Danbury Care

Danbury Care

Inspection report

The Stable, Lodge Fam
Old London Road, Woodham Water
Maldon
Essex
CM9 6RL

Tel: 01245227070

Date of inspection visit:
19 October 2017
31 October 2017

Date of publication:
08 January 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Danbury Care provides personal care and support to people in their own homes. They were supporting 48 people when we inspected on 19 and 31 October 2017. The provider was given 24 hours' notice of our inspection because the location provides a domiciliary care service and we needed to know that someone would be available.

There was a registered manager in post. The registered manager was also the provider. 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.

At our last inspections in March 2017 we found that the registered provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan to tell us how they intended to make the required improvements. At this inspection we checked whether these improvements had been made and found that the provider continued to be in breach of these regulations. Additional multiple breaches of the regulations were also found.

Following our inspection in March 2017 we issued a Warning Notice with a requirement that the provider was required to become compliant with the regulation by 30 May 2017. We also met with the provider to discuss their future plans for the business and the improvements needed.

Despite assurances from the provider that improvements would be made following our previous inspections, there continued to be widespread shortfalls in the way the service was led. There was a lack of managerial oversight and the provider was not pro-active. There were no formal quality assurance systems in place to ensure that the quality of care was consistently assessed, monitored and improved. People were not confident that concerns and complaints would be taken seriously and responded to appropriately.

Procedures for the recruitment of staff were still not robust enough to protect people from the risk of unsuitable staff providing their care. Risk assessments in relation to people's daily living were either not in place or lacked detail. There were no risk assessments in place relating to people's specific health conditions. Staff did not have up to date information or guidance in order to protect people from the risk of harm.

Care plans were task focussed and extremely limited in detail. Important information about people was not recorded in their care records. People had initially been involved in the planning of their care but had not been consulted or involved in updates.

Care plans did not record the level of support each person required with their medicines. There was limited monitoring of people's medicines and how staff recorded these. Medication training was brief and

ineffective and the medicines policy continued to be out of date.

There continued to be insufficient systems in place for the induction, training, supervision and appraisal of staff. Training provided was not effective in ensuring staff had the knowledge they needed to provide people with safe and effective care in line with their wishes and preferences.

People told us that staff gave them the opportunity to make decisions for themselves. However management and staff had not received training relating to the Mental Capacity Act and were therefore unware of the need to appropriately assess people's capacity to make specific decisions.

There was limited information included in people's care plans about their dietary needs and records lacked detail about their preferences. Where appropriate the service had made referrals to health care professionals such as the community nursing team and GP's.

Concerns remained regarding staffing levels and people regularly experienced late calls. People told us they felt safe whilst receiving care in their homes but the provider had failed to recognise that more robust systems were needed to ensure people were not at risk of abuse, including stronger recruitment procedures and adequate monitoring of care staff.

People told us that staff were kind, caring and considerate. Staff demonstrated empathy, understanding and warmth in their interactions with people. Although frontline staff delivered good care to people, the service overall did not demonstrate that they cared about the people they supported.

At our last two inspections we found that the provider lacked understanding regarding their responsibilities as the registered responsible person in accordance with regulation. It was only through the care and commitment of frontline staff that people had not come to any harm. This continued to be the case and the lack of provider oversight and leadership meant improvements were not being implemented, monitored or sustained. This resulted in continued non-compliance with regulations and put people at risk of unsafe care and treatment.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to; Ensure that providers found to be providing inadequate care significantly improve. Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's

registration.

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 in relation to people's daily living were either not in place or lacked detail. There were no risk assessments in place relating to people's specific health conditions.

Procedures in place to safeguard people from the potential risk of abuse were not robust.

People were not protected from the risk of unsafe recruitment.

Is the service effective?

Inadequate

The service was not effective.

Training provided was not effective in ensuring staff had the knowledge they needed to provide people with safe and effective care.

Management and staff had not received training relating to the Mental Capacity Act and were therefore unware of the need to appropriately assess people's capacity to make specific decisions.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although frontline staff delivered good care to people, the service overall did not demonstrate that they cared about the people they supported.

People told us that staff were kind, caring and considerate.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were task focussed and extremely limited in detail.

Important information about people was not recorded in their

care records.

People were not confident that concerns and complaints would be taken seriously and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well led.

