-led?

Good

The service was well led.

People told us the service was well led.

The service had a registered manager.

There was a system in place to monitor the performance of the organisation.

We have made a recommendation about improving the organisations policies.

# White Dove Care Ltd

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out between 18 and 30 July 2018. We gave the service short notice of the inspection visit because the location provides a domiciliary care service and we needed to be sure they would be available. Inspection activity started on 18 July 2018 when we visited the providers office and spoke with the registered manager. On 23 July 2018 an expert by experience spoke on the telephone with three people who used the service and six relatives. 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 expert by experience on this occasion had experience of both accessing and working in health and social care. On 30 July 2018 the inspector carried out telephone interviews with four care workers.

During the inspection we looked at the care records of three people who used the service. We looked at three staff recruitment files. We reviewed other records including medication records, risk assessments, meeting notes and audits.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department and the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Good

# Is the service safe?

## Our findings

Without exception, people told they felt safe. One person said, "They (staff) are very good with me, they (staff) do make me feel very comfortable and safe." A relative told us, "[Person] is very safe indeed – very comfortable with the care workers."

Staff could tell us about the different types of abuse and were clear on their responsibilities of reporting any concerns. This included how to escalate concerns external to the service, for example to the local authority. The registered manager told us they had recently attended role specific safeguarding training provided by the local authority.

The registered manager was clear in their expectation of the action staff should take in the event a person was not at home for a scheduled call. We also asked staff what they would do if they found a person had fallen, one staff member told us, "If they were on the floor, I would make sure their breathing was clear, check their condition and call 999." This demonstrated there were systems in place to reduce the risk of harm to people.

Each care plan we reviewed contained a risk assessment which identified the risk and actions required of staff to minimise and mitigate the risk. This meant care and support was planned and delivered in a way that reduced risks to people's safety and welfare.

The registered manager told us staff received practical moving and handling training although at the time of the inspection, they told us no one using the service required support with this aspect of their care.

People told us staff were on time and did not miss their calls. One person said, "They are always on time. They have not been late unless there is an emergency, then the office will call me if this is the case." A relative said, "Timing is not at issue. We have worked with the company for the times that suit my relative - this time is good for my relative."

At the previous inspection we found the registered manager was not consistently following their own recruitment policy in relation to recruitment checks to ensure staff suitability to work with vulnerable adults. At this inspection we found improvements had been made. We reviewed three staff files, two of which had been recruited since the last inspection. Each file contained an application form, employment history, two references and evidence they had attended an interview. A disclosure and barring (DBS) check had also been completed for each staff member. DBS checks return information from the Police National Database about any convictions, cautions, warnings or reprimands and help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. This evidenced appropriate checks were undertaken before staff began work.

The registered manager told us the service was not currently responsible for administering any medicines other than the application of topical creams. We reviewed the care records for two people who required support staff to apply cream on their behalf. Information was recorded which instructed staff as to when and

where they were to apply the cream although this was recorded in the care plan for one person and on a body map for the second person. A body map is used to provide clear instructions to staff and reduce the risk of confusion about the precise place to apply a cream. A topical administration record (TMAR) was also completed by staff to record their actions. The creams for one person were to be applied 'as required' but there were no directions as to the circumstances when staff should apply these creams to ensure they were applied in consistent and appropriate way. This was shared with the registered manager at the time of the inspection.

The registered manager told us and the staff we spoke with confirmed, they received regular face to face training in the administration of medicines. At the previous inspection we found staff's competence to administer prescribed medicines was not being assessed or monitored. At this inspection we noted medicines was included as part of the regular spot checks on staff's performance but as not all calls required to support with any aspect of medicines management, this had not been completed for all staff.

The registered manager told us staff were provided with personal protective equipment (PPE) for example, aprons and gloves, one of the staff we spoke with confirmed this adding they were also provided with hand gel to use if needed. This showed steps were taken to protect people and staff from the risk of infection.

