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De Vere 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection took place on 07 December 2017 and was announced. We last inspected this service on 19 January 2016 and rated the service as Good.

De Vere Care is based in Redbridge, Essex. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults.

Not everyone using De Vere Care receives regulated activity; the 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 our inspection, 80 people were using the service, who received personal care. The provider employed 75 care staff, who visited people living in the London Borough of Redbridge and other local boroughs.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered care homes, 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 previous registered manager had cancelled their registration prior to our inspection. The current service manager was in the process of applying to register as manager.

Prior to our inspection, we received some concerns about the management of the service from the local authority because the provider had recently cancelled people's care packages and the local authority had to find alternative care providers for those packages. This was because there were internal issues within the service which meant the provider was unable to fulfil their role fully.

Staff told us that they received support and encouragement from the manager. Most staff were happy with the overall management of the service but some staff were not happy and had decided to leave.

During this inspection, we found that people did not always receive safe care because visits from care staff were missed and some people went without a service for a number of days.

People had their individual risks assessed and staff were aware of how to manage these risks. However, specific risk factors were not always fully stated in risk assessments to help staff identify and mitigate the risks to ensure the safety of the person and the staff.

Staff had not received recent supervision and training to ensure the service they provided to people was effective.

The provider was not always compliant with the principles of the Mental Capacity Act 2005 (MCA) because people who did not have capacity to make decisions for themselves had not provided their consent to care through a best interest decision process.

This meant that the provider did not always assess, monitor and mitigate risks associated with the service to ensure people received safe care and keep accurate records of decisions taken.

People were not always treated with respect because care visits to them were not completed without explanation. We have made a recommendation for the provider to ensure staff are mindful of their responsibilities to people who used the service.

The provider had made improvements to make sure people were kept updated about changes to their regular care staff. However, some people told us the provider did not always communicate any changes to them.

Formal complaints about the service were not always responded to appropriately and within the provider's timescales as set out in their complaints procedures. We have made a recommendation about this.

The provider had sufficient numbers of staff available to provide care and support to people. Staff had been recruited following pre-employment checks such as criminal background checks, to ensure staff were safe and of good character.

Once recruited, new staff received an induction, relevant training and were able to shadow experienced staff in order for them to carry out their roles effectively.

When required, staff administered people's medicines and recorded medicines that they administered on people's Medicine Administration Records (MAR). They had received training on how to do this.

People's care and support needs were assessed and reviewed regularly.

The provider worked with health professionals if there were concerns about people's health. People were registered with health care professionals, such as GPs and staff contacted them in emergencies.

People were supported to have their nutritional and hydration requirements met by staff, who provided them with meals and drinks of their choice, when they requested.

People were listened to by staff and were involved in their care and support planning. They were treated with dignity when personal care was provided to them.

Care plans were person centred. They provided staff with sufficient information about each person's individual preferences and how staff should meet these in order to obtain positive outcomes for each person.

People were able to access information they were able to understand to help keep them informed and safe.

The provider was in the process of introducing new technologies to help manage the service.

The management team carried out regular monitoring checks on staff providing care in people's homes. This ensured they followed the correct procedures and people received safe care.

Feedback was received from people and relatives to check they were satisfied with the service. The management team ensured lessons were learned following serious incidents.

There was a culture of working together with staff to help improve the service.

We found four breaches 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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any presentations and appeals have been concluded.

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. People had experienced missed calls from care staff, which put their health at risk.

Staff understood how to safeguard people from abuse. They were aware of their responsibilities to report any concerns.

A recruitment procedure was in place to employ staff that were safe. Risks to people were not always identified to ensure staff were fully aware of them when providing care to people.

Staff understood how to safeguard people from abuse. They were aware of their responsibilities to report any concerns.

Staffing levels were sufficient to ensure people received support to meet their needs.

People received their medicines safely when required and staff received training on how to do this.

Is the service effective?

Requires Improvement

The service was not always effective. Staff were not receiving up to date training and support through regular supervision meetings.

The requirements of the Mental Capacity Act (MCA) 2005 were not always followed because people without capacity to make decisions did not provide their consent to care.

