Dynasty Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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

We undertook an announced inspection of Dynasty Care Limited on 31 July 2017.

Dynasty Care Limited is a small service which provides personal care and support services to people living in their own homes, including older people with dementia. At the time of our inspection the service provided support to 10 people.

At the previous inspection on 21 July 2015 we found that the service was meeting all the quality standards and was rated "Good". At this inspection (2017) we found the service to require improvement in several areas.

At the time of the inspection, the service had a registered manager. 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 provider did not have suitable arrangements to protect people against the risks associated with the management of medicines. We found that the registered manager did not ensure that staff followed National Institute for Health and Care Excellence (NICE) guidelines for the recording of medicines taken or refused which meant that the registered manager could not be sure that medicines were administered safely.

The registered manager did not have systems in place to ensure care staff received appropriate training and support to effectively meet people's needs. Although there was some evidence of supervision this did not happen regularly enough to enable the registered manager to properly develop staff. There was some basic training when a new employee started but little in the way of further development and no proper procedure to identify when staff required refresher training.

People told us they would feel comfortable raising any issues they had about the provider in an informal manner. However we found that there was at least one formal complaint which had not been appropriately dealt with by the registered manager and had not correctly followed the service's complaints policy.

The service did not have good governance arrangements in place to assess, monitor and improve the quality and safety of the services provided. Audits and checks by the registered manager were not always carried out, such as regular supervision, spot checks to monitor quality or developing quality assurance systems to receive and act on the feedback of people who used the service.

People and their relatives were satisfied with their service. Feedback from people was positive throughout. People felt that they were with a care provider they could trust and they liked their care workers who were described as kind, caring and respectful. They told us their needs were met and the way in which they were cared for reflected their preferences. People were involved in planning and reviewing their own care.

People were encouraged to make their own choices and maintain their independence.

People received personalised care in accordance with care plans which included risk assessments and instructions on how people preferred their care to be given. Staff had received basic training in and were aware of, policies and procedures designed to keep people safe, including safeguarding people from abuse and the management of medicines.

There were systems in place to guide staff in reporting any concerns. The registered manager and care staff were aware of the Mental Capacity Act 2005 (MCA) code of practice.

People were supported to eat healthily where this was part of the agreed plan of care. In addition, care staff brought any concerns regarding nutrition or fluid intake to the attention of the manager so that they could be raised with relatives if necessary. People received the support they needed to stay healthy and to access healthcare services.

We found four breaches of regulations during this inspection, in relation to safe care and treatment, staffing, complaints and good governance. You can see what action we have told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not as safe as it could be. The registered manager did not ensure staff followed National Institute for Health and Care Excellence (NICE) guidelines for the recording of medicines taken or refused.

There were sufficient numbers of staff deployed to ensure that people had their needs met in an appropriate and timely way.

Risk assessments were undertaken to establish any risks present for people who used the service, which helped to protect them.

Staff knew how to recognise signs of potential abuse and the action they needed to take.

Is the service effective?

Requires Improvement

The service was not as effective as it could be. The registered manager did not provide staff with sufficient training and support to ensure they had the knowledge and skills needed to perform their roles effectively.

Staff were aware of their responsibilities in relation to the Mental Capacity Act and acted in people's best interests.

People were supported to eat healthily, where the service was responsible for this and nutrition and hydration was monitored.

People were supported to stay healthy and well. If staff had any concerns about a person's health appropriate support was sought.

Is the service caring?

Good

The service was caring.

People we spoke with felt the care workers were caring and treated them with dignity and respect while providing care.

The care plans identified how the care workers could support the person in maintaining their independence and policies

emphasised the importance of maintaining dignity and respect

Each person's individual needs were identified in their care plan.

Is the service responsive?

Requires Improvement

The service was not as responsive as it could be. The registered manager did not respond to complaints in such a way that they were resolved or prevented from happening again.

People were involved in discussions and decisions about their care and support needs.

Care plans reflected people's choices and preferences for how care was provided. These were reviewed regularly by the registered manager.

Is the service well-led?

Requires Improvement

The service was not as well-led as it could be. The service did not have good governance arrangements in place to assess, monitor and improve the quality and safety of the services provided

The registered manager encouraged an open culture which enabled staff to feel they could raise any issues of concern.

Records were held securely and confidentially.

Dynasty Care Limited

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 inspection took place on 31 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

One inspector undertook the inspection and an expert-by-experience carried out telephone interviews of people who used the service and relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service. The expert-by-experience at this inspection had personal experience of caring for older people.

We reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports.

Before the inspection, the provider completed 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.

During the inspection we spoke with the registered manager and the registered provider. We reviewed the care records for four people using the service and the employment folders for three care workers. We looked at records and policies relating to the management of the service and four medicine administration records (MAR). We spoke with six people who either used the service or were family members of people who used the service. We received returned questionnaires from people and care workers as well as speaking to one care worker.

Requires Improvement

Our findings

People told us they felt safely supported with their care which was provided by care staff whom they knew and who were regular. One person said, "I very much trust the carer that we've had for a few years, now." Another person told us, "We have regular carers. They will always bring someone new with them and I recognise most of them that come now. We have a group of around four regular carers." Another person commented, "I have no reason not to trust them."

The provider did not have suitable arrangements to protect people against the risks associated with the management of medicines. Some care staff reported that there were sometimes delays in the supply and provision of medicine administration records (MAR) to people's homes. This meant that sometimes staff would administer medicines but not record this until such time as they received a MAR sheet, which may not happen for a day or more after administration.

We spoke with the registered manager about this. She informed us that she delivered fresh MAR sheets on the first day of every month and could not recall a time when there were any problems. However, she acknowledged that she did not record when she made those visits to deliver fresh MAR sheets and did not log her visit in the daily record sheet in the person's home.

She also acknowledged that it was possible that a care worker could find that there was a new medicine which had been prescribed for someone even though there was no place on the MAR sheet for it to be recorded as given. This would be the result of poor communication with the GP or pharmacist although generally there was a good relationship between the agency and GP.

The National Institute for Health and Care Excellence [NICE] guidelines recommend 'When recording medicines that have been taken or used, staff should make a note in the record as soon as the person has taken the medicine, including the date and time and make a note when a medicine has not been taken or used and the reasons why'.

The registered manager did not ensure that there were robust systems and procedures in place to ensure that staff were able to follow National Institute for Health and Care Excellence (NICE) guidelines for the recording of medicines taken or refused. This meant the registered manager could not be sure that medicines were administered safely or accurately.

The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014, concerning the proper and safe management of medicines.

At the time of inspection the service supported two people with their medicines. Care records contained details of any medicines a person used, together with instructions on how to administer or support people to take them.

The registered manager and care staff explained their responsibilities to identify and report potential abuse under the local safeguarding procedures. Staff had an understanding of how to report any potential abuse and who they could report it to.

People told us they discussed their support needs with staff. This included risks to their safety and welfare, for example, risk assessments that looked at all aspects of how people's support was provided. One person told us, "Yes, I feel safe - certainly the one who comes more than 90% of the time. In the last couple of months a second carer has been needed to be help being hoisted into a chair. We have had experience of our carer for the last 3 years and are very happy with her."

The service followed adequate recruitment procedures. Staff records showed that appropriate safety checks were carried out. Recruitment included an application, interview, reference checks and checks with the Disclosure and Barring Service (DBS). The DBS is a national service that keeps records of criminal convictions. Staff carried identification badges to further ensure that people felt safe and secure as to who was at their door.

People were made to feel safe if a care worker was running late, with telephone calls being made from the office or care staff to provide updates. Everyone we spoke with had had positive experiences with the reliability of time keeping from staff. One relative told us, "If our carer can't make it she will phone and tell us." Another relative said, "There's been a couple of occasions where the carer hasn't turned up because she had trouble with her car but that was sorted. But over the years, they've been very good indeed."

Requires Improvement

Our findings

People said they were confident that staff knew how to support them. One person said, "They have always done what I've wanted them to do and I'm quite happy with that." A relative told us, "I do think they're well trained. They have the right mentality."

The service had a total of ten care staff. Feedback from our staff questionnaire showed us that care staff had received an induction which helped them carry out their role and that they felt informed about the needs, wishes and preferences of the people they cared for.

Over half of the care staff respondents said that they did not feel their work and travel schedule meant they were able to arrive on time and stay for the agreed length. One care worker we spoke with said that often there would be occasions when two care staff were scheduled to care for someone but each care worker would have different start and finish times on their respective timesheets. Because individual care staff only received a copy of their own individual rota, they would only discover this at the time of arrival to the person's home.