There were no formal quality assurance systems in place to continually monitor the service provided. Systems were not sufficiently robust to ensure that the registered provider was operating within expected standards of governance and ensuring effective oversight of the service.

The provider lacked understanding regarding their responsibilities as the registered responsible person.

Continued non-compliance with regulations put people at risk of unsafe care and treatment.

Danbury Care

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 took place on 19 and 31 October 2017 and was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone was available to speak with us.

Before the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public. During our inspection we visited the offices of Danbury Care. We looked at the care records of eight people, training and recruitment records of staff members, and records relating to the management of the service. We visited two people in their own home accompanied by a member of staff. We also met with two relatives and spoke with a further six people receiving care and support from the service and five relatives on the telephone. We spoke with the provider who was also the registered manager, two care co-ordinators and three other members of staff.

Inadequate

Is the service safe?

Our findings

At our last inspection in March 2017 we found that procedures for the recruitment of staff were not robust and at this inspection we found this continued to be the case. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. DBS checks help employers make safer recruitment decisions and help prevent unsuitable care workers from working with people. At this inspection we found that the provider was relying on a Disclosure and Barring Service (DBS) check for one person which had been issued in February 2016 by another employer. There had been no check carried out by Danbury Care to ensure the person was safe to work with people who used the service. We discussed this with the provider who told us an application was in process however they were unable to evidence this. Without robust recruitment procedures people are at risk of being unprotected from unsuitable staff providing their care.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were still needed in how the service assessed and recorded risks in people's daily living. Care records did not include detailed risk assessments to provide staff with guidance on how the risks to people were minimised. For example, one person's care records showed that they were at risk of pressure ulcers, dehydration and urinary tract infections. They required full assistance from care staff to mobilise using a hoist. Despite the significant number of risks to this person's health and well-being the section of the care plan which asked what risks had been identified was blank. The only assessment of risk in the person's care records related to moving and handling, this had not been updated for 18 months and did not reflect the persons current moving and handling needs. This put the person at risk of receiving inappropriate care unsuitable for their needs.

Environmental and general risk assessments were mostly blank. Those that had been completed were generic and mostly recorded that there were no identified risks and therefore no control measures had been put in place to minimise potential risks to people to keep them safe.

There were no details or risk assessments for specific health conditions to guide staff as to how they could best support people with these conditions. For example, one person had swallowing difficulties and required all their food to be pureed due to their condition. However there were no details in the care file held in their home to inform staff that this was the case. The person's family prepared their meals however without this key information being available there was a risk that staff could inadvertently give the person food in the wrong format, putting them at risk of choking or aspiration (food or fluid entering the lungs) which could result in serious harm.

Staff did not have up to date information or guidance in order to protect people from the risk of harm. We asked the provider about the lack of information in peoples' care files and they told us that the reason for this was that people did not always want personal information about themselves in their files. However, without up to date information about people's health condition and care and support needs they were at

risk of receiving inappropriate or unsafe care. In many cases people lived alone. The provider had failed to recognise that providing key information as well as the interaction and observations of care staff about people's health needs were part of keeping them safe.

At our last inspection we found that people's medicines records did not clearly demonstrate the level of support they needed with their medicines. There had been no improvement in this. One person was administering some of their own medicines and being supported with others by staff, however the level of support required was unclear and records did not demonstrate how much staff had been involved. Care staff were required to apply a weekly pain patch for the person as well as apply eye drops and topical medicines in the form of medicated creams. There was no guidance in place to show staff how and where these should be applied. Another person was administered an Alendronic acid tablet weekly. These type of tablets should be administered at least 30 minutes before food or other medicines to ensure they are effective. Following administration, people should not lie down for at least 30 minutes to prevent irritation of the oesophagus (food pipe). There was no guidance relating to this in the person's care plan. Without the appropriate guidance for staff people were at risk of receiving their medicines in a way which could limit their effectiveness or cause harm.

At a previous inspection in September 2016 we found that the medicines policy was extremely limited in detail and failed to give appropriate guidance to staff to ensure that people received their medicines safely. The registered manager agreed in September 2016 that the medicine policy and procedure was in need of a review to ensure it was in line with current best practice guidelines and that staff were aware of their responsibilities. At our inspection in March 2017 we found that the document had still not been updated and the provider gave assurances that this would be done as a matter of priority. However, at this inspection we found that this had still not been completed. We discussed the National Institute for Health and Care Excellence (NICE) guidance with the registered manager. They were unware of this guidance but told us they would look at the information provided by NICE to assist them to update the medicine policy as soon as possible.

