1 Diamond Jones Services Limited

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Inspection report

1Diamond Jones Services Limited
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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

Overall summary

The inspection took place on 13, 14 and 18 May 2015 with the provider being given short notice of the visit to the office in line with our current methodology for inspecting domiciliary care agencies. The service was previously inspected on 16 January 2014, when no breaches of legal requirements were identified.

1 Diamond Jones Service Limited is a domiciliary care service which is situated in Carcroft on the outskirts of Doncaster. The service is registered to provide personal care to people in their own homes. At the time of our

Summary of findings

inspection the service was supporting people with a variety of care needs including older people and people living with dementia. Care and support was co-ordinated from the services office which is based in Carcroft.

There is a registered manager which manages the day to day operations of the service. 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 the time of our inspection there were approximately 21 people using the service. We asked people about their experiences using the agency; three people told us they were satisfied with the care, however, four people raised concerns with us about calls being missed or late calls.

At this inspection, we found that a number of breaches of legal requirements. This put people using the service at significant risk of receiving inappropriate or unsafe care.

People provided us with mixed views on the services they received. Whilst some people praised their regular care workers, some people told us of feeling rushed during care visits and care workers not listening to them. We found that some people received care visits that were shorter than half their allocated time, and that some people did not receive a consistent set of care workers who got to know their individual care needs and preferences. This meant people were not always treated in a caring way that met their individual needs.

We found that people were not being supported to manage their medicines safely. Most medicines records we saw had not been filled in to demonstrate that people had been supported to take their medicines as prescribed.

People's needs had been assessed before their care package commenced and they told us they had been involved in formulating and updating their care plans. We found the information contained in the care records were inadequate with some key information missing. For example support to enable people to take their medication safely, and support with personal care.

We found that people's complaints were not identified as complaints and addressed. Some complaints records showed they had not been addressed in a timely manner. This meant people were not listened to, and action was not taken to prevent any unsafe or inappropriate care that was being reported.

Safeguarding processes did not always keep people safe from abuse. The registered manager had not informed us of allegations of abuse relating to services provided by the agency. However, we received an alert form from the local councils safeguarding team which stated there had been a breach of confidential information involving several people who used the service. Following this inspection we raised a safeguarding alert on behalf of a person we visited.

We found that care workers were inconsistently trained, supervised and supported. Recruitment procedures were not sufficiently robust to ensure the right staff were employed to keep people safe. Staff were not supported to deliver care to people safely and to an appropriate standard.

Quality assurance checks on care plans were ineffective as they were recorded by the registered manager in a diary. This meant there were no records to demonstrate if care plans were up to date and were reviewed. People's views of the service were not always formally recorded and we found no action was taken when issues were raised. Records were not always provided to us in full when we requested them, which undermined our confidence in the transparency and management of the service.

Due to the many concerns that we found, we did not have confidence that the registered manager had oversight of quality and risk at the agency, and concluded that the service is not well-led.

We found overall that people using the service were at significant risk of receiving inappropriate or unsafe care. We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Summary of findings

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.

We found instances where people's scheduled visits did not occur as planned. This compromised people's safety and wellbeing.

We found concerns with the provider's safeguarding processes. The registered manager had not informed us of allegations of abuse relating to a breach in some people's confidential information which put their security at risk.

We found that people were not being supported to manage their medicines safely, because medicine records had not been filled in to demonstrate that people had been supported to take their medicines as prescribed.

We found recruitment procedures were not sufficiently robust to ensure the right staff were employed to work with people in their own homes.

Is the service effective?

Inadequate 

The service was not effective.

People had mixed views on the capability of staff. We found that care workers were inconsistently trained, supervised and supported. Oversight of these processes was not accurate and staff were not supported to deliver care to people safely and to an appropriate standard.

We found that some people received care visits that were shorter than half their allocated time, and that some people did not receive a consistent set of care workers who got to know their individual care needs and preferences. This meant people were not always treated in a caring way that met their individual needs.

Is the service caring?

Requires improvement 

The service was not caring.

Whilst some people told us of positive and caring relationships with their regular care workers, we received some feedback about care workers not listening to people, people feeling rushed, and people not being kept informed of changes to their care.

Is the service responsive?

Inadequate 

The service was not responsive.

People had mixed views on how well the agency responded to their individual needs including the timeliness of their care visits, and any concerns they raised.

Some people's care plans and care delivery records showed that their individual needs were not being responded to.

Summary of findings

We found that people's complaints were not identified and addressed in a timely manner.

Is the service well-led?