We asked the registered manager, when things went wrong how lessons learned were shared with staff. They told us about one person they supported who had regular falls. They said they had identified a pattern and following discussion with the persons family, adjustments had been to the persons call time. They said this had resulted in a reduction in their falls. The registered manager told us where relevant, information would be shared with staff at staff meetings or through speaking with the individual staff concerned. This showed action was taken where deficiencies were identified.

Good

# Is the service effective?

## Our findings

People and their relatives told us staff were skilled and knowledgeable. One relative said, "They (staff) are good, they are certainly trained and skilled." Another relative commented, "Very skilled and nice care workers who know what to do."

The registered manager recognised the importance of ensuring peoples care and support was delivered in line with current good practice guidelines.

New staff received an induction. This included shadowing the registered manager to ensure they had the skills and confidence to meet the requirements of their role. Two of the staff files we reviewed included evidence they had completed the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that all workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff completed training in a variety of topics when they commenced employment. This was subsequently refreshed at regular intervals. Staff we spoke with told us the training was a mixture of face to face and e-learning. Moving and handling was face to face and included a practical element. The registered manager told us they had recently introduced a further four e-learning training topics for staff, this included dementia care and mental capacity. This demonstrated the registered manager recognised the need to ensure staff had the appropriate knowledge and skills to perform their job roles.

The staff files we reviewed evidenced staff employed over twelve months had received an appraisal. Staff had also received regular one to one management supervision, although we saw these records were rarely signed by the member of staff. The registered manager also completed a mixture of announced and unannounced field based checks on staff's performance. This was evidenced in staff's personnel files and through talking with staff. One staff member said, "Sometimes [registered manager] told me and sometimes [registered manager] just turns up." This enabled the registered manager to monitor staff performance and development.

Everyone we spoke with told us staff prepared food which met their individual tastes and cultural needs. Comments included; "They prepare food just how I like it", "Food preparation is excellent by the care workers" and "They do prepare food, this is done to my relative's expectation".

The care plans we reviewed noted people's dietary preferences and cultural requirements. Staff said, "I offer breakfast and lunch, [name of person] tells what they want" and "I make sure I leave [person] with fresh jug of water."

People who used the service predominantly lived with their families. The registered manager told us access to appropriate health care services was managed by people's families. Staff told us if they were concerned about a person's wellbeing, they would speak with their family and the registered manager. One staff

member said, "If [person] was unwell, I'd call the manager, get advice. With the permission of my client I'd ring the (GP) surgery."

It was evident the registered manager was in frequent contact with people who used the service, their families and staff. They told us they shared relevant communication either verbally or, if appropriate via a text message to staff. Effective communication ensures people receive consistent, timely, coordinated, person-centred care and support.

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 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 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. In the case of Domiciliary Care applications must be made to the Court of Protection. The service had not needed to make any applications to the Court of Protection.

At the previous inspection we found the service was not meeting the requirements of the MCA. At this inspection we found improvements had been made. The registered manager told us they had recently attended training provided by the local authority in this subject. They also said the local authority had provided them with the relevant paperwork to enable them to evidence capacity assessments and decisions made in people's best interests.

Training in MCA had recently been added to staffs' training requirements, of the 12 staff listed on the training matrix, six staff had completed it. However, each of the staff we spoke with demonstrated a thorough understanding of the principles and how they were applied in practice. One said, "Everyone has the right to make their own decision, they can make wrong decision. If we make a decision for them, it is (in their) best interests. The people I support can make own decisions." Another staff member said, "Everyone has right to make decisions. [Name of person] can choose, but the family help and may leave out clothes. [Person] may tell me they don't like the clothes (left out for them), they may want something different so I offer them some different clothes that they are happy with."

The registered manager told us the people they supported had mental capacity to make relevant decisions regarding their care although one person lacked capacity regarding one aspect of their support. We reviewed their care records, which included capacity assessment regarding this matter. The assessment clearly recorded the steps taken by the registered manager to assess the persons capacity but there was no record of how the decision reached was in the individuals best interests. This process is carried out if the service needs to decide on someone's behalf and ensures the decision involves relevant parties, such as family members, and is made in the persons' best interests.

