Direct Line Consultancy Services Limited

Direct Line Consultancy Services

Inspection report

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Date of inspection visit:
10 July 2018

Date of publication:
07 December 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 10 July 2018 and was announced. At the last inspection in November 2017 we identified breaches of seven regulations.

We asked the provider to take action to address our concerns about fit and proper persons employed, receiving and acting on complaints and safeguarding service users. We took enforcement action and issued warning notices requiring the provider to meet regulations regarding good governance, safe care and treatment, staffing and person-centred care.

The provider had taken very limited steps and had only addressed our concerns about complaints. Following this inspection in July 2018 we continue to have significant concerns about person centred care, safe care and treatment, good governance, staffing, and fit and proper persons employed.

Direct Line Consultancy Services is a domiciliary care agency. It provides personal care to children living in their family homes in the community. Although registered to provide a service to older adults, younger disabled adults and children, the service was only providing care to children at the time of our inspection. Not everyone using Direct Line Consultancy Services receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection the provider told us they were supporting three children with personal care. After the inspection the local authority told us an additional four packages had been commissioned to include personal care.

There was a registered manager in post, although he was not present during the inspection. 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 had failed to address our previous concerns about the lack of detail in care plans and risk assessments. There was insufficient information to ensure care workers could provide safe care and treatment to children in a way that reflected their preferences. Children receiving care had complex healthcare needs including physical and neurological disabilities but there was no recorded joint working with other professionals. There was also a lack of information about how to respond to health related emergencies which meant children were at risk of harm. It was not always clear whether the provider had taken appropriate action to safeguard children from harm.

Parents told us they were unhappy with staff who had only received online training working with their children. Staff had not received the training they needed to meet children's needs. Recruitment records were not complete and did not show robust recruitment processes had been followed.

The provider collected information about children's religious beliefs and cultural background but did not consider if this affected how children wished to receive care. Care workers did not feel the provider was sensitive to the religious and cultural background of families they supported.

Care plans were reviewed regularly, and families were asked to provide feedback on their experience. However, key information was not recorded and changes in circumstances were not captured in the care plans.

Families told us they had developed trusting and positive relationships with named care workers, but they did not trust the provider to supply consistently skilled care workers. Families chose to go without care when their regular care workers were not available.

The audit and quality assurance systems in place had failed to identify and address issues with the quality and safety of the service. The response of the provider did not demonstrate they understood the seriousness of the issues or that the lack of information within files put children at risk of harm.

Families told us staff arrived on time and stayed the full duration of scheduled visits. The provider had taken action to ensure complaints were responded to appropriately. Families told us they knew how to make complaints.

During this inspection we identified continued breaches of five regulations regarding person-centred care, safe care and treatment, staffing, fit and proper persons employed and good governance. Full information about our regulatory response is added to reports once all appeals and representations have been exhausted.

The overall rating for this service remains 'Inadequate' and the service therefore remains in 'special measures.'

Services in special measures will be kept under review, and if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

If not enough improvement is made within this timeframe, so there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review, and if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvement when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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. Risks faced by children had not been appropriately identified and measures in place to mitigate risk were not sufficient to ensure children were safe.

Recruitment records were not complete and did not demonstrate safe recruitment practice had been followed. Parents chose to go without a service when their regular care workers were not available.

Incidents were not always escalated appropriately and there was no analysis of incidents to ensure they were not repeated. Staff had training on safeguarding and information about how to raise concerns was included in the safeguarding policy.

Is the service effective?

Inadequate

The service was not effective. Staff had not received the training they needed to perform their roles.

Needs assessments did not lead to the creation of care plans with sufficient detail to ensure children's preferences, healthcare or nutritional needs were met. The desired outcome for care was not captured.

There were no records to show appropriate liaison with other services involved in supporting children to meet their needs.

The Mental Capacity Act (2005) did not apply as the children were all under the age of 16. Parental consent was appropriately recorded.

Is the service caring?

Requires Improvement

The service was not always caring. The service did not always display a sensitive approach to children's religious beliefs and cultural background. There was no consideration about whether beliefs or culture affected care preferences.

Parents told us their regular care workers had established positive relationships with their children. Care workers were able

to describe how they identified and responded to children's emotional needs. However, there was no guidance within care files to support this.

Parents told us they felt care workers respected their households.

Is the service responsive?

