Dale Care Limited

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Inspection report

13 Hope Street
Crook
County Durham
DL15 9HS

Tel: 01388768271
Website: www.dalecare.co.uk

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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

The inspection took place on 4, 5, 6, 9 and 13 May 2016 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

We last inspected Dale Care on 11 February 2014, at which time it was meeting all our regulatory standards.

Dale Care is a domiciliary care provider based in Crook providing personal care to people in their own homes in the Durham, Stockton-on-Tees and Gateshead areas. The service mostly provides support to older people but is also registered to provide personal care to children and younger adults. At the time of our inspection the service provided personal care to approximately 1,250 people.

The service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had extensive experience of working in health and social care.

We found people's medicines were not always administered in a safe and proper manner and the service did not always learn from mistakes made.

We found there were adequate numbers of staff to ensure people's needs were met safely, although we found a number of instances of delayed or missed calls. We found people sometimes had to wait for care staff to arrive and this was a source of anxiety and risk.

Pre-employment checks of staff ensured the service reduced the risk of unsuitable people working with vulnerable adults. Safeguarding policies and procedures were sound and taken seriously by all staff we spoke with.

We found the service had a range of risk assessments in place to ensure people were protected against risks such as those presented by the environment and their mobility. We saw these risk assessments were regularly reviewed.

We found infection control procedures were in place and people were protected against the risk of acquired infections.

There were supervision and appraisal processes in place. All staff we spoke with confirmed they were well supported.

People who used the service, relatives and external healthcare professionals expressed confidence in the

ability of staff to ensure people were protected from abuse.

We found the majority of staff were trained in core areas such as safeguarding, moving and handling, first aid, as well as training specific to the individual needs of people using the service, for example dementia and PEG feed training. We found however that some staff had not received training specific to the needs of people they were providing care to, such as dementia awareness training and Mental Capacity Act (MCA) training.

We found staff had a good knowledge of people's likes, dislikes and preferences.

We found care plans to be sufficiently detailed to give members of staff relevant information when providing care to people who used the service. We saw professional advice was incorporated into care planning and delivery, and that people's consent had been sought prior to care being delivered.

People's changing needs were met through liaison with a range of external health and social care professionals and we saw these interactions were documented on the service's computer system.

People we spoke with and relatives told us they knew how to make a complaint if they needed to, and to whom. We saw the registered provider made the complaints policy prominent and accessible in various formats. We saw complaints were not always responded to as well as they could be, with responses sometimes defensive rather than open and transparent when errors had been made.

The registered provider did not always notify CQC of relevant incidents, particularly where medicines errors were repeated and put people who used the service at risk of harm.

Staff and the majority of people who used the service we spoke with were positive about the support they received from the registered manager and we found the registered manager and office staff to have a good corporate oversight of the organisation, as well as knowledge of people who used the service.

We saw the registered manager had in place a range of audits to identify areas of concerning practice although these did not always identify patterns and drive service improvement. There was a consensus of opinion from all professionals we spoke with that the service could improve the way it learned from mistakes and make improvements to the service people received.

We found the service to be in breach of four of the regulations. You can read more about the 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.

People's medicines were not always administered in a safe and proper manner and the service did not always learn from mistakes made, with evidence on three occasions of repeated errors.

Pre-employment checks of staff ensured the service reduced the risk of unsuitable people working with vulnerable adults.

Safeguarding policies and procedures were sound and taken seriously by all staff we spoke with.

Is the service effective?

Requires Improvement

The service was not always effective.

People who used the service sometimes had to wait for staff to support them. The registered manager acknowledged this was an issue and had begun to put in place measures to reduce the frequency of delayed or missed calls.

Some staff had received a range of the provider's mandatory training as well as training specific to the needs of people who used the service. Some staff had not received training specific to the needs of people they were providing care to, such as dementia awareness training.

Staff we spoke with were positive about the levels of support they received. Supervision and appraisals processes were in place to support staff.

Is the service caring?

Good

The service was caring.

The majority of people who used the service, relatives and professionals were consistent in their opinions that staff were dedicated, kind and compassionate.

People were treated with dignity and respect in their own homes,

with staff having regard to their rights.

People were involved in the planning of their own care, with people's likes, dislikes and interests reflected in their care plans.

Is the service responsive?

Good

The service was responsive.

Care plans were subject to regular review, with people and their relatives involved.