Good

# Is the service caring?

## Our findings

Without exception people told staff were caring and kind. People told us; "They (staff) look after me, they understand me. They are kind and caring", "Lovely care workers. Always polite, they treat me the same way as if I was their mother, always kind to me" and "I am extremely happy with my care workers." The relatives we spoke to were also unanimous in their positive feedback. They said; "They (staff) are excellent, my relative really looks forward to seeing them", "Their patience is brilliant", "They (staff) are always speaking to [relative], they do not just do things, they talk to [relative]" and "Excellent, our relative is very stubborn, for example [relative] will not want a bath but they will speak to [relative] nicely, caringly, [relative] listens and then gets a bath."

One of the staff we spoke with said, "I look after everyone like they are my own family." From our conversations with the registered manager and staff, it was clear they knew the people they were supporting very well. People and their relatives told us they had regular staff attending their calls.

People were treated with dignity and respect. One person said, "They respect me." A relative commented, "They [relative and staff] have a great respectful relationship." Another relative told us, "They [staff] give [relative] dignity when in the bath, they are so caring and respectful. [Relative] feels comfortable in their presence." Staff could describe the steps they took to maintain people's dignity, including closing doors and curtains during personal care and using towels to reduce body exposure when bathing and washing. One staff member said, "I close curtains. I stand outside (the door) if they are safe, go back when they need help."

The registered manager told us White Dove Care specialised in providing a service for people from the local Asian community. Staff employed at the service understood the cultural needs of the people they supported and could communicate with them using their preferred language. A person said, "We speak the same language, they (staff) understand me." A relative told us "My relative has a care worker who is the same nationality as them, they are the same culture, [staff] understands [person]." A member of staff said, "I understand as I speak their own language and we communicate in their own language. Everyone has their own beliefs. I treat (people) with respect, I don't treat any different, everyone is different and we have to understand."

The registered manager also told us some people's culture required the removal of outdoor footwear as they entered their homes. They explained to respect peoples wishes and ensure the safety of staff, shoe covers were provided so staff could cover their shoes as they entered people's homes.

People and their relatives were involved in their care plans. One person said, "We have been through a plan." A relative told us, "They (staff) keep in touch with us, they go through the care plan with us and they come at least once a month to see if we are all ok." Each of the care plans we saw was signed by either the person receiving care and support or a family member. This showed the service consulted with people about their care and support.

The care records we looked at were person centred and reflected the person's diversity. For example, care plans contained information on people's religion, communication needs and important relationships.

Good

# Is the service responsive?

## Our findings

Staff told us people had a care plan in their home which was reflective of their needs. The registered manager told us a copy of each care plan was kept in the persons home and at the office, "They (care plans) are reviewed and updated every three months or if there is a change to need."

Each of the three care records we reviewed was detailed, person centred and reflected the persons preferences and choices. This level of information helps staff to know what was important to the people they cared for and helped them take account of this information when delivering their care.

Although care records noted the care and support people needed, it was not always clear which element of support staff were required to provide at each scheduled call. We spoke with the registered manager, they told us this had been recognised and the care plan template had been updated. After the inspection they emailed us a completed care plan using the new template. We saw this provided clearer instructions for staff so they were aware of their allocated duties at each call.

We noted the care plan for one person recorded they could exhibit behaviour which may challenge the staff. Information was recorded as to how this behaviour may present but did not direct staff as to the best course of action to de-escalate this. We discussed this with the registered manager at the time of the inspection.

The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand, plus any communication support they need when receiving healthcare services. Each care plan recorded the support people needed with communication. For example, if they had adequate vision and hearing. Care records were all produced in English, the registered manager told us people who used the service each had close family members who were fluent in English. They told us documentation could be produced in an alternative format if required.

