# Kaamil Education Ltd

# Daryel Care

## 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? | **Good** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

This inspection took place on 31 May, 1 and 2 June 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service. At the time of the inspection Daryel Care provided domiciliary care and support for 91 people in their own home. The service worked primarily with older people living with dementia and a small number of people with physical impairments.

At our last inspection on 3 June 2015 the service was meeting the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post, although the recently appointed manager had applied for registration with the Care Quality Commission (CQC). A registered manger is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of law; as does the provider. The registered manager was present during the inspection.

Risk assessments did not provide staff with guidance on how to mitigate people's individual personal risks. Risks had been clearly identified although risk reduction measures were not outlined for all people when a moderate or substantial risk of trips or falls had been identified.

People we spoke with told us they received their medicines safely and on time. However, the service had not kept records of the assistance all relevant people received with medicines or lists of medicines each of these people took.

Staff supervision had been lacking from mid to late 2016 but had improved since. Staff told us that they felt supported by the new manager and knew that they were each being offered the opportunity to meet with them. Staff had been informed that this was to discuss their work and developments that were being introduced to the service. The provider could not, however, provide evidence of a small number of staff appraisals. The manager had identified this issue, had begun to take action, and had developed an action plan in order to address this in full.

The service could confirm that all staff had an induction which was described as being a "skills for care induction." The induction policy had recently been amended to stipulate that all new staff were expected to achieve the care certificate within twelve weeks of employment. However, the service could not confirm who among the already employed care staff had already done so.

Although some auditing of the service was in place this could not be evidenced prior to the new manager coming into post, although they had identified areas of improvement that were required and had developed an action plan for making the improvements.

The service operated safe staff recruitment procedures and ensured that all staff were suitable for the role before beginning any care work.

Procedures relating to safeguarding people from harm were in place. Staff we spoke with understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act 2005.

Staff were provided with on-going regular training to support them in their role.

People were involved in planning their care and had regular reviews to gain their opinion on how things were. Staff knew people well and people and relatives felt that they were treated with dignity and respect. Care plans were person centred and included information on how people wanted their care to be delivered as well as their likes and dislikes.

People and relatives were provided with information on how to make a complaint and their views were obtained and acted upon. People were treated with dignity and respect and trusted the staff that supported them.

At this inspection we found breaches of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The 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 always safe. Most people had risk assessments. However, risk assessments failed to provide staff with adequate guidance on how to mitigate specific risks of falls and trips for some people.

The provider did not keep records of assistance provided with medicines or details of medicines taken for all people that required assistance.

The provider followed safe staff recruitment practices.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

People received a continuity of care and usually had the same staff visiting them. Staff were on time and stayed the correct amount of time with people.

### Is the service effective?

**Requires Improvement**

The service was not always effective. There had been lapses in staff supervision and appraisals although since January 2017 supervision had improved. The provider had recognised and commenced actions to address shortfalls although this had yet to be fully implemented.

Staff received regular training and an induction before commencing their work although the service could not clarify how many staff had achieved the care certificate during their induction.

Staff were aware of the Mental Capacity Act 2005 (MCA) and how this impacted on the care that they provided.

People were supported to have enough to eat and drink so that their dietary needs were met.

### Is the service caring?

**Good**

The service was caring. People were supported and staff knew people well and understood individual's needs.

People were treated with respect and staff maintained privacy and dignity.

People were encouraged to have input into their care and their views were respected.

## Is the service responsive?

Good

The service was responsive. People's care was person centred and planned in collaboration with them, which people and relatives confirmed.

Staff were knowledgeable about people's individual support needs, their interests and preferences.

The service monitored the care provided to people and were taking steps to increase the level of spot check monitoring to ensure continuity and appropriate care delivery.

People knew how to make a complaint. There was an appropriate complaints procedure in place and the provider responded to any complaints that were made.

## Is the service well-led?

Requires Improvement

The service was not always well led. Whilst no concerns about medicines management or people coming to harm due to unclear risk assessments had been raised the provider had not audited these to ensure that the systems were appropriate and working effectively. The manager accepted that work was required to improve auditing and monitoring systems at the service.

Staff meetings were taking place. Staff felt the opportunities for these had improved, which we confirmed by looking at staff meeting minutes. There was good staff morale and guidance was readily available from the manager and other senior staff.

