The You Trust

Dorset Blue Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 24 and 27 March 2017. It was carried out by one inspector. Dorset Blue Care is registered to provide personal care to people living in their own homes. At the time of our inspection the service provided personal care and support for 27 people.

Dorset Blue Care had been acquired by the You Trust in November 2017 and they became the registered provider in December 2017. The previous registered manager had left the service in February 2017 and a manager from within the provider organisation had applied to add Dorset Blue care to their registration. At the time of the inspection there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not safe. People had been put at risk by calls being missed. The senior staff and managers were not aware of all of these incidents and the information had not been shared with other agencies appropriately. People told us that whilst they felt listened to when they spoke with staff across the service they sometimes could not get through to anyone when the office was closed.

Management were committed to making continual improvements to the quality of care people received. They were seeking to create a positive working environment where staff and people felt able to discuss any concerns or ideas openly. There were systems in place to review and monitor the quality of the service people received including feedback from people and staff. These had not been effective in ensuring the quality of care people were receiving from the service.

Staff understood how people made choices about the care they received, and encouraged people to make decisions about their care. Records, however, did not reflect that care was being delivered within the framework of the Mental Capacity Act 2005. We spoke with the registered manager about this and they began to address the omission straight away. We have made a recommendation about the recording of MCA decisions.

Staff were not being deployed effectively to ensure people received their visits as planned. People told us they were not confident that they would receive their calls at the agreed time and records reflected insufficient numbers of staff providing care. Staff were recruited safely and checks were made on their suitability to work with vulnerable adults.

Staff told us they knew how to identify and respond to abuse; including how to contact agencies they should report concerns about people's care to. An incident of missed care that made a person more vulnerable to harm had not been appropriately reported to other agencies.

People told us they received their medicines and creams safely. There were not safe systems in place to

ensure time dependent medicines were administered appropriately. Senior staff told us they would rectify this immediately.

People felt safe. They were protected from harm because staff understood most of the risks they faced and how to reduce these risks. Some risks people faced were not managed effectively and staff had varied understanding about how to mitigate these risks.

People were positive about the care and support they received. They told us staff treated them kindly and with dignity and respect. We saw people were comfortable with staff in their homes. Staff were consistent in their knowledge of the majority of people's care needs and spoke with confidence about the care they provided to meet those needs. They were motivated to provide the best care they could. Staff kept records about the care they provided. These records were not used to review people's care experience.

People had access to health care professionals and were supported to maintain their health by staff. Staff understood changes in people's health and shared the information necessary for people to get the appropriate treatment.

People were confident in the skills of the staff and where staff needed specific training to support people safely this was being provided. Where people had their food and drink prepared by staff they told us this was prepared to their satisfaction. People were left with access to appropriate drinks and food between visits.

We identified concerns related to the systems in place to protect people from abuse, staff deployment, the management of risk and the governance of the service. There were breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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. People had been put at risk by missed visits and systems in place had not picked this up. Staff were not deployed in a way that met people's assessed needs and this meant people sometimes received unsafe care.

People told us they received their medicines safely records did not indicate when time dependent medicines had been taken.

People were supported by staff who understood most of the risks they faced. They did not, however, always have information available about how to reduce identified risks. Staff had varied understanding where guidance was not available and this put people at risk of receiving unsafe care.

Staff told us they knew how to identify and report possible abuse. Processes to report abuse and neglect were not followed appropriately.

People were supported by staff who had been safely recruited.

Is the service effective?

Requires Improvement

The service was mostly effective. People were supported by staff who promoted their right to make choices. Records did not, however, reflect the framework of the MCA and this put people at risk of receiving care that did not reflect their best interests.

People were confident in the skills of the staff and their views were sought as part of staff supervision and development. Staff had access to training that responded to both their development needs and the needs of people using the service.

People were supported to access healthcare and with their diets where this was appropriate.

Is the service caring?

Good

The service was caring. People were cared for by staff who treated them kindly and with respect.

People were comfortable with staff and they had formed positive

relationships.

People had their privacy and dignity maintained.

People were involved in decisions about their care and told us their independence was promoted and valued by the staff.

Is the service responsive?

Requires Improvement

The service was responsive, although records related to care delivery were not always complete or used effectively. People had been involved in developing individual care plans which took into account their likes, dislikes and preferences.

People knew how to make a complaint and where they had made complaints these had been responded to appropriately.

Is the service well-led?