Inadequate

The service was not responsive. Records did not show children received personalised care and care plans were not updated to reflect changes in their needs. There was not enough information in care plans to ensure children received effective care.

Some children had life limiting conditions, but there was no record that families had been supported to consider their wishes in the event that end of life care would be needed.

The provider took action to respond to complaints appropriately.

Is the service well-led?

Inadequate

The service was not well led. The systems and processes in place had failed to identify or address issues with the quality and safety of the service.

The response of the provider did not demonstrate they understood the nature of the issues with the safety of the service.

The action plans in place did not address how to bring about improvements.

Staff felt the registered manager did not understand the risks involved in supporting children with complex needs.

Staff were unaware there were values underpinning the service.

Direct Line Consultancy Services

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.

We gave the service 24 hours' notice of the inspection visit because we needed to be sure someone would be in the office to give us access to the records. The inspection was completed by one inspector.

Before the inspection we reviewed information we already held about the service in the form of the last inspection report, the action plan the provider sent to us telling us how they would address our previous concerns and notifications that had been submitted to us. Notifications are information about incidents and events providers are required to tell us about by law.

During the inspection we spoke with two parents of children who received a service and four members of staff including the office administrator, the office apprentice and two care workers. After the inspection we spoke with a social worker and a member of the commissioning team. During the inspection we reviewed the care files of three children receiving personal care, including assessments, risk assessments, care plans and records of care. We reviewed four staff files including recruitment, training and supervision records. We reviewed various documents, policies and audit records relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2017 we were not able to assess if there had been any improvements in the management of medicines as none of the children receiving care were supported to take medicines. At this inspection we found care plans included information that care workers would administer medicines in emergencies. However, the information about what the medicines were, and the support staff had to provide was not clear. For example, one child was prescribed emergency medicines but the guidance for when to administer it was not clear, nor were the methods of administration. There were no records showing staff had received training in the specialist administration technique required for this medicine. The child's nutrition plan also included information about medicines and it was not clear if care workers were expected to administer medicines as part of the care package as the information provided to them was conflicting. One part of the plan said they did not, but the feeding information included medicines information. This meant the systems in place for supporting children to take medicines were not clear and children were at risk of not receiving their medicines appropriately.

In November 2017 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risk assessments were not robust and did not mitigate the risks faced by individual children. The provider had failed to address our concerns and risk assessments remained insufficient.

Children receiving care were living with complex health conditions including physical and neurological disabilities. The provider had failed to appropriately identify or mitigate risks. For example, one child's epilepsy risk assessment simply listed the types of seizure they had. There was no detail about how the child presented during seizures, or how care workers were expected to respond to seizures. Two of the children were described as having postural support needs due to their healthcare conditions. Although there was guidance regarding the use of hoists, there were no details of their positioning needs. The details regarding the use of hoists were not complete, as the size of sling was not completed. There were also details of different types of hoist in use, but it was not clear which hoist was used for each type of manoeuvre. Although one child was noted to have very frequent seizures, there was no guidance about how to respond if they had a seizure while using the hoist. One of the care plans referred to the child having a "Sore bum due to constant wearing of nappies." There was no risk assessment regarding pressure or moisture care to reduce the risk of pain and developing sores.

Two of the children receiving care received their nutrition via a percutaneous endoscopic gastrostomy (PEG). A PEG is a way of ensuring a person gets nutrition via a tube surgically inserted into their stomach. Although one child's file stated clearly that care workers were not involved in administering nutrition via the PEG, the other child's file included instructions that care workers were to prepare and administer feeds for the child. The guidance and risk assessments were insufficient to ensure this was done in a safe way. The only mention of PEG feeding in the risk assessment was in relation to infection prevention and control and this stated, "Carer to take extra care to wash hands before flushing the tube." The remaining guidance was undated and did not provide clear instructions. For example, it stated, "Put the food bag onto the feed pump then attach to [child's] button." The plan continued, "The syringe is washed with soap and water."

This was not sufficient instruction to ensure that PEG feeding was completed in a safe way and meant there was a risk of harm. The risk was heightened as staff had not received training in the use of PEG feeding systems.

The provider had introduced a generic infection prevention and control risk assessment to each child's care file. This advised staff to follow hand hygiene practices, wear personal protective equipment and not to attend work if they were unwell. There were no additional guidelines regarding risk associated with children's healthcare needs other than the reference to hand washing prior to flushing one child's PEG tube. This meant the risks of infection to the PEG site during personal care had not been appropriately identified or mitigated.