Assessments of people's needs were carried out to ensure effective outcomes for their care. Changes in people's care needs were updated in their care plans.

People had access to health professionals to ensure their health needs were monitored. Staff ensured people had their nutritional requirements met.

Is the service caring?

Requires Improvement

The service was not always caring. Internal issues meant that

staff did not always fulfil their duties to provide care to people at the agreed times and did not show respect for their needs and wishes.

People and their relatives had involvement in the decisions made about their care.

People were treated with dignity by staff when they received personal care.

Staff were familiar with people's care and support needs.

Staff had developed caring relationships with the people they supported.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were able to make complaints about the service. The provider investigated all complaints but responses were sometimes delayed.

The provider ensured information was accessible to people in a way they could understand it.

Care plans were person centred and reflected each person's needs, and preferences.

Is the service well-led?

Requires Improvement

The service was not always well led. There was a quality assurance system in place, which had identified some of the issues and shortfalls within the service but they had yet to be addressed. However, further improvements were also required within the service.

Staff received support and guidance from the management team.

People and their relatives were provided with opportunities to provide their feedback on the quality of the service.

De Vere 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7 December 2017. This was an announced inspection, which meant the registered provider knew we would be visiting. This was because it was a domiciliary care agency and we wanted to make sure that the registered manager, or someone who could act on their behalf, would be available to support us with our inspection. The inspection team consisted of one adult social care inspector and an expert by experience, who made telephone calls to people who used the service. 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 reviewed the information we held about the service and provider. We looked at any complaints we received and statutory notifications sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law. We also contacted health and social care commissioners for their feedback on the service.

During the inspection, we spoke with the service manager, a contracts manager, a care coordinator and two monitoring officers. We spoke with six people who used the service and seven relatives.

We looked at nine people's care records and other records relating to the management of the service. This included ten staff recruitment records, training documents, rotas, accident and incident records, complaints, health and safety information, quality monitoring and medicine records.

After the inspection we spoke, by telephone, with four care staff.

Requires Improvement

Is the service safe?

Our findings

During our inspection, we found concerns relating to the times people expected to receive care from the service. Care staff were usually monitored by senior staff, based in the office, who checked that they arrived at people's homes on time to provide care. Staff were required to log in and out of people's homes using a Freephone number and often used people's phones with their permission. People were kept informed by senior staff if their carer was running late or were delayed for their visit. Rotas showed the days and times care was to be provided to people. Daily records and call logs confirmed that most staff completed their tasks and calls at the scheduled times. Cover arrangements were made when staff were unavailable to provide care to people. For example, if there were staff absences, the monitoring officers or the manager, ensured they found cover staff or in some cases carried out the visits themselves. The service was monitored out of hours and at weekends. Staff were able to contact the monitoring officers and the manager, who were on call during out of office hours and weekends, in case of an emergency.

However, not all people received care at the assessed and agreed days and times. For example, two people experienced missed calls for two days or more. One did not receive a service for 10 days because their care package was cancelled by the provider in error. Another person did not receive a service for two days because staff had failed to attend the person's home and did not inform managers of this. The emergency on call system was not notified of the missed visits because the person was able to do some tasks for themselves and was not at serious risk. Despite this, we noted that safeguarding alerts were in progress following these incidents and that the local authority had notified the provider about the first person's missed visits. The provider had not been aware that the person had not received any care for 10 days until that point.

The manager told us that administrative mistakes were the cause whilst a number of care packages were being handed back to the local authority and one package was cancelled incorrectly. The manager said they would ensure that such events would not be repeated and had put in place new procedures for staff to follow when communicating with the local authority. They told us, "It was an accident. Luckily the person is quite independent and they didn't feel the need to phone us. I will make sure that I see, check and approve any actions first. We will be more thorough." Although the management team had acknowledged the errors, had apologised to the people affected and had put actions in place, there was a failure from the provider to ensure people had received or were receiving care at the agreed times. This led to missed calls not being identified immediately by the management team. People's health was put at risk because they were left without the required care that they had been assessed for.

