Delta Care Ltd

Delta Care - Trafford

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Delta Care – Trafford is a domiciliary care agency providing personal care to 58 adults and one child at the time of inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People were experiencing late and early calls which didn't support their needs. People did not know who would be supporting them and were concerned about the of continuity of staff visiting them. Medicines were not always safely managed. Where late calls impacted on people, the risks needed further exploring by the provider.

Audits to monitor and improve the service had not highlighted the concerns with late and early calls and that staff were not staying the allocated time of the visit. Audits to monitor medicines had highlighted some concerns but it was unclear what action had been taken to improve. There was a lack of oversight of the pressures the staff were under to complete visits to people in a timely manner.

There was a clear theme of a lack of communication between the provider and people using the service. People overwhelmingly told us, they had to ring the office and find out why their call was late and sometimes there was no response. People felt rushed and did not always receive dignified interactions from staff.

Staff told us, and we saw, on some occasions the correct information to support people was not available in care plans. People told us they had to tell staff what to do during a visit and some staff confirmed this. People did not always know who to complain to but on the occasions they had, were not always satisfied with the response.

People were not always complimentary of the support they received with eating and drinking. Improvements were needed to ensure people received consistent, effective and timely care. People had their capacity reviewed and the provider worked in line with the Mental Capacity Act 2005.

People were not always supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests; however, the timelessness of calls impacted up on people's wellbeing.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection This service was registered with us on 15/11/2018 and this is the first Inspection.

Why we inspected
This was a planned inspection based on the provider's registration date.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 improvements 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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Delta Care - Trafford

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was also a manager working at the service and responsible for ensuring the service was safely managed. For the purpose of this report, we will refer to the manager as "The manager" and the registered manager as, "The registered manager."

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 6 November 2019 and ended on 12 November 2019. We visited the office location on 6 November 2019.

What we did before the inspection
Before the inspection, we reviewed notification's and information about the service.

The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
During the inspection we spoke with the registered manager, the manager, the project manager, the training manager, seven care workers, 12 people who used the service and three relatives. We reviewed six care files and four medication administration records. We viewed four staff recruitment records and information relating to the induction, training and supervision of staff. We looked at audits to monitor and improve the service and any quality assurance documentation.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at in detail at call records and raised concerns about visits to people.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- People were not receiving some of their medicines at appropriate intervals due to the calls being early or late. We saw two examples where one person received two medicines close together on 13 different occasions. The manager told us this was a recording error and there was no harm to the person.
- Medication administration records (MAR) were completed on a smart phone app and we noted missed signatures which meant we could not be assured people had received their medicines as prescribed.

People were not receiving the support they required to ensure medicines were administered safely and recorded accurately. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received training to administer medicines and were competency checked before they supported people with medicines.
- Staff told us they felt confident to administer medicines.

Staffing and recruitment

- People and relatives told us staff did not always attend the planned call for care and support at the agreed time and some calls could be an hour early or two hours late.
- We viewed call logs for October 2019 for five people and found calls could be up to 50 minutes late.
- Staff rotas varied the times, staff needed to be at each property and were not in line with the person's care plan. Staff told us, they didn't have enough time to travel between calls.
- People did not receive care and support from a regular staff member. One person received care and support by 14 different staff members in the month of October 2019.
- People and relatives told us, staff did not always stay the allocated time commissioned by the local authority. Staff logging in and out records confirmed this.
- Staff were not always logging in and out of calls. For one person who had received 124 calls over the month of October 2019, the call had not been logged on 24 occasions.

People were not receiving timely, appropriate, personalised care and support to meet their needs. This was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received appropriate pre-employment checks prior to commencing employment, however, one of the four staff recruitment files we viewed, did not contain the applicant's full employment history and any

gaps in employment had not been explored.

Systems and processes to safeguard people from the risk of abuse
● People told us they did not always feel safe as they were not sure which staff members would visit them and who had access to their door keys via their key safe..
●Two people told us, staff had let themselves in via the key safe and wandered around their property without permission. A third person told us, a staff member arrived one evening with a 'friend' while the staff member delivered care, and this made them feel frightened. We raised with this with the manager who advised the 'friend' was another staff member and staff have been reminded not to do this. The person said they didn't report the concern as they weren't sure if the 'friend' would have access to their key safe code.
● We received mixed feedback from people about reporting concerns. Some people said they had reported late calls while others said they were not sure who to report to.
● Staff received training to recognise and report any abusive practices. One staff member told us they had reported an alleged abusive practise of people's money and bank cards going missing. We saw these allegations had been reported to the local authority for further investigation. Other staff members told us they were confident any concerns they reported would be acted upon.