The above issues with medicines and risk management are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In November 2017 we identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the policy framework for supporting staff to raise safeguarding concerns was not robust, and staff had not received appropriate safeguarding training. The provider had addressed our concerns regarding their policy framework and there were now clear policies which informed staff how to escalate their concerns.

However, although all staff had completed an online training course on safeguarding children, the local authority told us the provider had not utilised the free training they provided for all services to ensure staff had a robust understanding of safeguarding children. A care worker told us, "There was safeguarding in the online training and the handbook. They [provider] didn't reinforce it. Just give us the information and left us to get on with it."

We reviewed the incidents folder and found there had been no incidents involving children who the provider told us received regulated activities. There were four recorded incidents for children since January 2018. One of these related to a child making an allegation that a care worker had shouted at them. There was no record this had been escalated to the local authority. The local authority confirmed they had not received any safeguarding concerns from the provider. Other incident reports described incidents where children had behaved in a way that put themselves and their care workers at risk of harm. After the inspection the local authority told us one of the children involved in an incident had a care package involving the provision of personal care. The provider told us the child's family had declined the personal care aspect of the service. The only actions recorded was that care workers were replaced. The office administrator told us that one of the children now had a male care worker and there had been no further incidents. However, how this decision was made, and any liaison with social services and family members was not within the incident files. This meant it was not clear the provider had robust systems in place for responding to incidents and ensuring appropriate safeguarding of children. It was not clear that lessons were learnt to prevent future incidents occurring.

In November 2017 we identified a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) as the provider was not recording the interview or assessment process for staff appointments.

There were now records of interviews that had taken place, and candidates answers had been scored. However, the actual answers had not been captured so it was not clear how the judgement had been made. Whereas previously the provider had carried out appropriate checks regarding the identity, right to work and criminal histories of staff, this was no longer the case. One member of staff had provided proof of address information that did not match the address they had supplied. Another member of staff had a criminal

records check completed by a previous employer that was more than three months old. Providers are required to complete their own checks or, if the candidate has subscribed to the update service, run an update check. The provider had not done carried out this check. This meant the provider had not ensured safe recruitment practice has been followed.

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

The office administrator told us they continued to use a group messaging application service to monitor staff attendance at visits. Parents we spoke with told us the care workers usually attended on time and kept them informed if they were running late. In November 2017 we identified that each child only had one member of staff allocated to work with them, and this meant there was a risk that children would not receive care if that staff member was away from work for any reason. We saw the provider had attempted to introduce additional care workers to packages, but family members had told the provider they only wanted to work with regular care workers. When we explored this with parents they said this was because the additional care workers were untrained, or did not have enough information about what they were expected to do. They told us they trusted their regular care workers, but did not feel willing to provide additional support to get more care workers trained to the standard they required to work with their children. This meant the provider had not fully addressed our concerns about staff deployment.

Inadequate

Is the service effective?

Our findings

In November 2017 we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff had not received the training they needed to perform their roles. The provider had not taken effective action to address our concerns and had not met this regulation.

Care plans showed children receiving care required support from staff who were skilled in specialist nutrition and medicines administration techniques as well as moving and handling. No staff had received practical training in moving and handling, nor had they received training in PEG feeding or specialist medicines administration techniques. A relative told us, "I check what training they have done when they arrive. I send them away if all they have done is e-learning. E-learning is not enough to be able to care for my child." A care worker said, "There was online training which was pretty bog standard. There was no practical training."

Although records showed staff completed shadowing sessions when they joined the service, this was contradicted by staff. A staff member said, "There was no shadowing. I was very disappointed. I was nervous and they left me to it." Staff feedback also contradicted the records regarding supervision. The records showed regular spot checks and detailed observations of practice. However, a staff member said, "There was no supervision. They did a check on me. It was just a five minute thing. They checked the folder and that I was wearing my ID. They didn't observe me doing my job, they didn't read the actual notes, just checked that I'd written them." Despite this feedback, this staff members file contained a record of a detailed observation of their practice.

In November 2017 we identified that none of the staff had completed the care certificate. The care certificate is a recognised qualification which gives staff the foundation knowledge required to work in a care setting. Staff files contained copies of e-learning completion certificates, and the training matrix stated staff had completed the care certificate. However, staff files did not contain records of care certificate completion. Each file contained a "care certificate self assessment" where each staff member had self-evaluated their knowledge in relation to the care certificate. There was no record to show the staff had completed related training to demonstrate they had met the requirements of the care certificate.