Inadequate

The service was not well-led.

We found that missed visits were not always recorded or investigated, so that action could be taken to prevent reoccurrence. From the records we looked at we found missed and late visits were not always accurately reported to the registered manager. This meant people did not always receive the support they had been assessed as needed.

Records were not always accurate and up-to-date. Care plan records were not sufficiently detailed and this meant the care provided may not be safe.

1 Diamond Jones Service 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.

The inspection team consisted of an adult social care inspector and this inspection took place on 13, 14 and 18 May 2015 and was announced. The provider was given 48 hours' notice because we needed to be sure that someone would be available when we visited people in their own home. We also needed to ensure the registered manager was available at the office for us to speak to her.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the registered manager. We also obtained the views of service commissioners from the local council who also monitor the service provided by the agency. Because they told us about concerns that had been logged against this service we decided to bring forward this inspection and the local authority contracts and commissioning officer joined us on this inspection. We also spoke with a social worker and a diabetic nurse regarding the care provided to two people who used the service.

At the office we spoke with the registered manager. We also spoke with a person who had been appointed as acting manager who had been asked to assist with the inspection. We were also introduced and spoke briefly to a person who had been appointed to undertake spot checks on staff and deliver training to staff. We also visited and spoke with two people who used the service and spoke with 7 people who used the service and their relatives by telephone. We telephoned and spoke with four care workers who worked with people who used the service in the community.

We looked at documentation relating to four people who used the service, staff and the management of the service. This took place in the office. We also looked at two people's written records, including their plans of their care. This took place in people's own homes and we asked permission from the people before we looked at these records.

Inadequate

Is the service safe?

Our findings

People we spoke with gave mixed responses when asked if they felt safe when care was being delivered by care workers. One person said, "The staff always makes sure they lock up after they have gone, they put the key back in the key safe, so that I know I am safe in my house." Another person said, "Most of the staff are kind and support me to be independent but I don't like it when the young staff come. They stand and look at me as though they don't know what to do and that makes me feel uncomfortable." A relative told us that one of the care workers forgot to place the key back in the key safe and took it home so other carers could not get in. The relative told us they brought it back the next day and apologised. Another relative told us that sometimes carers come to deliver care and their relative has never met them before which make them feel unsafe.

The local authority contracts and commissioning officer recently made us aware that a list of keysafe numbers which were found in the street. The list had names of people who used the service which meant there had been a breach of confidential data. This incident was placed into safeguarding and the registered manager was asked to contact people on the list and advise them to change their keycode as a safety precaution. The registered manager did not report the incident to the Care Quality Commission (CQC). The registered manager was unaware that the incident should have been reported.

We looked at the safeguarding file kept at the office and found two further safeguarding incidents recorded in the records. The records did not state the date they had been received and just stated the first names of the people that had made the referrals. The registered manager was able to confirm that both incidents had been reported by the social worker of the two people who used the service. From our records held on the service neither had been reported to CQC. The registered manager did not have copies of the necessary notifications which should be reported to CQC.

This was a breach of Regulation 17 (1) (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the registered manager had investigated the safeguarding referrals and found that one incident involved a person not receiving their medication correctly. The registered manager had recorded an action plan detailing how the service would implement measures to address the incident to prevent it reoccurring. However, when we visited this person we found the same errors in the recording of medication. The relative of this person told us that late and missed calls were also still occurring which affected when the person was prompted to take vital medicines. We discussed this with the registered manager when we returned to the office on the third day of this inspection and advised that we intended to report this to the local safeguarding authority. We submitted a safeguarding referral later that day.

Other actions the registered provider intended to make following this safeguarding investigation was to undertake more spot checks and introduce audits of care plans. The registered manager was unable to demonstrate that these had been introduced. This meant the provider was not following procedures and taking action in a timely manner to keep people safe.

The second incident showed the registered manager had taken statements from the staff who supported the person but was unable to tell us if the investigation had been concluded. We spoke with the social worker who raised the alert and they informed us that the investigation had not been concluded at this time.

This was a breach of Regulation 13 (1) (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at safeguarding adults training records for the staff and found some staff had completed on-line training. Most staff had dates when they were to attend the local authorities training in this subject. The staff we spoke with had a good understanding of how to report anything which may result in an alert being raised.