Risks to people who received care and support, were identified during assessments of their needs. Risk assessments informed staff how to manage and reduce any risks, to keep people safe. Care plans contained this information and any actions that were required to be taken. The assessments identified what the risks might be to the person, the severity of the risk and what actions were required to minimise the risk. These included any risks associated with the person's mobility, their home environment, their medicines and any skin conditions they had, such as the risk of pressure sores. There was information and guidance for staff about each identified risk. For example, one person was at risk of 'profuse bleeding' and their risk

assessment said, "Carers should be mindful when supporting [person]. Try to protect [person] from knocking or catching corners and sharp edges when supporting them with transfers and mobility."

We noted that the local authority provided supporting information about the person as part of the assessment, which contained background information on the person's health needs and risks. Some of the risks identified by the local authority were not always transferred thoroughly to the provider's risk assessments. For example, staff were required to "lock away [person's] medication after use to reduce the risk of [person] taking medication again and overdosing." This information was not comprehensively stated in the corresponding risk assessment and was only in the schedule and tasks section of the person's care plan. Action staff needed to take should the person overdose was not stipulated in the risk assessment. This meant that staff would not be completely aware of the specific risks, what impact they could have, what action to take and why it was important that the person's medicine was put away.

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

People we spoke with told us they felt safe and that staff usually arrived on time. People said that care staff arrived and stayed for their allocated time. One person said, "Yes I am happy. Another person told us, "Yes they [staff] always arrive on time." Another comment from a person was, "Very safe. They [staff] take very good care and are very careful. Always happy." Staff told us they had enough time to travel between their visits to people and deliver the support detailed in people's care plans. One staff member said, "I am happy with my schedule and have enough time to get to my clients."

Staff had knowledge of the whistleblowing policy, which enabled them to report any concerns they had about their employer to regulatory authorities, such as the police or the Care Quality Commission. People were protected from the risk of abuse and there was a safeguarding procedure in place for staff to follow. Staff were aware of their responsibilities for safeguarding people and understood how to report any abuse, such as physical, financial or verbal abuse. One member of staff said, "I would report to my manager if I saw abuse. I know the procedure."

The provider had an infection control procedure in place to help protect staff and people who used the service. Staff told us they used hand sanitisers, gloves and aprons, to prevent the risk of infections spreading when they provided personal care. Where a person required assistance getting out of bed or a chair, two staff worked together in order to move the person safely, using equipment such as hoists. Staff checked that all care equipment they used was safe so that they could deliver effective care and support. They reported any faults with equipment to the office.

The manager and staff were aware of what actions to take in the event of accidents or incidents occurring. We saw records of any serious incidents that had taken place. The provider was committed to learning from incidents to ensure that there was continuous improvement and people using the service remained safe. We saw that an investigation into one serious incident that we were aware of, was in progress. The manager assured us that appropriate action was taken to ensure the safety of the person and staff involved.

There were safe recruitment procedures in place. For new staff that had been recruited since our last inspection in January 2016, the provider carried out the necessary criminal checks to find out if the person had any convictions or were barred from working with people who use care services. We saw that new staff completed application forms and provided two references, including a character reference. Evidence that the applicant was legally entitled to work in the United Kingdom was also obtained. Applicants were required to list their previous experience where applicable and their employment history.

Monitoring officers visited people's homes to ensure staff were following safe and correct procedures when delivering care. We saw monitoring records, which showed that staff carried out safe care while wearing their identification badge and uniform.

A medicine policy and procedure was in place for staff to administer medicines safely when required. Staff recorded the medicines they administered on the Medicine Administration Record sheets (MARS), which contained details of people's medicines and their personal details. We saw that MAR charts were completed and accurate. Staff who were required to prompt or administer medicines to people told us they were confident with managing medicines. Their competency was assessed and they had received training on how to manage, administer and record medicines. One member of staff said, "We have received training recently. We can administer medication using blister packs. I record it on the MAR sheet." One person said, "Yep. The carers give the medication." Another person said, "Yes I do get my medication. The carer helps me with that." Another comment from a person was, "I take my own medication." We saw that the manager carried out monthly audits to check that MAR sheets were completed appropriately and medicine procedures were being followed by staff.