Requires Improvement

The service was experiencing a period of change and staff and people were experiencing some negative impacts of this.

There was a management team being formed roles and responsibilities did not support the team's ability to provide person centred care.

The systems that were in place at the time of our inspection were not effective in monitoring the quality of the service people received.

Dorset Blue 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. This was the first inspection of this service since it was acquired by the You Trust in November 2016. The You Trust became the registered provider with the CQC in December 2016.

We visited the office on the 24 and 27 March 2017. The provider was given 2 days' notice of our inspection because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be at the office and to assist us to arrange home visits. We made calls to people and staff following the visit to the office. The inspection was carried out by one inspector.

Before the inspection we reviewed information we had about the service. This included notifications relating to the service; a notification is the way providers tell us important information that affects the care people receive. We had not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to establish this information during our inspection. We also spoke with a social care professional with experience of working with the service before we visited and two health professionals during the inspection.

We spoke with two people in their own homes and observed interactions with two members of staff. We also spoke with people who used the service or their relatives by telephone. In total we spoke with three people and four relatives. We spoke with nine staff and the manager who had recently applied to add the location to their registration and another manager employed by the provider organisation. We reviewed records relating to ten people's care and support. We also looked at records related to the management of the service. This included five staff files, training records, meeting minutes and the documentation of audits and surveys.

Inadequate

Is the service safe?

Our findings

Staff were not deployed safely to meet people's needs and some calls to people had been cancelled and some had been missed. One person had a missed call and was also been recorded as upset by a further two calls that were more than three hours late. Other people had their visits cancelled as staff could not be deployed to attend their visits. For example, one relative explained they were being asked to support their relative to bed as staff could not be provided and they had not been able to use the time they had allocated to ensure they had breaks as staff could not be provided. Two other people were being supported for some visits by staff from another organisation. Another relative told us that they had supported their relative to get up as staff had not arrived for their morning visit when we spoke with them after noon. People did not receive care at the time they needed it.

People and staff told us that rotas and scheduling had been an on-going issue for the organisation but that it had got worse. Staff told us that they received their rotas one day at a time late in the evening and that afternoon rotas were sometimes not available until the day. People and relatives told us they often did not know which staff would be visiting them. One relative told us: "the last two or three weeks has been bad." Staff told us that efforts were made to reduce the impact on both staff and people and risks were being considered when decisions were made about cancelling visits or sending one staff member instead of two. However, they also gave examples of people's visit times being changed in ways that impacted on their lives. For example one person did not have their tea visit until close to the time they usually went to bed. A relative told us they felt it was difficult to make plans as they could not be confident in the time they would get support. They were worried about how the staffing difficulties may impact on family plans for Mothering Sunday. Another relative described the current staffing situation as "very stressful". We discussed these issues with the office manager and reviewed the impact of deployment difficulties on care provided to the 27 people receiving personal care. Twelve of these people had been affected by missed visits, other agencies being asked to provide care, one staff member undertaking care assessed as requiring two staff or relatives providing care.

We spoke with managers about the risks associated with the appropriate deployment of staff. They explained that the current situation was difficult due to changes in office staffing and availability of staff. They detailed the plans that were in place to stabilise the situation including reducing the hours of care provided by the service, recruitment and contractual changes for staff. The office manager knew about one of the missed visits but not the others and the manager did not know about any of the missed visits. This meant they had not identified the problem, analysed the cause or reduced the risk of it happening again. At the time of our inspection people were at risk of not receiving safe care at the times when they needed it. We asked the provider to take immediate measures to ensure that the visits were not missed to the most vulnerable people they supported. They assured us they would do this.

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

Staff were confident about how to identify and report abuse. They told us they had received training and knew where to find the provider's policy and procedures. They were also able to describe to us how they would recognise potential abuse and how they would report any concerns that they had. However, we noted that a missed visit had resulted in a person being unable to access fresh food and drinks or continence care from 1720 until 1015 the following day. This had not been reported to the local safeguarding team or the Care Quality Commission (CQC). We discussed this with the office manager who explained they had not identified it as a safeguarding issue as it had not been intentional and the person involved had sometimes slept in their chair previously by choice. We requested that they report it to the local authority safeguarding team. None of the five missed calls we identified had been reported to the local safeguarding team or CQC. We sought advice from a safeguarding professional and they confirmed that missed and substantially late visits should be reported when the person is vulnerable. Systems and processes were not established to effectively investigate allegations of neglect.