The registered manager confirmed that she did not normally provide rotas to staff which included details of co-workers or contact details. The registered manager maintained that staff knew each other and could contact the office if there were any problems. However, the inspector found that this was not the most effective system for ensuring staff worked as a team or that they were clear about who they were working with. This lack of communication and clarity could also have a negative impact on people's care if care staff were not rostered at the same times for care that required two care staff.

During our inspection we saw that staff had completed training in the Skills for Care Common Induction standards or Care Certificate. However, this was usually accomplished by the end of an employee's induction. Several staff were undertaking qualifications in health and social care at levels 2 and 3 through the Qualifications and Credit Framework (QCF). The QCF is a new credit transfer system which has replaced the National Qualification Framework (NQF).

The company's website makes several references to "excellently trained" and "highly trained" staff. However, this was not reflected in staff records or the company's systems and data. We saw certificates in care staff files of training they had completed, such as moving and handling and medicines administration. However, the service did not hold a record of training that staff had undertaken or details of any refresher training scheduled. The registered manager carried out most of the training and had qualified as a trainer.

This was some years ago and there was no record of further training or professional development for the registered manager.

Records showed that staff had received one-to-one supervision sessions with the registered manager. These sessions were sporadic and took place approximately every six months. There was no annual appraisal of staff performance.

The above was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, concerning the provision of support, training, professional development, supervision and appraisal to staff.

Staff had received training in The Mental Capacity Act 2005 (MCA) to help them to develop the skills and knowledge to promote people's rights. Staff understood people had the right to make their own decisions and what to do if people needed assistance to make some decisions.

However, staff had mixed views regarding receiving the training they needed to enable them to meet people's needs, choices and preferences, or to help them understand their responsibilities under the Mental Capacity Act (2005) (MCA).

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). For people receiving services in their own homes applications would be made to the Court of Protection.

Relatives we spoke with told us staff offered support to their family member and checked they wanted to receive care, and their wishes were respected.
At the time of inspection there were no people whose circumstances required an order to be made by the Court of Protection that resulted in the person being deprived of their liberty.

People were supported to eat and drink enough and to maintain a balanced diet, where this was part of their agreed care plan. Staff had received training in food hygiene and handling. One relative told us, "The carer will talk to him about what he would like. She has been cooking for him for several years now, and I have been there when she says I can offer you this and this and he will make a decision."

There were arrangements in place to support people with their health needs. The service held details of people's GP and had contact details of local community teams. The registered manager told us, "If there are any health problems staff will let me know immediately so that I can follow up with the community team or next of kin with the client's permission.

People had positive comments to make regarding the help they received with their healthcare. One relative told us, "Yes, they are very good from that perspective. If a medical appointment is needed the carer will let us know and we will try and arrange an appointment at a time the carer will be there." Another relative said, "There was one occasion about three weeks ago my wife was standing and I was cleaning, and I couldn't see

what she was looking like. The carer said "Let's sit her down quick". The carer was in no hurry to go until we sorted her out."

Good

Our findings

People were positive about the service and told us that the staff and management team were very caring and kind. One relative told us, "Yes I think they are. My {relative} and the carer have good conversations together." Another relative said, "Yes definitely. The way they talk to {my relative}, the way they don't hurry them. {My relative} is quite repetitive and they will just slot into that. They're interested in the things she does."

All of the people we spoke with and all who responded to our questionnaire told us that they were happy with the support they received and that they were treated with respect and dignity. On the company's website there were several testimonials praising the agency, although these were not dated.

Staff were equally positive about their work and the people they cared for. One care staff told us, "I love my job. I could work with another agency, or go somewhere else, but I love my clients."

People had their dignity and privacy respected and promoted. Staff had received training in person-centred care which included dignity and respect as topics.

Care plans for people showed us that staff knew people and their history, likes, preferences, needs, hopes and goals. The relationships between staff and people receiving support demonstrated a friendly and respectful service.

The service supported people to express their views and be actively involved in making decisions about their care, treatment and support. Care plans were person-centred, and included input from families. One relative told us, "Yes there is a care plan, and when they first came and from time to time they look at it. The first thing the carers asked for when they came in is the care plan. It's more or less renewed each year." Another relative said, "Yes. I had an hour and a half conversation with the manager."

Requires Improvement

Our findings

We looked at how the service responded to any concerns or complaints. We saw that there had been two separate concerns raised with the registered manager which required the registered manager to speak to individual care staff about. Although there was a note in the individuals' supervision records that the matter had been raised, it was not concluded. There had been no formal investigation into the concerns and no response given to the care staff or the people who raised the concerns.