Requires Improvement

Is the service effective?

Our findings

We saw that staff had received training to enable them to provide safe and effective care. Topics included food hygiene, medicine administration, person centred care and privacy and dignity, which staff had recently undertaken. Staff told us they were supported by senior staff and the training helped them to perform their roles. One member of staff said, "Yes we do get some training and I had an induction when I started." Care Certificate standards was incorporated into the training. The Care Certificate is a set of 15 standards and assessments for health and social support workers who are required to complete the modules in their own time. Staff that completed the standards or a diploma, received a certificate to show they had a qualification in health and social care. There was an induction programme in place for new staff, which provided them with the necessary training. New staff were able to shadow experienced staff for three days to help them settle into their role providing personal care to people and prepare for their roles.

However, we found that not all staff were provided with up to date training since our last inspection in January 2016. This included mandatory training needed to perform their roles effectively. Nearly 30 staff had not received refresher training in equality and diversity, infection prevention and control, the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), moving and handling and safeguarding adults. Refresher training enables staff to re attend training courses after one, two or three years, depending on the importance of the course. These help them keep their knowledge and skills up to date and in line with current legislation. A training schedule showed that staff had been overdue some of the training for nearly two years because their previous training had expired. This meant that staff had not received the required training and professional development, to enable them to carry out their duties to provide safe and effective care to people. The manager told us, "We have had some issues with training. Our in house trainer left and we have not been able to get our staff trained. About 50% have not had their refresher training. We have recently recruited a new training manager to progress it."

Supervision meetings, where staff have the opportunity to formally discuss any issues or concerns with the service manager, are a requirement for providers of health and social care. Records confirmed that some supervision meetings took place. Topics included their current workloads, training requirements and the support needs of people they cared for. Staff were able to highlight and discuss any issues with their supervisor. Annual performance appraisals for staff had also taken place previously. However, we found that staff were not provided with up to date supervision. The provider's policy stated that supervision meetings between staff and their line manager should occur at least four times a year. An annual appraisal for each staff was also required. We found that at least eight staff had not received planned, recorded supervision for more than six months and some for a year. The manager told us that attempts had been made to arrange supervision meetings and appraisals but staff had failed to attend. They said, "It has been difficult to get them in and have them sit down for a meeting. They don't seem to be keen." This meant that staff were not receiving adequate support, supervision and appraisals to enable them carry out the duties they were employed to perform. One member of staff said, "We haven't had much training at all. This could be better. We don't often have supervision, once in a while."

The above concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

We looked at the provider's policy on the Mental Capacity Act 2005. The 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 that the provider was working within the principles of the MCA.

We found that a capacity or best interest assessment for one person had not been completed. The person had not provided their signed consent to receive care. The manager told us that the person's relative had legal authority to make decisions for them. However, there was no evidence of this or of any capacity assessment to state that this was in the person's best interest. This meant that the provider was not acting in accordance with the requirements of the MCA, where a person lacks mental capacity to make an informed decision. Any decisions taken in relation to their care and treatment were not documented to ensure their legal and human rights were protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us staff met their individual needs and that they were satisfied with the quality of care they received. One person said, "Yes they are trained. They have a lot of experience." Another person told us, "I always feel comfortable with them [staff]." A relative told us, "For sure, they are pretty good." Other comments from people included, "Always feel comfortable with the [carers];" and "[Carer] has been coming long enough to know what to do."

The provider received referrals from the local authority or the Clinical Commissioning Group (CCG), who referred people that required assistance with personal care at home. The CCG is a local health service that works with patients and healthcare professionals and in partnership with local communities and local authorities. We saw assessments of people who required support, which set out the needs of the person. Discussions were held with other health or social care professionals for further information. Referrals were also received for people who wished to purchase their care privately.

Each person had a copy of their care plan in their home, which contained details of what support people wanted for each part of the day, such as in the morning and in the evening. People's needs were assessed by the provider before the person started to use the service. The provider produced their own care plan based on the outcomes the person wished to achieve and ensured they were in line with recognised health and social care guidelines. One person's outcome was "'to be able to manage a balanced and healthy diet and also adequate fluid intake.'" Care plans were reviewed regularly and updated to reflect people's changing needs when they occurred.