The service had a positive open culture that encouraged learning. Staff felt supported by management to carry out their role effectively.

People's views were obtained and were acted upon.

# Daryel Care

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 May, 1 and 2 June 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by one inspector and two experts by experience that carried out telephone interviews with people using the service and relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We looked at thirteen care records and risk assessments, five staff files, eight medicines records and other documented information related to the management of the service.

During our inspection we made received feedback from two people using the service and seven relatives. We spoke with four care staff, two care co-ordinators and the manager of the service.

Prior to this inspection we had received positive written feedback from a local authority that commissioned most of the care packages that the service provided.

Requires Improvement

# Is the service safe?

## Our findings

We viewed thirteen people's risk assessment and care assessment records. We found that one person had a risk assessment recorded on their care needs assessment but no risk reduction measures and another had no risk assessment recorded. Five people had risks assessments rated as either moderate or substantial in respect of a risk of trips or falls but had no risk reduction measures recorded. The risk assessment policy stated that any risk rated above moderate should be reviewed every three months and those at substantial must have action taken before work can commence. This had not occurred and the provider could not evidence that risks to all people were assessed or mitigated against in order to prevent any harm to them as a result of the falls risks identified.

Staff we spoke with during the inspection were aware of the risks to the people they supported and no concerns had been raised with the Care Quality Commission (CQC) about people having come to harm as a result of any risks they individually faced.

At the time of this inspection nineteen people required assistance to take their medicines either fully or by prompting. The agency described this as "Total Support" or "Mechanical Support."

We obtained details of medicines assessments and consent to provide medicines for eight people and requested copies of medication administration charts (MAR) for these people. Copies of one person's MAR chart for January to April 2017 were made available but no others. These had been ticked by care workers and had full details of the medicines and times of administration.

The manager stated that two of the other people had MAR charts and copies of these were returned to the dispensing pharmacies by their families and were not available to the service. The remaining people had no MAR charts supplied by the dispensing pharmacies. However, the service had not recorded any information on care records about the medicines these people took, the strength of the medicines or the times each day when these should be given.

All staff had undertaken medicines training in the last twelve months and two we spoke with who assisted people with medicines were able to describe in detail how this was done, including completing MAR charts. No concerns had been raised regarding medicines errors or omissions and no-one we spoke with, who required assistance to take medicines, had any concerns about being assisted with their medicines.

The manager informed us in writing shortly after this inspection that they had liaised with all pharmacies supplying medicines. Ten that were supplying these already would continue to do so and the remaining nine would do so from now on. The manager also stated that they were working with the pharmacies in order to be able to audit MAR charts. However, at the time of the inspection the provider could not evidence that suitable records of safe medicines administration existed or that people's medicines were known about or given in the correct or safest way to everyone.

The above is evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 in relation to risk assessments and medicines.

People using the service told us, "Yes. I trust my regular carer. I would call the agency" and "Yes I do [feel safe]. The girls that come around are really good. I like them. I would tell my grandson if I didn't."

A relative told us, "Yes I do [about thinking the service was safe]. So far there is nothing to complain about. We have all the help we need. I would call the agency and speak to someone there if I needed to." Another relative told us, "Yes they are excellent. They will do anything that you need. They will do anything you ask them to do they are very helpful."

We looked at the arrangements in place to cover the care needs and call times that had been agreed with people. Staff told us they usually supported the same people but would sometimes cover other visits if needed due to staff leave or sickness. Staff told us and rotas for April and May 2017 confirmed that staff were provided with adequate travel time in between care visits. Staff said that they felt that they had enough time at care visits to complete all the tasks necessary. People and relatives did not raise any concerns about missed calls and told us that if staff were running late they were informed.

The service had an electronic monitoring system in place. This is a system where staff log in and out of their care visits and therefore enabled the service to monitor any missed visits. In addition to the log books each member of staff, regardless of their role, had a secure mobile phone application they had downloaded onto their mobile phone. This enabled staff to quickly send secure messages, for example if they were running late, or to receive messages from the agency office. Two of the care workers showed us this on their phones and they described it as a helpful way of using technology to help with communication. We were told and were shown records which demonstrated that It was rare for any late or missed calls to occur as this system. Along with the on call out of hours contact number this meant that any risk of missed or late calls were quickly responded to.