The registered manager explained that she believed the matters had been resolved in an informal manner. However, there was no evidence that any investigation had taken place or that it had been resolved with the complainants or the care staff. There were no records logging the concern or how it was resolved. This meant that there was a risk that people felt their concerns were not acted upon and that the service was unable to learn from these concerns and improve practice.

The above was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, concerning the requirement for providers to have an effective and accessible system for identifying, receiving, handling and responding to complaints.

People felt that care staff took into account any needs associated with age, disability, gender, gender identity, race, religion, belief or sexual orientation. This was supported by clear policies and procedures which emphasised person-centred care, equality and people's rights.

One relative said, "They bought {my relative} a little birthday present which was a mug with cats on it as they know {my relative} loves cats. The carer knows what they are interested in and will prompt {my relative} to do the things they like."

Another relative told us, "I think they try keeping humour in their job, and at the same time keeping {my relative's} dignity."

Staff recorded the care they had provided at each visit and recorded any concerns they had about a person's wellbeing or conditions.

People told us they were happy with their support and that they felt able to say if anything around the support they received needed changing or could be improved. One person told us, "It's very easy to contact them. I have a phone number." A relative said, "It's very easy. They have a number for weekends and out of

office."

Requires Improvement

Our findings

We explored with the registered manager and registered provider how they believed the service delivered high quality care.

We found that part of the reason for the shortcomings mentioned elsewhere in this report was the lack of proper managerial oversight of systems and procedures and a lack of a robust auditing of the quality of the service.

For example, although the service aimed to carry out spot checks (unannounced visits to people's homes to check the quality of care being provided) there had been no spot checks within the last 12 months. This was despite being a small service providing support to only ten people.

There was no system in place that provided the management with oversight of the needs of staff with regard to ensuring their effectiveness at work, their training or their care practice. For example, supervision of staff and staff meetings were sporadic and infrequent. They did not contain a proactive agenda that was designed to inform the registered manager and registered provider of issues that affected the quality of service. No system was in place that provided the registered manager with a clear overview of staff training needs or performance over the year. Two-thirds of the staff who responded to our questionnaire stated that they did not feel the staff in the office gave them important information as soon as they needed it.

Policies and procedures that were in place were sometimes not followed adequately, such as with following up concerns or carrying out quality assurance reviews with the people the service supported.

Although the service was a member of the United Kingdom Homecare Association (UKHCA) and attended the local authority's domiciliary care forum the registered manager was not affiliated to any good practice or accreditation schemes or initiative that focussed on developing the provider's commitment to good business and people management excellence. Examples of accreditation schemes might include membership of a Skills Academy Manager's local network, Investors in People, Skills for Care, Gold Standard Framework for end of life care and the Dementia Pledge.

The lack of managerial oversight and robust quality assurance meant that there was a risk that the service was unable to measure and review the delivery of care, treatment and support it provided to people and staff against current guidance and quality standards. There was also a risk that gaps in quality would go unnoticed because of the lack of good governance systems designed to drive continuous improvement.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, concerning the requirement for providers to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

People told us they felt satisfied with the way the service managed their care and communicated with them. One relative told us, "I think it is managed as well as it can be for a small organisation. Even in a large organisation things can go wrong." Another relative said, "It seems to be well managed. {Name of care worker} does practically everything and if she isn't going to be there they will make the arrangements."

The provider had notified the Care Quality Commission appropriately regarding notifications of safeguarding or other incidents.

Records and other information were stored securely and confidentially.

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager did not have robust systems and procedures in place to ensure that staff were able to follow National Institute for Health and Care Excellence (NICE) guidelines for the recording of medicines taken or refused. This meant the registered manager could not be sure that medicines were administered safely or accurately. (Regulation 12(g))

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Although there was a complaints system, it was managed inconsistently. When people raised complaints or concerns the service did not always take their views on board fully, investigate them thoroughly, tell the person the outcome or change practice to improve. (Regulation 16(1))

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The lack of managerial oversight and robust quality assurance meant that there was a risk that the service was unable to measure and review the delivery of care, treatment and support it provided to people and staff against current guidance and quality standards. There was also a risk that gaps in quality would go unnoticed because of the lack of good governance systems designed to drive continuous improvement.
(Regulation 17(2)(a))

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The level of support, supervision and training was not consistently demonstrated by the registered manager and this meant that staff were not adequately monitored or supported in their professional development. (Regulation 18(2)(a))