As part of the services initial assessment process we saw an environmental safety risk assessment had been completed. This helped the registered manager to identify any potential risks in the person's home that might affect the person using the service or staff. We saw risks had been considered and identified in the care plans we looked at. However they were not sufficiently detailed and sometimes were not identified within the persons care file. For example one person's list of medication did not include one of their prescribed medicines. The care plan did not give direction to staff to ensure how this medication should

be prompted at the evening call. Another person's file identified the person was at risk of falling but gave staff no direction what they should do if they found the person had fallen when they visited.

We looked at the accident and incident book held at the office and found no record of any fall for this person. However when we visited the person we were shown reports from emergency services which detailed the assistance staff had given following the fall. The daily records stated that they had contacted the relative regarding these falls.

Some people told us they experienced occasions when their planned care visit did not occur. One person told us, "They come early in the morning. I don't want to get up at 6:45am they should come at 7:30. They don't stay for the full time so I end up getting dressed by myself." Some people told us their calls were often late, One person told us that calls can be up-to two hours late.

We checked the summary schedule at the office which confirmed missed and late calls were occurring. This meant that people did not always receive their assessed needs in a person centred way at the times agreed in the care plans. This potentially puts people at risk of harm.

This was a breach of Regulation 12 (1)and (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to see staff rotas to determine if sufficient, suitable staff were employed to work at the service. The registered manager was not able to produce the evidence to demonstrate how staff were deployed to work in the locations where people lived. We were told by the registered manager that 12 staff were employed however we were given a list 17 staff who worked at the service. Three of the staff listed had only recently been employed so were not yet working in the community.

The registered manager gave us a list of calls provided to people who used the service. This showed 19 different staff who delivered care to people during April and May 2015. We noted that on several occasions the call required two carers to attend where only one name was listed as giving the care. There was a discrepancy between the number of staff the registered manager told us were employed and the staff names included within these documents.

We looked at the training records for the staff identified on the call schedule and found some staff had not completed the required training to ensure they had the skills and competencies to deliver the care safely to people who used the service.

This was a breach of Regulation 18 (1) (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at ten staff files to check if the service was following robust recruitment procedures. We found applications were not completed fully and this had not been identified by the registered manager. For example, dates of previous employment only had the year employed from and to. This meant the interviewer was unable to check any gaps in employment. We found none of the files had any interview notes so it was difficult to confirm if employment and training history was checked as accurate. Disclosure and Barring Service (DBS) checks for two staff confirmed that they had criminal convictions. However there was no evidence to confirm how the registered manager had considered the information and determined that the two staff were suitable to work with vulnerable adults. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We discussed this with the registered manager and they were unable to give any explanation for this omission. We also found some references were missing from staff files which meant they were unable to check if the staff were of good character and suitable to work at the service.

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

We looked at medication records held within care plans and spoke to people about the support they needed with taking their medicines. We looked at the medication administration record (MAR) for the two people that we visited. One person's MAR did not list the full amount of medication that the person was prescribed. For example one of their medicines which required varying dosages was omitted from the MAR and there was no evidence on the care plan to say how staff supported the person to take the correct dosage. The amount of this medicine could differ each time the person had their blood levels checked, therefore this was an essential medication that the person needed to take correctly. This person was also prescribed a

medicine to help control their diabetes. The MAR did not state what type of medicine was used or the amount and frequency to be given. MAR charts were left blank therefore we could not check if medication had been given at the times and frequency prescribed.

The second person's MAR listed the medication the person required, however prescribed creams used to prevent pressure sores had been omitted. The person told us that staff prompted them to take their medication but staff applied the prescribed cream. The MAR had not been completed and there was no care plan to describe how to support the person with their medication.

We looked at the training records for staff to ensure they understood their responsibilities when supporting people with their medication. The registered manager told us that staff completed on-line training in the safe handling of medication and competency checks were completed periodically. Certificates on staff files we looked at provided confirmation of completion of the training. Although we confirmed training had been completed by staff, in practice people were not protected against the risks associated with unsafe use and management of medicines.

This was a breach of Regulation 12 (2) (f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People provided us with mixed views on the services they received. Whilst some people were satisfied with their regular care workers, some people told us of feeling rushed during care visits and care workers not listening to them. We found that some people received care visits that were shorter than half their allocated time, and that some people did not receive a consistent set of care workers who got to know their individual care needs and preferences. This meant people were not always treated in a caring respectful way that met their individual needs. One relative we spoke with said, "Calls were never at the agreed time and most of the care workers only stayed for minutes rather than the full time agreed in the care package which was 30 minutes." Another relative said, "Mum never knows who is coming and this causes her to become anxious." One person we spoke with said, "They (the agency) can't seem to keep their staff so we never get to know them and they can't understand my needs."