There was a breach of Regulation 13 of the Health and Social Care Act.2008 (Regulated Activities) Regulations 2014.

People were not always provided with safe care due to the impact of staffing difficulties. For example, one person's call was missed and they had not been able to access food or their medicines. Another person did not receive a call and spent the night in their chair as they were not supported to go to bed and had spent the night in their chair. Another person, who was at high risk of falls and needed assistance to get changed and prepare food, had not received care on three occasions in the month prior to our inspection. Two of these visits had been missed and on the other carers arrived more than five hours late and it was too late to provide the care required. Another relative, whose loved one was assessed as needing two carers to provide care safely, said: "Sometimes they are sending only one. They are so low in staff." We asked how often one carer was providing care alone and they told us it was about once a week. Staff also told us that visits had been missed, cancelled, rescheduled and provided by one carer. One member of staff told us: "They say if we don't go on our own the visit will have to be cancelled. We have had to stop going to some people." Records reflected that staff were sometimes supporting two people who were assessed as needing two staff to assist them to move safely on their own.

When staffing was correct, people's care reflected the risks they faced but gaps in assessment and guidance meant opportunities to reduce risk of harm may be missed. People told us they always felt safe whilst receiving their care. One person told us, "I always feel safe – I trust them with anything." Risk assessments had been carried out and actions identified to reduce some of the risks people faced. Risks associated with mobility, falls and medicines were all assessed and the actions staff should take were recorded.

Some risks people faced were identified but not assessed formally. There were, however, plans in place to address some of these facets of these risks within people's care plans. For example two people were at risk of tissue damage and risk assessments related to this had not been carried out to identify the severity of the risk or all the factors involved. Staff were addressing these risks in a number of ways such as: applying creams, ensuring people had drinks and where necessary by helping them to move. Some relevant information was not, however, present to assist staff. For example one person needed assistance to drink and hydration is an important element of skin care. Staff were recording the amount the person drank and they told us that they reviewed what they had drunk recently when they started their visit but they were not sure how much the person should be drinking or if anyone was keeping oversight of this. There was also no clear guidance about what setting this person's air mattress should be on or how to support this person to decide what position they should move to.

Where risks were identified staff did not always have information available to support safe care and

treatment. Two people were diabetic and had insulin administered daily by a district nurse. There was no information available to staff about indicators of dangerous changes in blood sugar levels. One staff member was able to describe a time when they had sought emergency support for one of these people, however, staff had varying knowledge about how to identify these risks.

People told us they received their medicines safely, however, the record system did not support safe administration. One person told us: "They are good with my medicines and they always leave a four hour gap between my paracetamol. They wouldn't give me them if there hadn't been the right gap." However, a member of staff told us that it was difficult to give time dependent medicines safely as records did not identify the time they had been given. The office manager who organised the rota told us that when people needed medicines at a set time for example to alleviate the symptoms of Parkinson's disease they planned the rota to ensure these medicines could be given safely. We reviewed the recording of medicines taken that needed to be taken four hourly and saw that it was not possible to tell when within a visit these medicines had been given and as a result it was not possible to determine if the person had taken their medicines with a safe gap between doses. People were also receiving their medicines at inconsistent times due to difficulties described in the deployment of staff. This put people at risk of medicines not being administered safely. We spoke with the office manager who told us they would address this immediately. Staff had received training and been assessed to ensure they were competent to administer people's medicines.

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

We heard from a health professional who highlighted the success staff had had working with a person who was at a high risk of self-neglect. They told us that Dorset Blue care had been successful in achieving positive outcomes for this person despite the complexity of the risks they faced.

People were also supported to ensure their homes were safe for example some people needed assistance to secure their home when they wanted this. There was guidance for staff about how to reduce risks in-between visits by ensuring people had personal safety alarms and what they needed before leaving them.

Staff were recruited in a way that protected people from the risks of being cared for by staff who were not suitable to work with vulnerable people. Care staff files included references from previous employers, applications forms and interview records. Checks with the Disclosure and Barring Service (DBS) were in place before staff started in their role.

Requires Improvement

Is the service effective?