People were supported to have their nutrition and hydration requirements met by staff and told us that staff provided them with food and drink, when they requested. One person said, "[Carer] gets my breakfast and evening meals." Care plans stipulated if staff were to support people with meals or if the person's relatives were responsible for this. One relative said, "I feed my [family member] because they are PEG (Percutaneous endoscopic gastrostomy) fed."

People's care was planned and delivered to maintain their health. Records confirmed that people's relatives and their GP were informed of any concerns raised about people's wellbeing or any deterioration in their

health. A relative told us, "The GP comes to the home. The carers help where necessary." One person said, "Yes carers are involved with medical appointments." Another person told us, "They give us a number and there is a folder and my [relative] deals with emergencies." Staff were aware of how to respond to any concerns they had about a person's health. A member of staff said, "We have all the information about who to contact if someone is unwell."

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that care staff treated them with respect and kindness. One person said, "I trust [carer]. The carer has been with us a long time, 7 years." Other comments from people included, "Yes, I am treated with dignity and respect at all times;" and "Yes definitely. There is always a friendly atmosphere."

Although people were happy with the way care staff treated them, the provider had recently experienced issues with staff who were unhappy because they were not paid on time. This led to some staff refusing to work and led to care packages being cancelled. There was some disruption to the service and the care people expected to receive. Many staff decided to leave the provider without giving sufficient notice. One staff member informed the management team that they intended to provide care at a person's home but they failed to attend, as they no longer wished to work for the provider. The staff member did not alert the service or the person of their actions. This did not demonstrate a caring attitude and respect towards people who used the service because they were left without care and an appropriate explanation.

We recommend the provider seeks best practice guidance on ensuring all staff are aware of their responsibilities towards people who use the service.

Staff who remained working for the provider, had a good understanding of all people's care needs and personal preferences. One relative told us, "[Family member] is more than happy. For when they see [carer], [family member] knows [carer] is going to take them out." People mostly received care from staff who were familiar with their care and support needs. They and their relatives confirmed they usually had the same staff providing care. This helped with consistency and enabled people to have a positive relationship with care staff. People and relatives told us they felt comfortable with staff who visited them regularly and enjoyed their company. One person said, "I am very happy with my carer." A relative told us, "Yes. We are happy as [carer] has been coming a long time." A member of staff said, "I have a good relationship with my clients. We get on well."

Staff had an understanding of how to treat people equally, irrespective of their race, sexuality, age or gender. Staff we spoke with were respectful of all people's care needs, personal preferences and their religious beliefs.

People's privacy and their homes were respected by staff, who told us they entered people's homes by ringing the doorbell or using a 'keysafe', before announcing themselves and greeting the person or their relatives. A 'keysafe' requires a passcode for entry into a person's home and care staff were given permission to access the code and enter at the required times. One person said, "[Carer] comes and rings the bell. [Carer] then comes up stairs to my room does the personal care and dresses me."

People and relatives told us staff were friendly, helpful and treated them with dignity. A relative told us, "The carers are good and respect us. They are honest and have been coming since 2006." One member of staff told us, "When giving personal care, I make sure [person] has privacy by pulling the curtains. I also make sure they are appropriately dressed."

People and their relatives were involved in making decisions regarding the person's care plan. They signed the plans to evidence that the contents of the care plan was discussed and agreed with them. Comments from people and relatives included, "Yes and it is signed and used each time;" "Yes, my [family member] has signed it in the folder" and "Yes I think my [family member] signed it." Another person said, "Yes, the representative from the company comes around when they review the care plan."

People's care records identified their specific needs and how they were met. They required assistance from staff for most of their needs, although they were supported to remain as independent as possible by staff. For example, we noted that one person's care plan said, "'I want to have peace of mind and gain some independence in my own house, by accessing my house safely without fear of falling.'" This showed people were supported to do things for themselves as much as possible but were assisted by staff with other aspects of their personal care.