We found instances where people's scheduled visits did not occur as planned. This included very late visits or where only one of two planned care workers attended. This compromised people's safety and wellbeing. The registered manager told us that missed and late calls were recorded in care plans which were out in the service. These matters were not investigated as the registered manager could not demonstrate how the service was trying to ensure the care was delivered safely and at the times agreed in the person's care plan.

The registered manager told us that care workers left a timesheet in the person's home which they completed each time they visited and recorded the times of the visits. The registered manager told us the person who received the service was asked to sign at the end of the week to agree that the visits had taken place. We looked at a number of completed records including those of the people we had visited and found the records did not correspond to the times that people were telling us that they had received their visit. For example some records put the agreed times such as 7.30am to 8am but had only stayed for a few minutes. Other time sheets just had the care workers name and no date or time they had visited.

None of the sheets we looked at had been signed as accurate by the person who used the service. The registered manager had not reviewed the records therefore could not confirm care was delivered as required.

This was a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's supervision policy stated: "All care staff will have a minimum of two sessions per year of formal supervision and one appraisal." However, we found this was not being followed. From the ten staff files that we looked at eight staff had not received supervision and four staff had not had an annual appraisal. We saw that the information recorded was poor and some documents had been signed by the member of staff but did not have any information written on it. One supervision we looked at had recorded an inappropriate response to a question about the knowledge of the staff member about equality and diversity. This record also stated that the member of staff required training in all aspects of care delivery. The record for their second supervision did not give any indication if training had been received. The document was blank with just the signature of the staff member.

We spoke with the registered manager about how they carried out spot checks on staff to ensure they were supporting people correctly and for the length of time according to the persons agreed care plan. She told us that she had carried out spot checks but had no formal way of recording the observations. The registered manager told us that a newly appointed trainer would have responsibilities to undertake this task. On the second day of this visit the trainer showed us a spot check that she had undertaken on one member of staff. It was recorded on a recruitment application form as she had not been given any other document to record it on.

We looked at completed copies of staff's induction which was set out as a number of questions which required the staff member to become competent in. On one staff members induction they had been deemed competent throughout all care tasks on the same date. The registered manager said this was when the person completed the record not when they were deemed competent to work with people in the community. There was no record which confirmed when the staff member had achieved the level of competency required by the provider. The registered manager told us that any future new staff would have to

complete the 'Care Certificate'. This replaces the 'Common Induction Standards' in April 2015. The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

The registered manager did not have suitable arrangements in place to ensure that staff were appropriately trained and supervised to deliver care to service users safely and to an appropriate standard.

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

We spoke to the registered manager about gaining consent to care and treatment. She told us that only three staff had received training and two staff were booked to attend training in the Mental Capacity Act. However, she said that most people they supported had some capacity to say how they wanted their care delivered in their own homes. Where people received support who had limited capacity we found they were living with a spouse who shared caring responsibilities with the care workers and other relatives. Therefore the agency did not need to use the guidance and principles of the act at the time of the inspection. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. However it is important that staff understand the Mental Capacity Act and how the principles apply in practice to ensure they act lawfully at all times.

We looked at care records and only one of the four care plans we looked at in the office had a record to sign to say they had been consulted and had agreed their care package. Most of the people we contacted on the telephone were able to tell care the staff how they wanted their care to be delivered. Relatives we spoke with told us that they acted on behalf of the spouse or relative to ensure staff asked for consent before attending to their needs.

People were supported with snacks and meals although most of the meals were cooked in the microwave. However, when we spoke with a social worker about one person's care they told us that the carer assisted the person to cook a meal that met their cultural needs. They went on to say it was difficult to know how to meet this persons nutritional needs because the person would often say that they had eaten, although when the social worker looked in the fridge there was no food. The social worker had asked the care workers to notify them when food was running low so that they could arrange for the delivery of new supplies but this had not happened. This meant it was difficult to confirm if the service were appropriately supporting this person to eat sufficient food to meet their nutritional needs.

This was a breach of Regulation 12 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

During our inspection we visited two people in their own homes. The visits were planned to ensure a relative was present. We also spoke with several people and their relatives on the telephone to ask them what they thought about the care provided by 1 Diamond Jones. Some people told us that the care workers were nice although most said there had been a lot of changes to staff so they were still getting to know them. However, some people raised concerns about the caring approach of staff, particularly those who did not attend to them regularly. One person we spoke with said, “They (the agency) sometimes send young staff to me who make me feel uncomfortable.” One relative said, “My relative likes certain things doing before they leave, like putting the telephone within reach, new staff don’t always do that which makes my relative anxious as they like to keep in touch with family.” Another relative said, “They are always rushing to next call and sometime that means they forget things that are important to my relative.”