The above issues are a continued breach of Regulation 18 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

In November 2017 we found a breach of Regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were task focussed and lacked detail of children's needs and preferences. The provider had failed to address our concerns and care plans remained insufficient to meet children's needs and preferences.

For example, although one child's care plan noted their family member's first language there was no information about which language to use when communicating with the child. Another plan instructed care workers to, "give [child] a fully body wipe using a bucket in the living room with warm water and soap from

the bucket in the living room using a sponge and a flannel. Change nappies." There was no information about how to do this in a way that ensured the child's engagement or what their preferences were. Where children needed support with dressing there was no information about the types of clothes they liked to wear, or whether or not they had to wear uniforms for school. Care plans simply directed staff to children's parents.

Furthermore, where children were receiving care to get ready for school, there was no information about whether care was also delivered during school holidays, and if children's preferences varied during the holidays. This meant there was a risk staff would continue to attend and follow the school-day routine during the holidays when this would not be appropriate. One child's review records noted they were currently unable to access the community, but their care plan had not been updated to inform staff of alternative activities they could engage the child with until they were able to access the community again.

A care worker we spoke with told us about how they supported a child to eat their breakfast and after school snacks. The level of detail provided by the care worker was not available in the care file which did not include any details about the child's needs or preferences about food. Another care file instructed care workers to administer nutrition but the information about how to do so was unclear. This meant there was a risk that children would not receive the support they needed to have their nutritional needs met as they were not clearly captured in the care file.

The above issues are a continued breach of Regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009.

Care files contained information that suggested children received support from various agencies. For example, meeting minutes in one child's file mentioned specialist nurses, healthcare professionals and social services involvement as well as the child's school. Care files contained no records that the service liaised or worked with other services involved in supporting the children to ensure a coordinated approach. Care records showed care workers completed the drop off and pick up from school on a daily basis, but there was no instruction for care workers to liaise with the school and no recorded feedback or communication with the school in the daily notes. This meant there was a risk that important information about children's progress and support was not captured or shared with people who needed to know.

Parents told us they took the lead with supporting their children with their healthcare needs, and did not require care workers to support their children to access healthcare services. The children whose files we reviewed had complex healthcare needs which required staff supporting them to be confident in responding to medical emergencies, for example if the children experienced seizures. There was insufficient information within the care files to ensure care workers were able to identify and escalate concerns about children's healthcare needs. While the care plan described their communication, it did not explain how to identify if they were unwell or what steps staff should take. Despite this, family members said regular care workers now knew their children well enough to be able to identify when they were unwell. One relative said, "[Regular care worker] can spot when he isn't well now. She'll tell us if she thinks he's under the weather."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 in in their best interest and as least restrictive as possible. The MCA (2005) only applies to people over the age of 16. The provider was not delivering care to anyone over the age of 16. Records showed appropriate parental consent had been sought and given to provide care.

Requires Improvement

Is the service caring?

Our findings

Care workers spoke about the children they supported with kindness and affection. One care worker said, "I've got to know [child] very well now. Sometimes after school they get very tired, and will get very upset. Oh the screaming! I'll be gentle, help them have a shower, a change of clothes and if Mum says it's OK then a packet of crisps." Another care worker said, "I want to help the families, I like working with the children and helping them to develop."

A parent told us they thought their care worker had got to know their child well enough to meet their emotional needs. They said, "She [care worker] knows him now. She can read his mood. I like to meet the care workers before they start, I need to trust them before they start."

At our last inspection in November 2017 we reported our concern that the service relied entirely on parents to inform care workers about how to build relationship with the children they were supporting. While there was now some information about children's communication needs in some of the care files, the quality of this information varied. It was not enough information to ensure that care workers were able to identify and respond to children's emotional needs. For example, one child's file described how they expressed themselves when they were happy and content, but despite stating the child was often in pain did not describe how they expressed pain. This meant there was a risk that staff who were less familiar with the children would not be able to identify or respond to children's emotional needs.

In November 2017 we made a recommendation about ensuring people's religious and cultural needs were identified and supported. The provider had not fully followed this recommendation. Care files now contained information about children's religious beliefs, and the religious beliefs of the household. However, there was no information about whether this had any effect on their care preferences. For example, whether it affected their diet or what time they wished to receive care. A care worker told us they did not think the office understood the impact religious beliefs and culture had on people's experience of care. They told us they had tried to raise a concern with the office and had been told, "Oh, they [family] are [specific religious faith], that's why they are a bit weird."