The manager was aware of how to access advocacy services to enable people to air their views and to ensure their rights were protected. People's personal information and care plans were filed securely in the office, which showed that the provider recognised the importance of people's personal details being protected. Staff said they were aware of confidentiality and adhered to the provider's data protection policies.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in January 2016, we recommended that people were contacted and updated of any changes to their care by the provider. This was because people were not always kept up to date when, for example, their regular care staff were on annual leave or were not available. We found there were inconsistencies with the service in notifying people of replacement care staff.

At this inspection, we found that some improvements had been made and most people we spoke with told us that the staff based in the office would contact them if there was going to be a change of care staff. We saw from people's feedback, obtained by monitoring officers, that they were asked if they were kept informed of changes to their care package and people had replied 'Yes'. One person said, "Last weekend it [the service] fell down, but otherwise they are OK." Another person told us, "Yes most of the time they do." Another comment from a person was, "Usually yes, they let me know."

However, some people and relatives expressed concerns and frustration about apparent lack of communication from the service. One relative said, "When the regular carers go on leave we are not always informed. There needs to be better communication in this respect." Another relative told us, "They are very poor at that when the carer is off. I have to chase up with the office even though I know the carer told them in advance they were going on holiday because [carer] told me so."

Where people were unhappy with the service, they told us they would contact the office or make a complaint. One person said, "If I had a problem, I would talk to [senior staff]. [Senior staff] also pops in from time to time to ask me if I am happy with the service." Another person said, "I would talk to the manager." However, some people were not confident that issues would be addressed. One person said, "They would listen but doubtful they would do much." Another person said, "The office [staff] don't do anything. I think the office people don't listen or act." We spoke with the care coordinator who said, "We try to keep people updated about changes. They would call us as well if their carer is late or they have any queries about their care and we will find out for them."

The manager addressed concerns people had about the service and a complaints procedure was in place. People were aware of the complaints process and knew how to complain. One person said, "I would just call the agency." Another person told us, "If I had a complaint or was not happy, I would tell the manager." Since the last inspection, the service had received two formal complaints. After a complaint was received, it was investigated by the manager and a response was written, informing them of the outcome of an investigation. We saw that one complaint was investigated but a response was not sent to the complainant until two months later. We spoke with the manager about this who said that they had kept them updated verbally about the investigation, although the formal written response was delayed. We noted the manager apologised to the complainant for the delay.

We recommend that the provider further reviews its processes to ensure all complaints, updates and queries are followed up more promptly.

Most people and relatives told us the service was responsive and said that they were satisfied with the care their family members received. They were complimentary about the service and said they were happy with their regular carers. A relative told us, "Overall I am quite happy with them." Another relative said, "I think they are good. We want to keep this company as they are very good."

People confirmed that they had a care plan. Care plans were personalised in a document called "How I like My Care to be Delivered". It contained their likes and dislikes and some details about their preferred daily routines. For example, one person's care plan said, "'Likes watching television, listening to music and likes swimming. Carer to ensure I have all my swimming things when I go swimming." This information helped people receive a personalised service and staff responded to people's requests and needs. One relative said, "[Carer] knows everything [family member] likes and dislikes."

Some people were supported with palliative care, which meant they had a terminal illness and were reaching the end of their life. We found that staff ensured people were comfortable, were cared for and regularly checked up on. Support was received from health professionals, such as district nurses and local hospices, who provided advice and training to staff on managing people's end of life care sensitively and in accordance with their wishes.

The management team contacted people who used the service to check if they were happy with the level of care. This ensured that care was being delivered and people were satisfied with the service and their care worker. One person who recently started receiving care from the provider said, "I am new. I have been getting care for 3 months. I am OK." We saw records of assessments and observations of staff who provided personal care. We looked at daily records written by staff and found that they contained details about the care that had been provided to each person and highlighted any issues. This helped to monitor people's wellbeing and respond to any concerns.