The service had a safeguarding policy that staff had access to. Staff were trained in safeguarding during their induction and had received this training prior to being able to begin to deliver care. Staff were able to explain how they would keep people safe and understood how to report it if they thought people were at risk of harm. Staff were able to explain different types of abuse and signs to look for if people may be suffering abuse. A staff member told us that safeguarding was, "To check if any abuse is taking place and will always report any concern to the office." Another staff member gave us an example of what safeguarding was and said, "If I was concerned I would call the office for advice and to report my concerns, haven't needed to, but anything I am concerned about I also make sure that the family know."

Staff understood what whistle blowing was and how to report concerns if they needed to. Whistle blowing is where staff are able to make any concerns known to an organisation external to their company, such as the local authority and CQC, without fear of recrimination. Staff we spoke with were clear about this and without hesitation they all told us they would not hesitate to report any concerns.

The service followed safe recruitment practices. Recruitment files showed pre-employment checks, such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. Where staff members required a visa to work in the UK, this was documented and a system was in place to update these permissions as they became necessary. This minimised the risk of people being cared for by staff who were inappropriate for the role.

The service recorded any incidents that had occurred and it was reported by people and relatives, as well as

staff, that very few, if any, had taken place. The service responded appropriately to incidents or other concerns that had been reported.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection we found that staff received regular supervisions. However, between August and December 2016 there had been almost no recorded staff supervision. The manager told us that as they had not been in post at that time they did not know the reason why this had occurred. However, since January 2017 staff supervision had been occurring across the staff team. Staff we spoke with said that they were being contacted to come to the agency office for supervisions and this had increased since the new manager came into post. Records of staff supervision confirmed this and the manager had identified the need to introduce planned quarterly supervision and had taken steps to do so.

The vast majority of the 72 care staff who were currently working with the agency were appointed within the last twelve months due to the large expansion of the service. An annual appraisal would not have yet been required for these staff although ten staff had worked for the agency for over a year and in some cases for up to three years. There were no records of an annual appraisal for any of these staff. The manager informed us that they were aware of this and would prioritise the need for these staff to have an appraisal although these staff had participated in supervision. The manager had recently reviewed the appraisal policy and this stated that a six monthly review of job performance was being introduced. The new system had yet to be implemented.

Induction included training in line with the former skills for care common induction standards [These were common standards used for inducting staff into care services and ensuring they had the necessary core skills to carry out their duties]. Staff induction did cover necessary core skills, for example medicines, moving and handling and keeping people safe from harm. Induction commenced with a three day classroom based introduction followed by shadowing a mentor [this being an experienced care worker] for up to seven days. This could be reduced or extended depending on the experience of the person and the report of their awareness and knowledge made by the mentor. The manager was able to provide dates when all staff had completed their induction, which the stated was a "skills for care induction", but no confirmation about whether this had resulted in care staff achieving the care certificate. The provider had recently revised their policy for induction of staff to state that all new staff would be required to achieve the care certificate with twelve weeks of commencing in employment, however, this had not been applied to care staff that were already employed.

The provider could not evidence that staff appraisal or professional development opportunities were currently suitable for all staff.

The above is evidence of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service that we spoke with told us, "Yes. They make sure I understand exactly what is going on" and "She [care worker] looks after anything I need. She is very good."

Relatives told us that they were usually satisfied with the care service provided, and that usually the staff,

either care workers or at the agency listened to what they wanted. One person told us they thought that care staff did learn. Relatives also told us that, "Yes they will call me and will make extra visits if they thinks [relative] is not well" and " When they are using the hoist they will support [relative] and tell them what they are doing and make sure they are happy to let them do it."
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. We checked whether the service was working within the principles of the MCA.

Staff understood their responsibilities in relation to meeting the requirements of the MCA and the service had assessed people's capacity and there were records of best Interests meetings where people may have lacked capacity. People's capacity had been documented on a specific assessment form which was included in their care plan records. Where people were unable to be involved in planning their care, relatives had been consulted and this was referred to on people's care records and the details of who had been involved and their relationship to the person were also included. Staff had received training in the MCA and records showed that new staff received this training during their induction. The service was not involved in any activity that required the use of deprivation of liberty safeguards to be applied.

All people's care plans that we looked at had been compiled and reviewed and we noted that most were recent as the service had taken on a large contract to provide care in a nearby local authority within the last twelve months. However, on ten of the thirteen care plans we looked at these had not been signed by the client or a family member if required. We noted, however, that people we contacted told us about providing consent so the lack of signature was an administrative issue rather than a failure to obtain consent. The manager stated that this would be rectified.