Care workers told us they followed the instructions of parents with regards to promoting children's independence, promoting their dignity and engagement with activities. One care worker said, "I show my respect to the family by doing what they ask me to. The mother supervises my work and she says [child] likes me." However, another care worker told us the instructions from parents made it difficult to promote the independence of the child they were supporting. They said, "It's difficult, I'm meant to support one child, but their sibling is always there. That means my attention is divided and I can't focus on the one child. It ends up feeling more like babysitting."

Parents told us they felt their regular care workers respected their households. One parent said, "Now we have one [care worker] we can trust, I am confident she respects us." Feedback forms completed by families, and feedback collected from social workers confirmed that families felt that care workers worked in a way that was respectful to their homes and lifestyles.

Inadequate

Is the service responsive?

Our findings

In November 2017 we identified a breach of Regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans had not been kept up to date and reviews had not been completed. The provider had taken some action to address this but it was not effective.

Records showed care plans had been reviewed and updated since our last inspection. However, despite records showing meetings and telephone calls with family members there had been no increase in the level of detail about how to perform care tasks in a way that met the needs and reflected the preferences of the children receiving care. Family members confirmed to us they asked for changes but these were not acted upon by the provider. One relative said, "We told [provider] what we needed but they didn't listen to his needs. They eventually did, but then the actions were something else. When we said we needed something they told us they would sort it, but then they didn't."

Care workers also told us the provider failed to make changes when requested or when differences were highlighted. One care worker said, "I called the office to bring it [support issue for child] to their attention but nothing happened. They just left me to it." Review notes captured changes, for example, that one child no longer accessed the community, but care plans had not been updated to reflect these changes.

Office based staff sought regular feedback from family members in addition to the reviews. While these showed that family members had stated they would rather go without care than have replacement care workers they had failed to identify the reasons for this. In discussion family members and care workers both stated this was due to the lack of clear information provided to care workers before starting work with children. As one care worker said, "If I go on holiday [parent] doesn't like to have others. They manage because they are not comfortable going through it all again."

We reviewed the records of care completed by care workers, where these were available in the office. The quality of the records varied, and in some cases it was very difficult to work out what tasks had been completed as the written English was poor. For example, one child's notes stated each day, "I fide her berk parcs." Through conversation with the office administrator it was established this meant, "I feed her breakfast." Another child's notes were clearer but remained very brief and did not show how the child presented during care. Each day they stated, "Assisted [child] with all aspects of personal care. [Parents] gave medication. I took [child] to the school transport. All well on leaving." This description did not include information about nutrition and hydration which were included as tasks in the care plan. This meant it was not clear children were receiving personalised care as the records were brief and lacked detail.

The above issues are a continued breach of Regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In November 2017 we identified a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because complaints had not been appropriately identified or

responded to. The provider had taken action to address this issue and was now compliant with this regulation.

The provider had a complaints policy in place and parents told us they would make complaints to the office over the telephone if they needed to. The policy included details of the expected timescales for investigation and response to complaints. We reviewed the records of complaints and saw verbal complaints made during feedback had been appropriately identified and escalated as complaints. There were clear records of the communication with the complainant and records of how the issue was resolved. This meant the provider had addressed our previous concerns.

The service provided support to children who had life limiting conditions, however, none of the children had been identified by the service as approaching the last stages of their lives. This meant we were not able to assess if the provider was supporting children appropriately at the end of their lives. There were no records to suggest that families had been supported to consider their wishes by the service.

Inadequate

Is the service well-led?

Our findings

In November 2017 we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the systems and processes in place had failed to identify and address issues with the quality and safety of the service. The provider had failed to take appropriate action to address these concerns.

The registered manager and supervisor completed audits of care files. The records showed they audited a sample of care files each month. However, these audits had failed to identify the issues with the level of detail in care plans and records of care found during the inspection. Of the three children's files we looked at during the inspection, only one had a completed audit in the file. This had stated the care plan was "completely satisfactory." This meant the provider had failed to identify it was task focussed and lacked detail on how to meet this child's needs. Additionally, the audit file stated that another of the children's files had been audited in February 2018 but there was no copy of the audit within the file.