There was limited monitoring of people's medicines and how staff recorded the administration of these where needed. This put people at risk as errors and omissions may not be identified which could mean people were not receiving their medicines as prescribed.

Staff had received medication training however this consisted of watching a DVD followed by six questions to be answered. These questions did not adequately assess staff's level of understanding and were marked by a member of office staff who had not received medication training themselves and were therefore not qualified or competent to assess whether staff had the appropriate knowledge required. An observation of administration of medicines for a member of staff who had recently started working at the service had been signed by the staff member but had not been signed or dated by anybody who had observed them. It was unclear whether any observation had actually taken place as the provider was unable to tell us when this had occurred and by who.

The lack of guidance, appropriate training and monitoring relating to management of peoples medicines is of serious concern as it places people at risk of harm due to unsafe or inappropriate administration of medicines which could be detrimental to their health and well-being.

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

Concerns remained regarding staffing levels. People regularly experienced late calls and it was unclear how

staff were able to provide care for the amount of time assessed and allocated due to the number of calls they were expected to complete each shift. For example, the work schedule for one member of staff showed that they were expected to complete eight and a quarter hours of calls in a five and a half hour shift. One member of staff told us. "We are rushed off our feet." Staff told us that they worked beyond the times shown in their roster in order to complete all the calls. However, the effect of this was that people were receiving their calls later than they expected and this often impacted the time that people were assisted with their lunch. A record of phone calls received due to late or missed visits showed that there had been 13 phone calls in September and nine phone calls in the first two weeks of October. The majority of these were due to late calls over the lunchtime period. There had been no analysis of these phone calls and it was unclear if any action had been taken to attempt to resolve the issue. One person told us, "I don't get any rota and I find that I just have to sit and wait for them to arrive. If I phone the office, they often just tell me that they're not late and they will get to me. I'm made to feel guilty for calling, but I need to make sure someone will turn up because I'm all on my own." There was also no system for monitoring visits to ensure that staff were completing them as scheduled. People were not always receiving support as it had been assessed and allocated which meant meals, fluids and medicines may not be given at the appropriate time, putting them at risk of poor health and well-being.

Two senior members of staff had been given the responsibility of supervising the care staff and completing and updating care records. However both were also required to work shifts to cover staff shortages which meant there was little time available to complete these important tasks to ensure staff were competent in their role and to keep people's records up to date.

At our previous inspections the registered manager told us that they continued to actively recruit although they had found that it was difficult to recruit new staff. A member of staff told us, "We are at capacity, we need more staff. [Provider] says [they] are still looking for staff." However, it was unclear what steps were being taken in order to achieve this as staff in the office were unaware of any jobs being advertised.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.□

Staff understood their roles and responsibilities regarding safeguarding people and protecting them from harm. They were able to demonstrate how to report concerns should they see or hear anything which concerned them. However, the whistleblowing policy was out of date and gave incorrect guidance regarding reporting procedures. The provider had also failed to recognise that more robust systems were needed to ensure people were not at risk of abuse, including stronger recruitment procedures and adequate monitoring of care staff.

Inadequate

Is the service effective?

Our findings

At our inspections in September 2016 and March 2017 we found there were insufficient systems in place for the induction, training, supervision and appraisal of staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst there had been some improvements in the supervision of staff there was still no consistent or planned approach. Two care coordinators had been tasked with ensuring that staff supervisions and appraisals took place and we saw that some observational supervision of staff had taken place. However, due to the number of hours the care coordinators were working in order to cover gaps in the rota, they had been unable to complete all supervisions required. The care coordinators had also been given no support or training to enable them to carry out this role effectively.

Induction and on-going updated training continued to take the form of staff watching DVD's and completing a question and answer sheet to test their knowledge which was marked by a member of staff in the office with no care qualifications themselves. One member of staff told us, "The training is not good enough." Another staff member said, "I don't think the training is up to scratch. Where I worked before we used to have proper people come in to do the training. I've been saying for a long time it needs to be sorted. [Staff] get a bit lazy, don't do what they should do. There is no practical [moving and handling] training. When we have a new carer start they are shown the equipment but it's mostly done by video and written work." The code of conduct issued to all staff stated, "Lifting/hoist help can be given upon request. Please ring office for training dates." This showed that moving and handling training was not considered to be essential for all staff.