People were being put at risk of harm and did not feel safe in their own home. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● Risk assessments to support the risks people presented were in place, other than for one person who needed to eat 15 minutes after receiving medication from the district nurses. The late calls impacted on this which meant the person felt dizzy and need to get themselves to the kitchen to make a snack.

This put people at risk of further harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's properties received a robust risk assessment to ensure they were safe for the person and the staff team.

Preventing and controlling infection
● Staff carried disposable gloves with them when delivering care, however, we received mixed reports of staff's adherence to managing infection control.
● One person told us, they had needed to ask staff to wash their hands and another person told us, staff didn't always wear gloves. A third person said, "Staff don't use gloves or aprons and I have asked them to."
● We observed a staff member administer medicines, serve food and then assist with redressing a person wearing the same gloves.
● Staff received training in infection, prevention control.

We recommend the training is reviewed to ensure staff are aware of their responsibilities for prevention and controlling infection.

Learning lessons when things go wrong
● Accidents and incidents were recorded and analysed to prevent future occurrences.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- Some people received support with eating and drinking and we received mixed feedback. One person told us the staff were unable to make porridge oats for breakfast while another person told us, a staff member couldn't make a cup of tea. A third person told us, "I asked for a Horlicks with warm milk, [staff] made it with cold milk so I couldn't drink it."
- Where people received support with eating and drinking, this information was documented in care plans. Like and dislikes of food and drinks were also confirmed in the care plan.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Scheduled calls to support people were not always completed in a timely manner with a consistent staff team.
- People had access to health care services and were mainly supported by their family to attend.
- Any concerns raised by staff around people's health had been reported to the family.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People received an assessment of their needs prior to being supported by the service.
- During the assessment process, the preferred time of care and support was documented, however, this preference was not always accommodated.

Staff support: induction, training, skills and experience

- Staff received an induction when commencing employment with the service.
- The induction including training to support staff in their job role.
- Some staff told us there was a lack of training around pressure care which included how to put on compression stockings or specialist footwear.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- People received appropriate assessments of their capacity and any decisions made to provide personal care and support were done so in the person's best interests.
- At the time of inspection, the service had not applied to the Court of Protection to deprive anyone of their liberty.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Of the 15 people and relatives we spoke with, 13 comments found the care to be rushed and the lateness of the calls and lack of communication about lateness was disappointing.
- One person told us, "[Staff] came over an hour earlier, I can't get up at that time and she (staff) said to me, 'Are you getting out of bed or what?'." We raised this with the staff member and the registered manager and they said they apologised and shouldn't have spoken like that.
- The lack of consistency of staff supporting people was evident with comments including, "I never know who is coming.", "If the normal girl isn't coming, they don't let you know." and "I don't have the same carer every day, some just dash in and out."
- Themes of lack of communication was evident from relatives and people and they told us, they can ring the office on many occasions and not get a response.
- People told us that while most of the staff they found to be kind and caring, some staff rushed the care and did not always know what to do to support them.
- One person told us, "Some people just walk in and ask what do they need to do?" Another person said, "I have to tell the staff what they need to do."
- A staff member told us, they worked on a smart phone app, and they didn't always have access to up to date information about how to care for the person. We checked and found someone who required support with pressure area care did not have the correct information recorded.
- Another person we spoke with told us they needed support with personal care and they felt the staff were reluctant to assist and was often dressed before they were properly dried after washing.