Organisations that provide NHS or adult social care must follow the Accessible Information Standard (AIS). The aim of the AIS is to make sure that people who receive care have information made available to them that they can access and understand. The information will tell them how to keep themselves safe and how to report any issues of concern. We spoke to the registered manager about how people could receive information in a way that they could understand. We saw a 'welcome guide' that contained easy to read information on what the service could provide and how to contact the provider. People's communication needs were identified and recorded in people's care plans with guidance on how to meet those needs. We noted that people could also request information to be translated into their preferred language, such as important details about the care they were to receive. We also noted that staff, who did not have English as a first language, were able to receive guidance information in their preferred language, which helped them carry out their care tasks to people.

Staff we spoke with told us they were able to communicate with people by using simple phrases and signs. Some people requested care staff who could speak the same language or had similar cultural backgrounds. We saw that these requests were met where possible. A member of staff told us, "I communicate with people depending on their needs. I can use verbal and non-verbal communication such as signs and gestures so we can understand each other. My client likes music, so I play music which helps us develop an understanding."

Requires Improvement

Is the service well-led?

Our findings

De Vere Care was managed by the registered provider, who also operated a number of similar branches of the domiciliary care agency. Prior to our inspection, we received concerns from the local authority about the management of the service in Redbridge. This included information that a large number of care packages for people were being returned to the local authority at very short notice. The local authority were tasked with finding alternative care providers for them. The provider had recently relocated the service and their head office in Redbridge, which caused system failures and they were unable to process payments to staff. This led to high levels of staff absences and resignations between October and November 2017. We noted that the provider had submitted an urgent action plan to the local authority and had been transparent in explaining the issues they had experienced. However, we were concerned about the remaining people who used the service and during our inspection, we checked whether people were receiving the care and support they needed. These included people receiving care funded by the local authority and people who funded their own care, privately.

During our inspection, the management team informed us that some staff no longer wished to work for the provider following issues with the processing of their wages. We found that the issue was being resolved and the majority of staff had decided to remain working with the provider. One care staff member said, "There was a problem with our wages but it is fine now. Back to normal. The managers are good." Another member of staff told us, "There was some uncertainty and we were wondering what would happen but the company is very supportive of us." People who had their care packages retained, were still receiving a care service from the provider's care staff. However, we found that the provider was not taking sufficient steps to ensure there was an effective system in place to assess, monitor and mitigate the risks to the health and safety of people and to maintain accurate records.

The lack of quality assurance, to ensure people had received or were receiving care at the correct times, meant that missed calls were not picked up by the management team. This could have a negative impact on people's health and put them at risk. The manager explained to us why these incidents happened and said that a system was now in place to make sure mistakes were not repeated. However, the provider had failed to ensure that care provided to people was monitored effectively, particularly during a period of transition and change.

We found that staff were not provided with up to date training. Staff were also not provided with regular supervision. The manager told us that attempts had been made to arrange supervision meetings and appraisals but staff had failed to attend. This meant that leadership and management systems were not adequately fulfilling the requirement for staff to receive appropriate training and professional development, support, supervision and appraisals. These would enable staff to provide safe and effective care to people.

Where people did not have capacity to make decisions about their care and treatment or provide their consent, there was no assessment to state what decisions should be made in the person's best interest. This meant that the provider was not acting in accordance with the requirements of the MCA. Complete, accurate and contemporaneous records for the person and decisions taken in relation to their care and treatment,

were not documented to ensure their legal and human rights were adhered to.

We saw that some staff attended team meetings, where the management team discussed any concerns and particular needs of people who used the service had. Meetings included more general discussions to share information. However, the meetings did not appear well attended by staff and we noted that there had not been a meeting for nearly four months. Meeting minutes were not clear as they had been written up by hand and there was no set agenda about what was to be discussed. This meant not all staff would be kept informed of important information effectively and provided with necessary guidance through a structured format.

There were quality assurance systems in place to monitor and improve the quality of the service. The manager carried out monthly and quarterly compliance audits which looked at areas such as medicines, care plans, supervision, training, complaints, safeguarding and staff attendance. The audits were measured against the CQC's five key questions and a score was calculated to measure how well the service was performing. We saw that the last audit in August 2017, generated a score of 60.5 out of 100, which according to the provider's systems, meant they required further improvement. For example, we noted that one area for further action was for up to date staff supervisions to be held ''in a more formal way by calling in the staff member to the office at a specific time and not on an ad hoc basis.'"