People told us they were satisfied with the service but they knew how to complain if the need arose. Comments included; "Any issues I will call the office," "[Registered manager] is brilliant. Always deals with anything we raise with respect" and "The office manager always keeps in touch with us. [Registered manager] comes to see us, any issues or concerns we have she deals with them for us."

The registered manager told us they had not received any complaints about the service. They said, "If a complaint was made I would record this, investigate, meet with staff member and see both sides so it can be solved."

Information on how to complain was in the service user handbook, the registered manager told us this was issued to people and their families when they began to use the service. We asked if this was available in alternative language formats, the registered manager said it was not but it could be easily provided if this was required.

At the time of our inspection, the service was not supporting anyone who required end of life care. People's

care plans did not refer to any aspect of end of life care, there was no inclusion of people's personal or cultural preferences in the event their wellbeing deteriorated. However, the registered manager was aware of how to access support from other healthcare professionals if required. We recommend the service seek advice and guidance from a reputable source regarding advance care planning. This is a key means of improving care for people, enabling people to discuss and record their future health and care wishes and to appoint someone as an advocate, thus making the likelihood of these wishes being known and respected at the end of their life.

Good

# Is the service well-led?

## Our findings

Without exception people and their relatives were very happy with the performance of the registered manager. One person told us, "I am extremely happy with the service provided." Another person said, "I am extremely happy with the service provided- I would never change them." Feedback from relatives included; "Excellent service received, we have recommended this company to our [name of relative", "Same language, same culture, brilliant service provided, ten out of ten" and "I would highly recommend this service. We have a wonderful care worker, any problems the company is there for us. We are both so happy with the service provided"

Staff were also positive. One staff member said, "No problem, it is a good place (to work), like a family. She [registered manager] is very nice, very helpful. Another staff member said, "Everything is really good, [registered manager] talks to us nicely and communicates well. The rota is good."

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of our inspection and therefore this condition of registration was met.

Our previous two inspections have identified regulatory breaches, including a failure to ensure robust systems of governance were in place. At this inspection we found improvements had been made and the service was compliant with the requirements of the Health and Social Care Act
2008 (Regulated Activities) Regulations 2014.

The registered manager told us they monitored the performance of the organisation through staff supervision and observational checks on performance, speaking with people who used the service and checking staff's records, such as call logs. Each of the care records we looked at evidenced a monthly audit, this checked to ensure the records were correct, feedback had been obtained from the person and/or their family and their primary care workers performance had been checked. Regular audits enable concerns and weaknesses in systems to be identified, enabling timely action to be taken to reduce future risk.

It was evident from discussions with the registered manager, staff and people who used the service, the culture of the organisation was open and inclusive. Staff were clear about their role and responsibilities and were confident any issues raised with registered manager would be addressed.

Staff meetings were held monthly and staff signed to confirm their attendance. We saw a range of topics were discussed, including training, holidays and record keeping. We also saw a specific subject was discussed in more detail at each meeting, for example medicines management and what to do if a person had fallen. Meetings are an important part of a registered manager's responsibility to ensure important information about the service is disseminated to staff appropriately.

Surveys had been sent to people who used the service and their families, earlier in the year. Of the nine surveys sent out, five had been returned. The feedback was positive, comments included; 'All staff have an

excellent attitude' and 'I am always involved in care plan'. This demonstrated people were asked for their views about the service they received.

The registered provider had a range of polices available for staff to refer to, they were often generic, did not always refer to recent industry specific guidance and were not specific to White Dove Care. For example; the medication policy referred to nursing staff's requirement to keep themselves up to date with the Nursing and Midwifery Council Guidelines for the Administration of Medicines, but the service did not employ nursing staff. We also noted the polices were not dated with either the date they were implemented or the date they were due for review. Regular reviews enable the registered provider to ensure polices are updated to include changes to legislation and reflective of current good practice guidance. We recommend the service seek advice and guidance from a reputable source to ensure policies are up to date and service specific.