We queried how staff were trained and assessed in regard to practical moving and handling training. The provider told us that they held a train the trainer qualification but was unable to evidence that they had attended any refresher training since 2010. When we asked them how they kept their own knowledge up to date they told us that this was not important as, "Moving and handling regulations haven't changed for the last 15 years." This was concerning as guidance regarding best practice in relation to moving and handling of people is continually updated. The staff file of one of the care coordinators responsible for assessing staff competency in relation to moving and handling showed that they had been trained in this area by the registered manager. We were concerned that this meant staff were not being trained or assessed in line with current best practice guidance putting people at risk of inappropriate moving and handling and at risk of harm.

The service provided care in the main for people who were vulnerable and/or frail due to their age. This included people who had dementia related ill health, Parkinson's and swallowing difficulties. Staff did not receive training in order to give them the knowledge they needed to support people with specific health conditions such as Parkinson's. Only five out of 16 staff had received training to give them additional insight in to the specific needs of people living with dementia. One relative explained how a lack of understanding regarding how their relative's dementia affected them meant that staff sometimes acted or spoke in a way which they found upsetting. The training provided was not sufficient to ensure staff had the knowledge they

needed to meet the assessed needs of people in a safe and effective way.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At our last inspection in March 2017 we checked whether the service was working within the principles of the MCA. We found that staff were aware of the MCA and knew how to support people with decision-making about everyday tasks. However, training and guidance in the Mental Capacity Act (MCA) 2005 for all staff had not been provided despite this being a shortfall at the previous inspection in September 2016. At this inspection we found that this training was yet to be delivered to all staff. Two care co-ordinators were booked on a MCA train the trainer course to enable them to deliver this training. However, until staff were provided with the knowledge they needed to support people with limited or inconsistent mental capacity there was a risk that people's wellbeing and rights could be affected.

There was limited information included in people's care plans regarding their dietary needs and no information about their preferences. Care plans did not guide staff as to how they could support people with their food and drink in a way which may help them be less at risk of malnutrition or dehydration. For example, the care plan of a person at risk of dehydration and urinary tract infections did not provide staff with information to give them a clearer understanding of how to support the person to drink. One of the person's relatives told us, "[Staff member] can manage to get [person] to drink, others are not always so successful". This put the person at further risk of dehydration and potential infection which would be detrimental to their health.

People and their relatives told us that the service had made referrals to health care professionals such as the community nursing team and GP's or involved families where appropriate. A relative commented, "If they think we need to get the doctor they will tell us." Another relative told us, "[Relative's] regular carers have my number and they will always ring me if they have any issues. One of them called me the other day because she was concerned that [relative] was developing a bed sore. I got the nurse in straight away and thankfully, it's cleared up already."

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found that although frontline staff delivered good care to people, the service overall did not demonstrate that they cared about the people they supported. This continued to be the case as the provider was still failing in multiple areas and this did not convey a caring attitude towards the people they supported. One relative told us, "[Relative's] carers are lovely and [relative] is very attached to them, but they are so let down by management inadequacies."

People told us that although they were initially involved in the planning of their care they had not been consulted or involved in updates. One person told us, "I do remember sitting with someone from the agency before I started having any care and we talked about what I needed help with. That became a care plan, which lives in my folder. I was asked when I wanted visits, at what time and if I preferred female carers, but my plan was written well over two years ago. I did ask the office if anyone was going to come and see me to update it. They told me that they had an updated one in the office, but no one has talked to me, so how can it be updated?" A relative said, "We spoke with a [member of staff], and we talked at length about everything [relative] couldn't do anymore and how they could help her. [Relative] was keen to have showers on set days, which was arranged and we were asked what times [relative] wanted the carers there. Nobody's been to see us since and that must be 18 months ago. Thankfully [relative] has improved and can do more for [themselves] now, but the care plan hasn't been looked at by anybody." Staff were relying on knowledge that they built up about people over time to tell them how people liked their care and support to be provided. Without this information being regularly reviewed to ensure its on-going relevance the provider was unable to demonstrate how it was meeting and respecting people's personal choices and views or providing support in line with people's current care needs.