Although the provider was able to identify issues and concerns within the service that required further action, the internal systems needed to be more robust to ensure all concerns found during our inspection were picked up.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and relatives told us the service was well managed and said they were happy with the way the service delivered care to them. One person said, "Yes it is good. I am happy with them." Another person told us, "They have improved a lot. They are much better now than they used to be." There were some negative comments from people such as, "They are full of apologies but nothing changes. They are not good at communication. The carer is not very good." Some people were also not sure who the manager was. Comments included, "I can't remember the manager's name;" "I don't know who the manager is;" and "The last manager came around often. Not sure about now."

The manager of the service had been working for the provider for 18 months but was not registered with the CQC. They were in the process of registering as manager during our inspection. The previous registered manager had cancelled their registration a few weeks before the inspection. The manager was supported by the registered provider, who was unavailable on the day of our inspection. The manager was also supported by a contracts manager and other senior staff. These included two monitoring officers, who undertook checks and phone calls to gain people's views about their care and support. There were three care coordinators, who worked on different days and checked that care staff were following their individual rota at the scheduled times.

The manager notified us of serious incidents that took place in the service, which providers registered with the CQC must do by law. However, during our inspection we found they had not notified us of the missed visits that had taken place in November and December. We asked the manager to formally notify us of these incidents because safeguarding alerts had been raised by the local authority.

Staff said they were happy with the management of the service and were confident they could approach the

management team with any concerns. The manager told us, "It has been a very challenging time. The past month has been very stressful but I am here for my staff. I don't want to let them down. We need to support our carers because without them, we are nothing. [Registered provider] has been very supportive. I can go to them for help." Staff based in the office and care staff told us the manager was approachable, friendly and supportive. One staff member said, "[Manager] is the backbone of our company." Another member of staff said, "[Manager] is very hands on. We are very close and work well together."

We looked at the online system which showed the schedules for each care staff and the times they were required to provide care to each person. We noted that the system required further updating because there were time clashes showing that carers were scheduled, in some cases, to be visiting two different people at the same time. A monitoring officer said, "Yes, we need to update the times on the system. This happens because carers and service users sometimes arrange times between themselves." The manager told us they had recently implemented a new electronic system which enabled care staff to log in and out of their calls using a portable device connected to the provider's online system. Staff were required to enter a four digit code from the device into their mobile phone after they had dialled a phone number. This would log them in and later out of their visit and office based staff would be able to see this on the system. The manager said, "We have not rolled it out completely because it was charging our carers to use it. We will sort this out and do further tests before we start using it all the time."

Daily records contained information on personal care tasks that were carried out and helped staff to follow up on any concerns and report on the wellbeing of each person. The records were brought back to the office and checked by monitoring officers to ensure they were being completed appropriately. We looked at records of staff practice and competency when carrying out personal care and saw that they were completed by the monitoring officers.

People and relatives completed annual surveys and feedback forms. Surveys helped to ensure people were satisfied with the care and support that was delivered. One person told us, "Yes I have done a survey." We saw that the feedback was generally positive with most people either 'satisfied' or 'very satisfied' with the service. One person wrote in their feedback, "No issues or concerns. Still happy with the service." Another person had written, "Always have the same carer. No concerns, very happy."

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 11 HSCA RA Regulations 2014 Need for consent Complete, accurate and contemporaneous records for people and decisions taken in relation to their care and treatment, were not documented to ensure their legal and human rights were adhered to. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way because people did not always receive care at the agreed and assessed times, which put their health at risk. Risk assessments were not consistent and not contain comprehensive information to mitigate risks. Regulation 12(2)a,b

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform. Regulation 18(2)(a)

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 17 HSCA RA Regulations 2014 Good governance The provider was failing to take proper steps to ensure an effective system was in place to assess, monitor and mitigate the risks to the health and safety of people; maintain accurate records and to improve the quality and safety of the services provided. Regulation 17(1)(2)(a)(b)(c)

The enforcement action we took:

We have served a Warning Notice to the provider.