The majority of people who used the service and their relatives were positive about the ability of the registered provider to meet their changing needs.

Where advice was sought from external care professionals this was incorporated into care planning.

People who used the service and their relatives knew how to make a complaint. We found the provider's responses to people's complaints about the service were sometimes defensive rather than open and transparent when errors had been made.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered provider did not always notify CQC of relevant incidents, particularly where medicines errors were repeated and put people who used the service at risk of harm.

There was a range of auditing procedures in place, although these did not always identify patterns of incidents in the service and drive improvement.

Not all care plans we reviewed contained accurate and up-to-date information.

People who used the service and their relatives were mostly complimentary about levels of communication from office staff and the registered manager.

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Detailed findings

Background to this inspection

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

We visited the service on 4, 5, 6, 9 and 13 May 2016 and our inspection was announced. The members of the inspection team consisted of one adult social care inspector and seven experts by experience. An expert-by-experience is a person who had personal experience of using or caring for someone who used this type of care service. The experts in this case had experience in caring for older people, people living with dementia, mental health conditions and younger adults.

During our inspection we spoke with the registered manager, the senior care co-ordinator, the training manager, the complaints manager, the human resources manager and three care co-ordinators. We spoke with 50 people who used the service and 15 relatives. Following the inspection we spoke with nine care staff by telephone. We also spoke with three social workers, three commissioning professionals, four safeguarding professionals and two occupational therapists.

During the inspection visit we looked at 20 people's care plans, risk assessments, staff training and recruitment files, a selection of the service's policies and procedures, meeting minutes and quality assurance processes.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports. We also examined notifications received by the Care Quality Commission, previous complaints and safeguarding alerts. We contacted three commissioning professionals prior to the inspection, who raised concerns regarding the regularity of delayed care calls.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This document sets out what the service feels it does well, the challenges it faces and any improvements they plan to make. We used this document to inform our inspection. We also reviewed responses to questionnaires CQC sent to people who used the service, relatives, staff and community professionals. We

used these results to inform our inspection.

Requires Improvement

Is the service safe?

Our findings

There were adequate medicines policies and procedures in place and audits of medicines practices. We reviewed the medicines policy and found it to be informed by guidance from the RPS regarding medicine administration in home care. We saw the policy had guidance on self-medication and, when we spoke with people who used the service who self-medicated, they confirmed staff regularly checked that they had taken their medicine. We spoke with the registered manager about controlled drugs and their understanding of the administration of controlled drugs was consistent with guidance issued by the Royal Pharmaceutical Society (RPS). We saw that appropriate medicine administration training had been delivered and that annual supervision of staff regarding their competence in administering medicines took place. The majority of people we spoke with who used the service stated they had confidence in the ability of staff to safely administer medicines, saying, "They give me my medication, put my stockings on and my eye drops in," "They give me my medicines and they always do it right."

Staff we spoke with displayed a knowledge of administering medicines in line with the medication policy and relevant to people's assessed needs. We saw medicines audits were undertaken when MAR records were returned to the office or when a person's care needs were reviewed. We saw these audits identified a range of issues such as a carer leaving a medicine with a person for them to take at a later hour rather than observing them take the medicine. We saw, when such issues were identified through audits, the member of care staff involved attended a meeting where next steps were established. In this case the member of staff presented no concerns otherwise and was placed on 6 months monitoring. In another case we saw a medicine audit identifying an error made by a member of staff contributed to the termination of their probationary period. This demonstrated the registered manager took medicines errors seriously and took corrective and, if necessary, disciplinary action when concerns were identified to help protect people who used the service.

We saw there had been 30 medicines errors in the past year and asked for more details regarding these instances. We saw one person had not been given their prescribed medicine on three occasions due to a mistake when removing the respective tablets from the dosette box. A dosette box is a pre-packaged container with people's medicines already sorted by day and time. Whilst medical advice indicated that these omissions were unlikely to have caused significant harm, they demonstrated that medicines had not been administered in a safe manner.

The development officer we spoke with regarding the matter identified a potential cause as carers having written words to the effect of 'dosette box given' on the Medication Administration Record (MAR) rather than individually listing the medicines and confirming they had been administered. The Royal Pharmaceutical Society (RPS) guidance on this matter states that home care agency staff can record the administration of medicines by stating this, provided that there is accompanying evidence attached to the MAR that allows care staff to confirm the corresponding number of medicines have been given. Likewise, the registered provider's medication policy is clear, stating, "Identify the appropriate medicine container(s), checking the labels match the record including: the service users name is on the container; the medication; the dosage; the time to be administered." In this case, staff had left a tablet in the dosette box on each occasion,

meaning they had not checked the dosage before administering. Medicines had not therefore been administered safely.