Our findings

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

People who were able to make decisions about their care told us that they did so on a day to day basis discussing with staff how they would like the care and support they required provided. One person said: "They ask what I want." Staff described how they checked people were happy with the care they were providing, responded to people's wishes and how they promoted choice making. They were also able to describe appropriately what they would do if people refused care and they were not sure the person understood the consequences of doing so. The records did not however indicate that assessments had been made of people's capacity or that where appropriate power of attorneys had made decisions or best interest decisions had been made regarding people's care. For example, in one person's care record they were assessed as not having capacity to make decisions about their care and identified as disagreeing about the level of support they needed. They had then signed a consent form agreeing to the care. Another person had consented to their own care but other people were now making decisions for them due to the development of their dementia. Their capacity to consent to care had not been revisited formally although staff explained they checked with them before providing care. Another person was described as not having capacity to consent to their care. This had been signed for by someone who may not have had the legal status to do so. This failure to follow the processes laid out in the MCA created a risk that people may receive care that did not reflect their best interests. We discussed this with the office manager and they assured us they would review this as a matter of priority.

We recommend you seek appropriate guidance about the implementation of the MCA principles and processes in domiciliary care provision.

There was a system in place for ensuring that staff kept their training current and areas of training need identified by staff at a recent staff meeting were being addressed. This had included booking training around the care of people's catheters and the provision of face to face training to ensure competency in the safe administration of medicines and helping people to move safely. The Care Certificate, which is a national certificate designed to ensure that new staff receive a comprehensive induction to care work, had been implemented for staff who met the criteria. There were also online training courses available through the providers web based training system to develop knowledge in areas such as Asperger's and mental health support. When people had new mobility equipment such as hoists the service worked closely with health professionals to ensure the equipment was used safely.

People told us the staff had the skills they needed to do their jobs. Everyone we spoke with commented on

how able the staff were. One person said: "They are 100% they definitely have the skills" and another person commented: "They are all competent – they know what they are doing." People receiving care had been asked about how staff were doing during monitoring visits that checked staff competency. This information had been used in the supervision process to identify what staff were doing well and where they may need additional support.

People who had help with food and drink commented that this was done to a satisfactory standard. One person told us: "They can all cook ok." People were left with access to drinks and snacks between visits. Staff were made aware if people who were at risk of not eating or drinking enough, or had difficulty swallowing safely. They explained this information was always in people's care plans and described how they used the records kept to monitor nutritional intake.

People told us they were supported to maintain their health. Changes in people's health were reflected in their care plans which also detailed the support they needed to maintain their well-being. For example one person's health was variable and the support they needed was regularly reviewed in conjunction with health professionals. Staff fed any concerns back to the office and had regular contact with district nurses and GPs. During our inspection a person became unwell and staff were able to remain with them until their GP made contact. Changes and health updates were communicated effectively to staff and care plans updated in a timely manner. A health professional commented that they were: "confident that the staff share information and call us appropriately". They told us they had confidence in the support people received from the service.

Good

Is the service caring?

Our findings

People were supported by staff who they told us were kind and caring. People and relatives made comments like: "The carers are really smashing" and "Whoever comes is terrific. They are all really nice." People were positive about the caring nature of staff and we heard how important this was. One relative described how they felt the staff went above and beyond to make their life better. They told us: "They always take the time to talk and have helped us sort out little problems." Another person described them as "really caring people".

We saw and heard that people were relaxed and comfortable with staff; we heard light-hearted conversations taking place. These interactions were familiar and warm and respectful at all times with people being encouraged to make decisions about their care whenever possible. One person told us: "They are always respectful. All of them are respectful." Staff demonstrated they knew people well through their discussions with us and conversations we observed in people's homes; they asked after family and significant events in people's lives. Relatives told us they felt respected and cared about also. One relative told us: "They look after me too. They are so supportive."

People told us their privacy and dignity were respected. One person said: "I am always treated with dignity." Privacy and dignity were supported by guidance in people's care plans with clear guidance on how to promote dignity and respect throughout personal care and whilst staff were in people's homes. Care plans also reinforced the importance of promoting independence and people reflected this in their descriptions of the support they received. One person said "I do what I can." This reflected a values based approach which was evident in how the carers spoke with us and in the care we observed.

Staff spoke with warmth about people they provided care to and they were confident in the care given by their colleagues; one member of staff told us: "People always say everyone is very caring… I hear so and so is very good all the time." One member of staff described how they liked to go to work every day because they enjoyed visiting the people they provided care to. Another member of staff said: "I do the job because I want to give people good care. I am so dedicated to my clients."

Requires Improvement

Is the service responsive?