People were not always treated with dignity and respect. People received inconsistent support and staff were not fully supported to understand people's needs. This was a breach of regulation 9 (Person Centred-Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

- People did not feel involved in decisions about their care. One person told us they had asked for a specific staff member to support them, but they were not responded to.
- People told us most staff tried their best, but they were rushing from call to call and didn't have the time to chat.
- Staff told us, they didn't always have the time to chat to people as they were conscious they needed to get to the next call.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were formulated and stored on an app which staff accessed on their smart phone. Paper copies were kept at the office and in people's properties, but these were not the most up to date version.
- People told us, the care files in their properties were never looked at by staff and one person told us the information isn't correct.
- We saw for two people, their needs had changed, and the paper care plan no longer reflected this. We reviewed the information on the app, and the information did not reflect current needs.
- Two staff told us, they didn't always have the time to check the app, especially if they were supporting a person they didn't know. One staff member said they relied on the person knowing what was needed.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People told us, as their information was kept on an 'app', the could not always access it.
- The registered manager told us there was a family link which allowed relatives to see an overview of the care provided.
- The provider wasn't currently providing personal care to any one who needed assistance with information in another language format.

Improving care quality in response to complaints or concerns

- Complaints were recorded, and outcomes shared to the complainant and staff team for learning.
- People did not always know who to raise a complaint with or did not complain as they did not want to get staff into trouble.
- Some people and relatives told us, they had complained about the lateness of calls but didn't feel listened to.

End of life care and support

- People could be supported by the service should they be at the end of their life.
- There were care plans available that could be developed should someone be at the end of their life.
- At the time of inspection, the service was not supporting anyone at the end of their life.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- No action had been taken to ensure people received personal care and support from staff in a timely manner.
- It was evident staff were aware of call times being an issue and told us, "I let the office know I will be late, but they don't let the client know." and "It's embarrassing when I turn up to people's houses and they don't know I will be late."
- A relative told us, "All they need to do is ring and communicate with us, but they can't even do that."
- Staff told us, they don't have a regular rota of people and they only receive the rota the Thursday prior to their current week and were aware some calls were rescheduled at the incorrect time to 'fit in'.
- Risks to people were not always fully considered when calls were not at the agreed time.
- There were audits in place to monitor and improve the service, and while some concerns had been identified around the management of medicines and measures put in place to ensure the concerns were not repeated. We could not be assured what action had been taken to review the risks presented to a person in relation to overdose of under dose of a medicine.

Systems to manage the quality of the service were ineffective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People were not receiving person-centred care and support. It was evident for a long time, staff had not been staying the correct duration of the visit and this left people feeling isolated and not having their needs met. We raised this with the registered manager who told us the local authority had accepted some travel time was used within the allocated time, however, the local authority told us, this was not acceptable.
- One person who told us staff were in and out, also told us, "This is what happens when you get older." For this person, for 69 visits from 124, they did not receive an adequate allocation of support from the visiting staff member.
- The service had a registered manager in place who visited the registered office at least weekly. There was also a manager in place who was working towards, registering with the Care Quality Commission as registered manager.

Managers and staff did not understand the impact of lack of person-centred care was having on people. This

was a breach of regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● The provider had recently requested feedback from people who used the service via a questionnaire. Six responses had been received and three were positive with the remaining three not being completed.

● One person told us, "I recently received a questionnaire and the manager asked me why I hadn't completed it, I told them if they can't return my call, then how can I complete a questionnaire. The manager told me, how can they improve if I don't complete it. I haven't completed it, I don't want this service anymore."

● Although staff were aware of the poor service being provided, they often carried on by doing the best they could and tried to fit in all the calls and provide the personal care required. One staff member told us, "I visit this property, then I have to travel across to another area then come straight back to another property in this area. It doesn't make sense but that is the way it is and I don't even drive.

● Care plans were not always updated with people's most up to date information which meant staff were not always providing the correct care and support.

The delivery of high quality care was not assured by the leadership of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received supervision and were able to attend staff meetings.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood their responsibility to act on duty of candour, however, the people we spoke with overwhelmingly told us, they were not responded to when they enquired about late calls.

● The manager told us, people were offered a list in advance of the staff who were due to support them, however, only one person we spoke with confirmed this.

Working in partnership with others

●The service worked with the local authority to monitor and review the quality of the organisation.

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 People were not receiving timely, appropriate, personalised care and support to meet their needs. People were not always treated with dignity and respect. People received inconsistent support and staff were not fully supported to understand people's needs. Managers and staff did not understand the impact of lack of person-centred care was having on people.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not receiving the support they required to ensure medicines were administered safely and recorded accurately. People were being put at risk of harm and did not feel safe in their own home.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to manage the quality of the service were ineffective. The delivery of high quality care was not assured

by the leadership of the service.

The enforcement action we took:

Warning notice