Care workers we spoke with were able to describe the needs of the people they cared for and how they would respond if any concerns arose about their well-being. Staff were clear about seeking people's permission to provide care and a care worker also told us of a particular situations where they had responded, for example seeking medical assistance if people were unwell when they visited.

Staff training records showed that staff had received training in the last year, including at the point they were first employed by the service. The topics covered included safeguarding, dementia and behaviour, moving and handling and health and safety. Staff told us that the service provided regular training and were reminded when they were required to undertake updated training. The provider had a training programme in place for 2017 to 2018 which outlined a programme for each quarter and how frequently staff should undertake core skills training. This demonstrated that the provider recognised that staff should be skilled and knowledgeable about the care they provided.

The service usually only provided light meal preparation for people where this was required. This was heating food up for people or making a snack such as sandwiches. One person did, however, tell us, "She [care worker] makes the food for me. She cooks what I like." Two other people told us about the types of foods the staff help them to heat up and serve although in most cases family members did this so care staff were not required to do so. Staff had been trained in food hygiene and nutrition. Where people required support with meal preparation or encouragement to eat, care plans documented people's likes and dislikes around food.

People and staff told us that the service did not routinely attend healthcare appointments with people and that this was usually managed by people themselves with assistance from their family as needed. However,

the manager stated that this would be considered carefully if there was a need to provide assistance to do so if someone was unable to be assisted by a relative or friend. Staff told us they knew how to respond to any emergency situations. This was confirmed by people and their relatives some of whom gave us example of when this had been needed and that they believed that staff had done this very well.

Good

# Is the service caring?

## Our findings

People and relatives were positive about the attitude of the staff. People said, "Yes she [care worker] does, she does everything really well and really good. I think it is a reflection on the personal individual. The agency is fine. They make an effort to understand, for example, I wanted to change the time on one day as I had an appointment and they changed the time for every day." People told us that staff knew them well and relatives agreed with this although one did say that they wanted a care worker that spoke their relative's first language. They went on to say they hadn't yet asked for that from the agency.

In terms of staff respecting people's right to privacy and dignity one person told us, "Yes. They do little things like closing the door when I am in the shower, knocking on the door and waiting for me to answer. Things like that." Another person told us, "Yes. For example today as it is hot, I had a shower with the door open and [care worker] did not enter. I think she understands as we have built up a relationship."

Relatives were also very positive about the way staff demonstrated respect for people's privacy and dignity. We were told, "Yes they do. My [relative] follows Islam and does pray. Yes they do they are good." Another relative said, "They will always tell [relative] what they are doing. They are very good in the way they are treating him, always very polite and courteous."

Care records had a section with people's personal histories, likes and dislikes. Staff were able to tell us about what people they worked with liked and enjoyed. The involvement of people, and their relatives if also involved, was included in care plans. People were involved in planning their care and felt that the service listened to their needs and preferences. Where people felt there had been changes needed they told us the agency had listened and tried hard to make the necessary changes.

Staff had a good understanding of what dignity and respect meant to the people they were working with. Staff told us, "You only ever work with people whose needs you understand and who you can care for properly." Another member of staff told us that, "If we don't understand someone we cannot properly care, we are good at making sure we can do that and are introduced to people and get to know them." Staff understood the importance of providing choice to people.

Staff understood the importance of respecting cultural, religious and sexual diversity. People's faith was noted in their care plan and staff were aware if there were any specific requirements regarding people's faith or culture.

Good

# Is the service responsive?

## Our findings

Care plans were person centred and included people's likes and dislikes and the way they wished to be cared for. Information contained within care plans was specific to the type of support they required. For example, if people needed help to wash and dress this was included with details of how staff should do this in the way that people preferred. Often, people did not require that assistance but did need help to have a meal or carry out domestic chores; again staff were given guidance about how this should be done.

People using the service told us about being offered the opportunity to make choices and getting care they needed. They said, "Yes I can, I am very able" and "I can decide what I want to do." Relatives told us, "Yes [relative] definitely does. We set up the package and that is exactly what she gets" and "I think so. [Relative] will speak their mind."