Our findings

People told us their care was delivered in a way that met their personal needs and preferences. This was, however given context by examples of care that had not been provided due to the difficulties with staff deployment as this was impacting on people's experience of the service's responsiveness. They told us that staff listened to them and responded; that they had been involved in planning their care and as a result they received care and support which was tailored to their needs and reflected their preferences. One person told us: "When they are here they provide a great service." Another person told us: "They listen and they always do what I need."

People and their relatives, as appropriate, were involved in the development of their care plan through an initial assessment which took into account their likes, dislikes and preferences. Staff and people told us that the care plan could be adapted to ensure it met people's preferences as they began to receive care. Care plans usually described how carer's should support people with the areas they had identified they needed help with and made the desired outcome of the support explicit if this had been identified. They also provided a summary of their life story and background emphasising the things that were important to the person. We found that two of the care plans we looked at did not cover all the visits that staff made to the person.

We spoke with professionals involved with the care of these two people and were told that Dorset Blue Care staff were supporting these people to achieve positive outcomes. We identified these care plan gaps with the office manager who told us they would review these care plans immediately.

Whilst acknowledging that care plans did not always contain sufficient information relating to risk management, they did contain accessible detail about people's preferences alongside guidance about how to deliver care in a way that reflected these preferences. For example the staff had guidance explaining what personal care a person needed including how they liked this to be done and any specific details to support the person's experience such as which toiletries and towels they liked.

Staff told us the care plans were useful and that if any changes were needed the staff responsible for this would respond quickly. We saw that one person had recently had a change in the equipment they used and this information had been referred to the staff in the office in order that their care plan could be altered accordingly. Staff told us that changes to care plans were highlighted to them before they visited people. Another person had experienced changes to their health and this was reflected in their care plan. People and relatives described a flexible and responsive service. One relative said: "The carers have been absolutely amazing all through any changes." They went on to explain that they felt able to ask for changes or additional time and new that staff in the office would do their best to achieve this. Another relative however described how difficulties with staffing had meant their needs weren't met. They told us that they were providing care to their relative and half of their own hours to support them as a carer had not been achieved in the previous three months.

Care plans were also reviewed with people or when appropriate with their loved ones. This meant that

people and appropriate others had regular opportunity to contribute to the way that care was provided.

Staff knew people well and were able to describe their support needs and preferences with confidence. The care staff kept accurate records which included: the care people had received; physical health indicators and how content they appeared. These records, and people's care plans were written in respectful language which reflected the way people were spoken with by the staff. The daily care delivery records were not however being taken to the office from people's homes on a regular basis to be reviewed. This meant that an opportunity to review the care provided and the care missed and its impact was not being utilised.

People told us they felt listened to and were able to approach all the staff. One person said: "I can talk to them all. They know how I feel." People also told us they could phone the office with any issues and would feel comfortable to make a complaint if they had to. Most people told us they made these decisions within the context of their relationship with Dorset Blue Care. One relative told us: "We feel loyal to them. I understand things are difficult, but they need to sort it out – we are not getting a decent service." The complaints procedure was available to people in their homes and we saw that where complaints had been made these had been addressed in line with the policy and people had been informed of outcomes. It was possible to identify the actions taken following complaints and this meant that the service was improved as a result of these processes being followed. Staff understood their role in supporting people with complaints. They told us they would encourage people to raise concerns themselves but also highlighted the importance of advocating for people if necessary.

Requires Improvement

Is the service well-led?

Our findings

Dorset Blue Care was going through a process of change at the time of our inspection. The You Trust had bought the service in November 2016 and become registered with the CQC as the provider in December 2016. There was a delay in registering the new provider as the appropriate applications had not been made to CQC. We became aware of this during contact with the service and detailed the actions that were needed to rectify this situation. This meant the service was operating without appropriate registration for a month. The service was being supported by a manager who worked for the provider and was spending two days a week at this location. They had applied to add the location to their registration since the previous registered manager had left in February 2017. Other managers from within the You Trust had also spent time at Dorset Blue Care providing support and guidance.