People told us that staff were kind, caring and considerate. One person told us, "[Staff] are very good and understanding." A relative told us, "[Relative] has 3 regular carers and they are really good with her. Another relative told us, "My [relative] cannot communicate any more, but the carers are lovely and they make sure that they chat away while they are helping [relative] and I can tell by the smile on [relative's] face that [they are] loving being included in whatever they are chatting about."

People were encouraged by their regular carers to do things for themselves to help maintain their independence. One relative told us, "I cannot praise [relative's] regular carer enough. [Member of staff] has worked so hard at helping [relative] to regain [their] confidence to the point where they can have a shower again, albeit with support." However, although staff were proactive in their approach, people's care records did not provide sufficient details to show how the service were promoting their independence. This meant that when support was provided by staff who did not visit so regularly, people were not always getting the same standard of care. One person told us, "I suppose in a week, I can see eight or nine different carers covering my three visits a day. Most of the staff are lovely, but every so often, I'll get one who is in a rush." A relative said, "Some staff are better than others." Without details in care plans regarding the level of support required it was unclear to staff how much assistance the person needed, which things they were able to do for themselves or if they were working towards certain goals to become and/or retain independence.

Staff demonstrated empathy, understanding and warmth in their interactions with people. One person told us, "I love having a nice warm shower and the carers make sure that they run the water before I get in. They usually warm my towel up for me as well so I don't get cold while they cream my legs." A relative explained to us how the care staff knew their relative well and how they were working together to find ways to enable them to lead a more fulfilled life. They commented, "[Relative] has spent a lot of time saying that [they] want to get up. We've been working on that together [with the staff.]"

People told us that staff helped them to maintain their dignity and privacy. One relative explained this in relation to moving and handling support needs, "My [relative] needs hoisting numerous times each day. We always have two carers at a time. I can't say [relative] enjoys it, but the carers are very patient and they take their time to ensure [relative] feels safe and comfortable before they begin to lift [relative]. They talk through things really slowly and they don't lift until [relative] is happy." This showed that staff recognised the importance of privacy and dignity as core values and worked together with people to promote them.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found that the service provided to people by frontline staff was personalised and responsive to their needs. However care records were inconsistent and did not provide staff with the information they needed regarding peoples current support needs.

At this inspection we found that care records continued to be task focussed and gave very little indication of people's preferences or what was important to them. Important information about people's health conditions and level of support required was not recorded in their care records.

Although referral paperwork from the local authority gave details about people's medical conditions and what this meant for them this was not always included in the care plans in people's homes. For example, one person's referral recorded that they had an in-situ catheter, swallowing difficulties and was at risk of urinary tract infections, however there were no details in their care plan to guide staff as to how they should provide appropriate support regarding these health concerns. Without this important information there was a risk that staff would be unaware of how these conditions impacted on the persons health and well-being and may provide support which was ineffective and unsafe.

Information gathered in referrals regarding people's preferences, interests and what was important to them had not been transferred to the care records used by staff. One person's referral stated that they were interested in reading, cricket and talking but there was no mention of any of these things in their care plan. Their care plan document consisted of a list of tasks and gave no indication of preferences or information to help staff understand how to give personalised care which was responsive to the person's needs.

Care plans demonstrated a lack of recognition or understanding regarding the impact of people's specific mental health needs, including how best to support people living with dementia. The limited information given in people's care plans regarding people's mental capacity also conflicted with details given in their initial referral. For example, one person's referral details stated that they had poor cognition and poor memory. It also said that it could be difficult to know if they understood what was being said to them and at times when responding was confused. However this key information had not been passed on to staff to help them to understand how best to support the person and be able to provide the appropriate care and reassurance. Their care plan stated that the person's mental capacity was good and although vascular dementia was listed as a health condition there was no other detail regarding how this affected the person and what support they may need in relation to this.

Care plans did not record the level of support each person required with their medicines. This had also not been formally assessed to establish whether people needed to be prompted, observed or assisted with taking their medicines. The lack of clear guidance meant that any staff who were not familiar with the support needed would be unaware the level of assistance to give. This may mean that people who were able to take their medicines independently were not given the opportunity to do so or that people were not receiving enough support to take their medicines safely and as prescribed.