In addition there was a quality assurance folder which included completed telephone monitoring forms. These showed family members were asked to provide feedback on timekeeping, whether tasks were completed, the attitude of care workers, and the use of equipment. These were completed on a monthly basis and records showed that feedback was positive. This meant this had not been an effective was of seeking feedback about the quality of the service, as family members we spoke with told us their positive feedback was qualified. They were only satisfied with specific named care workers, and did not feel the service was consistently effective as there was variation in care workers supplied. This showed the systems to gather feedback did not provide opportunities for families to raise concerns or make suggestions for changes.

The provider had completed a staff survey. The aggregated scores came to the conclusion, "This is a very positive response and shows the agency in a very good light overall." The provider sent us their analysis and raw scores for this outcome. The information contained within the two sets of documents did not match. The raw data, where the individual survey responses were complied showed 15 or 16 responses to each question, but the analysis showed seven or eight responses for each question. The analysis methodology gave a much higher weighting to positive comments and there was no record to show negative comments or outliers had been investigated.

The survey did not reflect the feedback we received from care workers. One told us, "The office, they are good people. I don't see [registered manager] that much." Another care worker said, "I feel there is a lack of knowledge in the office. They don't know what they've got involved with. They just leave us to get on with it and that makes me feel very uncomfortable."

This feedback was supported by the response of the registered manager to the feedback given during the inspection. We provided written feedback which explained we had concerns about the detail in the care plans and risk assessment. The registered manager responded by stating, "You have stated that you are very concerned about the risk posed as the care plan does not mention how staff can mitigate risk associated

with epilepsy and PEG feeding. As part of our initial care assessment and review, parents are always involved in the preparation of their child's care plan. In all cases the agency will follow the instructions given by parents on how they want their child to be followed. These include how they manage the child's medication and where applicable their feeding needs. The care plan is signed by parents to indicate their agreement with the care. For example, if a care plan states "Do not administer", it clearly means that the parent does not want a carer role in medicine administration. All parents of the clients we provide care do not want a carer support with medication hence the instruction in care plan to inform the carer. I am therefore not in agreement with your observation/comments." This response shows the registered manager had failed to understand the extent of the concerns and had not understood that the information referred to was missing from care plans and this placed children at risk of harm.

We asked the provider to send us a copy of any development plans or action plans they had to improve the quality and safety of the service. We were concerned they had not followed the action plan they submitted after the November 2017 inspection. The provider sent us a document called "DCLS Annual Development Plan 2018." The plan identified eight priorities and clarified the registered manager had overall responsibility for achieving the priorities. The plan contained no information about how the priorities would be achieved. For example, the second priority was "Ensure that all staff are familiar with key systems and processes within the agency and ensure they are held to account to implement them." There was no detail about how staff would be supported to become familiar with the systems, and what being held to account would look like. In addition, the development plan did not include any plans to improve the quality of care plans and risk assessments. This meant there were insufficient systems in place to improve the quality and safety of the service.

Following further contact with the provider after the inspection, the registered manager submitted a further action plan. In the introduction to this document they re-stated their belief that care plans did not need to be detailed and the care workers role was to support family members in the provision of care to children. This demonstrates they had failed to understand the function of care plans, and the need for care workers to have foundational knowledge in order to be useful in assisting parents.

The above issues are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In November 2017 we identified a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was not displaying their ratings on their website. In response to this feedback the provider had taken down their website and it remained inactive. The rating was on display in the office.

The provider had a service user guide which included the organisation's statement of purpose and the values upon which they operated. Although this document existed, staff were not aware of the values of the organisation. When we asked staff what the values of the organisation were they were not able to tell us. One staff member said, "What do you mean, values? We just do the care."

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not personalised and had not been kept up to date. Regulation 9(3)(a)(b)

The enforcement action we took:

We issued a notice of proposal to remove the location to prevent the service from operating.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not been appropriately identified or mitigated. Regulation 12(1)(2)(a)(b)(g)

The enforcement action we took:

We took urgent action to prevent the provider working with new people.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to monitor and improve the quality and safety of the service. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

We took urgent action to prevent the service from working with new people.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Records did not demonstrate robust recruitment processes had been followed.

The enforcement action we took:

We issued a notice of proposal to remove the location.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

Staff had not receiving the training they needed to perform their roles. Regulation 18(2)(a)

The enforcement action we took:

We took urgent action to prevent the service from working with new people.