Care plans were specific to the agreed care that staff were required to provide. Late in 2016 the service had introduced a daily record log book for recording the care provided to people at each visit. This was a large book which the manager stated were returned to the agency office once fully completed and then replaced with a new book. We saw examples of seven of these that had been completed since their introduction and had been returned to the office. The book contained a front sheet that outlined the areas of care, for example with bathing, nutrition, medicines and light housekeeping. The relevant areas were ticked and next to this was a space for staff to record what task they had undertaken during their visit. This was a positive method of recording and tracking the care that people received.

Phone calls to monitor the standard of care for people were observed taking place during this inspection. People we spoke with told us that they were contacted by the agency and felt at ease with making contact themselves as and when they needed to. This demonstrated that the provider promoted open communication and included people in decisions about their care.

People and relatives were provided with information on how to make a complaint when they began using the service. People and relatives said that they knew how to make a complaint and felt comfortable raising any issues if they needed to, but almost no one we spoke with said they had ever needed to. There had been a small number of complaints since our previous inspection, all of which had been fully resolved. The service also received compliments and positive feedback from people and relatives. The local authority that largely commissioned with the service told us they believed the service pre-empted any potential issues by the way they engaged and responded to people's day to day needs.

Requires Improvement

# Is the service well-led?

## Our findings

The manager had commenced in post on 10 April 2017. He stated that the service had no manager in post since September or October 2016. The newly appointed manager had submitted an application to register with CQC, which was confirmed.

We were shown a medicines audit for two people using the service and quarterly care notes audit reports for six people. We also looked at a service user satisfaction survey published in May 2017, however, no other audits prior to April 2017 were available. The manager accepted that they could not locate any prior audits and had not been given a handover by the previous manager as they had left a few months before they had commenced in post.

The manager provided us with an action plan resulting from their own audit of the service dated 30 April 2017. This audit acknowledged areas requiring improvement and action, including medicines recording, risk assessments, staff supervision / appraisals and other areas of improvements to auditing of the service. This action plan did highlight areas that we had identified at this inspection and noted the action required within a reasonable time frame, most areas to be completed by the end of June or July 2017.

The service completed quarterly monitoring visits to check on staff and ensure that they were delivering appropriate care. The manager told us that the frequency of monitoring visits was being reviewed as although they were occurring they could be improved upon. Monthly monitoring visits were made to people when they had just started using the service to check on their care. The manager was introducing a monthly call system and once new staffing resources were agreed was aiming also to introduce monthly home monitoring visits rather than the three monthly systems currently in place for clients who had been using the service for some time.

Staff were positive about the manager and said that they felt supported. Staff told us, "He's [the manager] available and we can speak with him" and "There is always someone available by phone whenever I need to ask about something. I come to the office regularly too and people make time to talk, including the manager, which is very good."

A person using the service told us, "Yes I have been asked for my views. I am very happy with my care worker and I think it is a reflection on her as an individual." Relatives said, "Everything about them is very good I can't even think of something that isn't right" and "We've never had to deal with them [the manager] so it has all worked well."

Staff meetings took place, not just among the management team but for all staff and these were advertised regularly to give all staff the opportunity to attend a meeting. Staff we spoke with confirmed this and felt that these opportunities were increasing as well as being contacted regularly about things that they needed to know.

Shortly after coming into post the manager undertook a survey of just under half of the people using the

service and told us this was now going to be extended to the remainder. The survey outcome had been published in May 2017. The results showed a high degree of satisfaction by people who gave a view about how the service was run. The manager showed us a telephone survey questionnaire they were about to introduce in order to seek feedback each month from all people, or their relatives if more appropriate, about the quality of the service. This showed that the service was seeking people's views. The manager informed us that these would feed into a review of the action plan they had begun to implement and would form a part of an on-going review and monitoring programme.

The service operated an on-call system for any emergencies out of hours. This operated from 17:00 until 09:00 weekdays and all day at weekends. People and relatives that we spoke with were aware of the on-call system, both they and staff we spoke with told us this system worked well and the always received a response.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Regulation 12 (1) (2) (a) (g)<br><br>Risk assessments were not followed through with risk mitigation measures for some people.<br><br>Medicines assistance provided, and medicines taken, was not documented for some people. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Regulation 18 (1) (2) (a)<br><br>The provider could not evidence that staff appraisal or professional development opportunities were currently suitable for all staff. |