When we asked staff about the information provided to them in people's care plans they told us that they felt they knew enough about people, however this knowledge had not generally come from people's care plans. One member of staff told us, "Carers need to use their common sense."
Staff were providing intuitive care based on the relationships they built with people. However, without the appropriate knowledge about people's physical and mental health conditions staff were unable to provide people with the support and understanding required to ensure they were delivering a high standard of care which met all of people's needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they knew who to contact if they had any concerns or complaints. However, although people were happy to make contact with the office or care co-ordinators, some people and their relatives did not feel that their concerns were taken seriously by the provider. One person told us, "I know how to make a complaint and I will stand up for myself, but if I telephone the office, they always make me speak to [provider] who comes across as not having a single caring bone in [their] body. Not pleasant at all." A relative said, "I have tried to make a complaint, but I was told in no uncertain terms by [provider] that there was nothing they could do and I could take [relative's] care elsewhere at any time." A log of complaints regarding late or missed calls was kept by the office. Although office staff had noted what they had done in response to the call there was no evidence to show that the provider had assessed or responded to any of the information provided in the complaints log. This demonstrated that people could be confident that concerns and complaints would be taken seriously and responded to appropriately.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

In September 2016 and March 2017, the provider was found to be in breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection in March 2017 we issued a Warning Notice with a requirement that the provider was required to become compliant with the regulation by 30 May 2017. We also met with the provider to discuss their future plans for the business and the improvements needed.

Despite assurances from the provider that improvements would be made following our previous inspections, there continued to be widespread shortfalls in the way the service was led. There was a lack of managerial oversight and leadership was not pro-active. One relative told us, "If it were just the carers, I would recommend [Danbury Care] without hesitation, but they are badly let down by the management side of the business." Another relative said, "I feel sorry for the excellent carers, because I should be able to recommend them, but the organisation of the business is not up to scratch." The provider had continually failed to have systems or processes in place to assess, monitor and improve the quality of the service.

There were no quality assurance audits being carried out to check documentation relating to people's care and support. The shortfalls we found in relation to people's care records and risk assessments had not been identified by the provider. In addition, important updates needed in policies and procedures, such as the medication policy, had still not been carried out. Other policies and procedures were disorganised, out of date and did not reflect current guidance. This placed people at risk of receiving unsafe or ineffective care.

Whistleblowing procedures to enable staff to feel confident that they would be supported to raise a concern gave inappropriate guidance. The policy stated that, 'Such reports should be made to the Danbury Care Office and never discussed outside of the office with any other person than a responsible manager." This information did not empower or support staff to raise concerns outside of the organisation should this be necessary. This may mean that potential mistreatment, neglect or risk of serious harm is not reported to the appropriate professionals to be investigated. This placed people at risk of unreported abuse.

People and relatives were not routinely asked for their views as a method of continually evaluating and improving the service. One person said, "No one's ever asked our opinion of the service either face to face, over the telephone or by survey." When people had been asked for their opinion they did not have confidence that their comments would be listened to and used to improve the service. One person told us that they had received a survey asking their views of the service but commented that they didn't think the provider was interested in what they had to say. They explained that the provider had been to visit but, '[Provider] wasn't interested in me. They came to see [member of staff]'. Another person commented, "[Provider] asked if everything was alright and disappeared within five minutes. They never looked at any of the records and really didn't seem keen to listen to me at all." This meant that opportunities had been missed to learn from the experiences of people and use feedback gathered to make improvements to the service provision.

At our last two inspections we found that the provider lacked understanding regarding their responsibilities

as the registered responsible person in accordance with regulation. It was only through the care and commitment of frontline staff that people had not come to any harm. This continued to be the case and the lack of provider oversight and leadership meant improvements were not being implemented, monitored or sustained. This resulted in continued non-compliance with regulations and put people at risk of unsafe care and treatment.

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

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 Care plans were task focussed and extremely limited in detail. Important information about people was not recorded in their care records.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments in relation to people's daily living were either not in place or lacked detail. There were no risk assessments in place relating to people's specific health conditions.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People could not be confident that concerns and complaints would be taken seriously and responded to appropriately.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no formal quality assurance systems in place to continually monitor the service provided. Systems were not sufficiently robust to ensure that the registered provider was operating within expected standards of governance and ensuring effective oversight of

the service.

The provider lacked understanding regarding their responsibilities as the registered responsible person.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected from the risk of unsafe recruitment.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not adequate numbers of staff to ensure people would receive calls within the allocated time. Training provided was not effective in ensuring staff had the knowledge they needed to provide people with safe and effective care.