A few people were concerned about some care workers’ ability to communicate and listen, for example, a relative told us, and “Some carers do not speak or understand English." Another relative told us that when staff work in two’s they often talk about other people who use the service while their relative is present. They told us they did not think this was very professional. One person we spoke with said, “On the whole I’m fairly satisfied with the carers but when I telephone the office about a concern I may have I cannot understand what they are saying to me as they talk really fast.”

This was a breach of Regulation 12 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager how they ensured people who used the service were supporting people in a dignified, respectful way. She told us that people were telephoned weekly and asked if they were satisfied with care that was provided. We were shown a communications book which had some people’s names with a date when they were called. The records were not sufficiently detailed to confirm if people were satisfied with the care. Some records referred to complaints they had made. For example one record stated that the person wanted to know why their carer had not attended. A further entry on the same date stated the person was very unhappy with the care provided, and that the person had not had any dinner. The last entry was to say that they intended to cancel the service. There were no further entries. We asked the registered manager how this was dealt with. She told us that their action would be recorded in the person’s daily notes, which were not produced for us to confirm if action had been taken to address the concerns raised. Recording actions within the daily notes section of the care records would not enable the registered manager to have oversight of this process and monitor any actions taken to ensure this had been effective.

This was a breach of Regulation 17 (1) (2) (a) (e) and (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with care workers on the telephone about the people they provided care to. They told us they understood the needs of people using the service. They told us they treated people with respect and tried to involve them in making decisions about how they received their care. They told us that people’s dignity was maintained when assisting people with personal care and they gave examples of how they ensured this.

Most people using the service we spoke with told us that they knew there was a book kept in their home but did not know what was written about them. They told us that staff had to write down when they had been and what they had done for them.

We spoke to two people we visited about the information they had received about the service which told them what they could expect from the service. They showed us a folder which contained a ‘Service users’ Handbook’. People told us they had only recently received it. It stated that the registered manager would provide access to advocacy services who would speak up for them if required. However, the names of such support agencies were left blank. This meant information could not easily be obtained by people who used the service if required.

Inadequate

Is the service responsive?

Our findings

People had mixed views about how responsive the service was. Some people we spoke with told us that staff were flexible if they had a hospital appointment they would change the time they received their care. However, people also told us that they preferred the calls at the times that had been agreed. One person we spoke with said, "They came at 6:30am and I told them it was too early to get up. My time was scheduled for 7:30am." Another person said, "I have to go to bed when they come, which is about 8pm. This means I am in bed for 12 hours which is far too long for me. The agency said they could not come any later."

From the comments we received from people who used the service we found staff provides the basic care which are task-led and not person centred. All of the people we spoke with told us that staff do what they need to do, and then they go. This means most calls are less than the allocated time which we saw on schedules. One person we spoke with said, "Some carers stay and have a chat but most do what they have got to do and then leave. They are always telling us they are in a rush to get to the next call."

We found people who used the service did not receive personalised care and support. We looked at two support plans for people visited. This included records kept in their own homes and the office. We also looked at two further care plans at the office. We found the care records were disorganised and daily records were out of date order and showed some gaps in the recording. Some of the records were not written on the correct documentation. This made it really difficult to establish if the care people received was based on their assessed needs.

We found the care plans were very basic. They did not describe the care required to help maintain their wellbeing. One person's records stated that they should give assistance with washing and dressing and also showering and hair care. The daily records did not reflect how these care needs had been met or reviewed. The relative of this person told us that this element of the person's care was frequently not met as the care workers come at times when their relative was not ready to get up. This meant the person did not receive the care and support as required to meet their needs

Another person's care plan that we looked at was not sufficiently detailed to ensure staff could deliver safe and effective care. We were told by the acting manager that the person had continence needs and described how staff were to manage those needs. However, there was no care plan in place to the persons continence needs. People we spoke with told us that they often received care from staff who did not know them and the staff would not be able to determine all of the care the person required from these records.

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

We spoke with the social worker for another person who told us they had a lot of input into the persons care. They told us that they had brought the poor care plan records to the attention of the registered manager on three occasions and no action was taken. The social worker said that she had reported this to the safeguarding who had logged it for the local authorities contracts staff to deal with.