At the time of our inspection the service was not structured in a way that supported the work of the care staff. The organisational structure had been reviewed to reflect that of other services within the provider organisation. There had been staff who had worked in support roles leave the organisation or change the roles they carried out. The result of these changes was that and at the time of our inspection the office manager had taken on new roles and was responsible for a work load, including scheduling care and staff supervision, that they were not able to achieve effectively. Staff told us they received their rotas for the next day late in the evening and only had the office manager to turn to if they needed support out of hours. They told us they had not had formal supervision in the last three months. Records reflected this and we spoke with the office manager who acknowledged this was the case. This contributed to some staff's observation that they did not feel well supported or informed during the current changes. People and staff commented that they sometimes could not get through to someone when the office was closed and we saw this recorded in people's delivery records. This was not a safe organisational structure and did not reflect the support the staff needed. We spoke with the manager about these concerns and they assured us they would be taking on some out of hours support and that problems with the on call system would be analysed as a matter of urgency and measures put in place to address any issues found.

There were systems in place for monitoring the quality of the service but these had not been effective in identifying the concerns we found during our inspection. An initial assessment of issues had been developed into an implementation plan by the manager at the end of December 2016. This had identified that work was required to improve communication, planning for emergencies, recruitment, staff understanding legislation relating to the running of the service and feedback from people and staff. Some of the identified actions had been addressed. Feedback had been sought from people who used the service and there were plans in place to act on feedback or seek further information. For example five out of 22 people had indicated that replying to telephone calls was not good enough. It was acknowledged that this needed further exploration to help the provider to understand the problems people were experiencing. Other recommendations included the need for better time management. People were positive about the care they received.

A monthly audit had been carried out by the registered manager in January and February 2017 before they left and a manager from another service from the provider organisation had undertaken a peer quality audit

in January 2017. These audits had not picked up on errors in people's care plans picked up during this inspection. We spoke with the office manager about care delivery audits and they explained the process that had been completed prior to the You Trust buying the company. The member of staff who had undertaken these audits had left and records could not be located of this work being done. We discussed the importance of care delivery oversight during a time of change with a manager and the senior member of staff. They told us they believed that new processes were being developed to reflect the service needs.

Staff were aware of how to report accidents and incidents. There had not been any accidents since the new provider had taken over. Missed calls had not been reported as adverse incidents and as a result there had not been a robust management response including identification of the cause and support for staff to ensure they did not reoccur. Appropriate reporting of these incidents had not been made to the local authority of CQC. Systems and processes did not reflect the oversight needs of the service and did not ensure a safe service.

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

The care staff of Dorset Blue Care were held in high esteem by the people receiving a service however concerns about staff availability were raised throughout our inspection. One relative reflected on the impact of inconsistent staffing availability and told us: "I would recommend them to others if they could get the office sorted out. It is not knowing is the issue. If we knew we could arrange our lives." Staff were committed to their work and the people they visited. Some staff were supportive of the new provider whilst others felt uncertain and undervalued. One member of staff told us: "I am positive about them and am more sure now they have invested in training." Another staff member reflected on feeling like a pawn. All staff acknowledged the dedication and commitment of a senior member of staff who worked in the office but also raised concerns that the situation was currently unsustainable in relation to the planning and delivery of care.

The manager and the office manager referred to the staff with respect and valued the skills and experience evident in the team. The manager spoke about the importance of quality domiciliary care for older people to the provider and outlined plans to grow their work in this area. They explained that there had been a lot of change since the service had become part of a larger organisation including a consultation over terms and conditions and the need to stop providing care to some people as this could not be managed within the availability of the staff team. They acknowledged that this had resulted in uncertainty and low morale amongst the staff team. They described how staff had been kept informed, acknowledging where this had not been effective, and this was reflected in the experiences of staff. The uncertainty and low morale had contributed to the difficulties planning and delivering care.

Staff had been invited to attend two meetings since January 2107 where their concerns and developments were addressed. We saw that suggestions made were responded to. For example training had been implemented following needs identified by staff.

The staff team also worked with other organisations and professionals to ensure people received good care. Records and feedback from professionals indicated that the staff followed guidance and shared information appropriately.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to ensure that allegations of neglect were identified and reported appropriately.

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 12 HSCA RA Regulations 2014 Safe care and treatment People did not always care in a safe way because the provider did not ensure all that was reasonably practicable was done to mitigate identified risks.

The enforcement action we took:

We issued a warning notice requiring the provider to meet the requirements of this regulation within four weeks.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to ensure the safe running of the service.

The enforcement action we took:

We issued a warning notice requiring the provider to meet the requirements of this regulation within six weeks.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed to meet the needs of people receiving a service.

The enforcement action we took:

We issued a warning notice requiring the provider to meet the requirements of this regulation within four weeks.