The 'Service users' handbook' contained details of how people could raise concerns or complaints. This stated "We encourage service users to comment when relatively minor matters are a problem to them, such as receiving cold food or being kept waiting without explanation." It went on to say that complaints would be dealt with within 28 days.

When we looked at the records it was difficult to establish if complaints were dealt with within the timescales of the policy as records did not state when complaints had been received or who would investigate issues they had raised. One complaint had a statement from a member of staff that did not relate to that particular investigation. We also saw complaints were recorded in the communications book and had not been dealt with as described in their policy.

We saw records that were written in the registered manager's diary which should have been recorded as a complaint and she also showed us a text message conversation with one relative which should have been transferred to the complaints file.

This was a breach of Regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection the service had a manager in post that was registered with the Care Quality Commission.

People gave us mixed views on the agency's services and how well it was managed. Some people reported being happy with the service. Comments included, "I like my carer, she is very good but I don't like it when they send young staff who doesn't know me." However, some people reported negative experiences. Comments included, "I have raised several complaints and they say things will get better but it hasn't." I can't understand what the manager is saying to me as she speaks very fast." "They can't seem to keep staff; they are always sending someone new who I don't know." A relative said, "They are late to calls and sometimes they arrive very early and my relative wants to stay in bed so they just go."

Providers are expected to regularly seek the views of people about their service, to enable them to come to an informed view on the standard of care provided and manage risks identified from that. Some people told us they had not been asked for their views on the service. We looked at a file which contained only two questionnaires about the service. The surveys were not dated so it was difficult to establish when they had been sent back to the service. We asked how the service evaluated the service with such a poor response. The registered manager told us that more questionnaires had been received but they had been placed in the persons care file. She told us that they had not been evaluated but any action was taken to respond to comments. The registered manager was unable to give us an example to confirm this. Recording actions within the persons care records would not enable the registered manager to have oversight of this process and monitor any if this had been effective in addressing the concerns raised.

Telephone contacts were also used to gain the views of people who used the service. We looked at some of these records which showed concerns were raised about late and missed calls. However there were no details of how the provider had addressed this issue.

The registered manager did not have effective system to monitor safeguarding and complaints. We looked at the records for both complaints and safeguarding incidents and they were not fully completed. Dates and full name of complainants were missing therefore it was difficult to confirm how or when they had been received. We saw one concern about late calls and issues with the support required regarding a person's medication was recorded on the registered managers mobile phone. The information had not been transferred to the appropriate documents. This meant people's concerns were not investigated as required by their complaints procedures.

Some safeguarding incidents were recorded as complaints and the registered manager had failed to notify CQC as required. For example name addresses and key code information was found in the street by a neighbour of a person who used the service. This was reported to the local authority who asked that the service notify people named on the list to ask them to change the key code.

We asked how the service how they monitored people's care plans to ensure staff could safely deliver the care that had been agreed. The registered manager told us she visited people regularly to ensure the care was correct. The registered manager was not able to provide us with evidence of those visits or how they audited care plans. We found care plans were difficult to follow and contained very little information to enable staff to provide safe care. These inaccurate records did not protect these service users from the risks of unsafe or inappropriate care.

The registered manager was unable to demonstrate how the service monitored the times of calls to people who used the service. We looked at several time sheets which were completed by staff in people's homes. The time sheet should record the time they arrived and leaving the call. At the end of the week the person should have been asked to sign the sheet to verify the times and staff member's attendance. None of the sheets we looked at had a person's signature and some sheets just had the staff members name not the times of the calls. Other sheets had the agreed time of calls but not the actual time they attended. Most people we spoke with raised concerns that they had not had the calls as agreed and that staff had only stayed for a few minutes rather than the full agreed time of 30 minutes.

Staff recruitment systems were weak therefore did not protect people who used the service. People who used the service told us that there had been many changes in staff which meant they did not have time to get to know them. The registered manager confirmed that staff turnover was

Inadequate

Is the service well-led?

high which had caused some disruption in the service provided. Staff were not adequately supervised through regular spot checks and formal supervision to ensure they were provided care to a good standard.

The ineffectiveness of the provider's system of quality and risk auditing was also demonstrated through the breaches of regulations we found during this inspection that had not been identified by the provider before our visit. Therefore the assurance system of assessing and monitoring the quality of service provision at 1 Diamond Jones Service Limited was inadequate. There was no structured method of auditing the service which meant they were unable to identified areas in which improvements were required, 1 Diamond Jones Service Limited has failed to take account of this information to make and sustain improvements to protect people and this puts them at risk of harm.

This was a breach of Regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.