We saw one person had been administered medicines from an out of date dosette box. We saw information regarding where the new dosette box was kept had been entered into the person's care plan, but that care staff in this case had not acted on this information and accessed an old dosette box stored at the premises. The old dosette box contained one medicine that had since been discontinued, meaning the person took this tablet for an additional five days. Whilst there was no evidence of significant harm occurring, this error put the person at risk of harm through the unsafe administration of medicines.

We saw one person had not been given part of their medication on one Saturday, meaning they were at risk of harm through not taking the medicine. The medication was kept separate to the dosette box because it had an impact on other medicines when stored with them. We saw appropriate guidance was contained in the person's care plan regarding this but that staff had failed to administer this medicine on three occasions. We saw that, whilst the registered manager had agreed to a safeguarding plan, with family consultation, and care plans had been updated to protect against the same thing happening, the same medicines error occurred less than a fortnight later. This demonstrated that, whilst medicines errors were acted upon by way of retraining, additional audits and supervisions, lessons were not always learned or shared in such a way that successfully reduced the risk in future.

We saw that in each instance relevant information had been updated on the care plan but the care plan had not been adhered to. The risk of the repetition of errors had not been successfully managed. One social care professional told us, specifically with regard to medicines administration, "They address individual errors but it's a matter of time before someone is really harmed. They don't always learn from their mistakes."

This meant that people were not protected against the risk of the unsafe administration of medicines. This was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw in all three of these instances the registered manager and relevant development officers had engaged with the people involved, family members and safeguarding and health and social care professionals to investigate the errors and put in place control measures such as retraining and staff supervision. The consensus of opinion of external health and social care professionals was not that the service was inherently unsafe, but that the registered provider had not learned from mistakes.

All people who used the service we spoke with stated they had no concerns regarding their safety, other than the late calls they had experienced, which are discussed in detail in the Effective key question. People told us, "We get looked after safely," and, "I've no concerns – the carers are very good and know what they are doing." Similarly, questionnaires filled in prior to the inspection indicated 100% of people using the service and their relatives (out of 17 respondents) "felt safe from abuse or harm from my care and support workers." The majority of people who used the service consistently told us they knew how to raise concerns if they had them and that, whilst they were concerned about the regularity of late calls, they had confidence their carers were able to protect them from abuse. One external healthcare professional we spoke with said, "I've never had any concerns on that front," when we asked about whether people could be a risk of abuse.

We found the safeguarding policy to be comprehensive and informative with practical links, for example to the local authority's risk assessment threshold tool. We found this policy had not been followed on one occasion, meaning a delay in reporting a safeguarding concern and a potential significant risk to the person involved. Subsequent to this incident we saw the registered manager had ensured action was taken to

ensure the staff member underwent a training review with the complaints manager and had their training and knowledge of safeguarding procedures refreshed. When we spoke with care staff they displayed a consistent knowledge of safeguarding procedures and were able to give examples of when they would have concerns about people, for example through a change in body language, mood or bruising. We saw safeguarding was an agenda item on all staff meetings and the registered manager had introduced a 'safeguarding scenario' discussion to these meetings to ensure staff continued to consider the practical risks people faced. This demonstrated the registered manager ensured appropriate safeguarding policies and procedures were in place.

We saw risk assessments were undertaken at a primary assessment stage by a development officer, who identified, for example, immediate mobility and environmental risks people and staff might face. Subsequently a care worker would undertake a full risk assessment when the person started using the service. We saw this was subject to annual review, or more regularly where people's needs changed. We saw where people had been identified as at a higher risk of falling due to their mobility, support had been sought from occupational therapists, for example to ensure the provision of specialised equipment.

We reviewed a range of staff records and saw that all had undergone pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks. The DBS restrict people from working with vulnerable groups where they are considered to present a risk and also provide employers with criminal history information. We saw that the registered manager asked for at least two references and ensured proof of identity was provided by prospective employees prior to employment. This meant that the service had in place a consistent approach to vetting prospective members of staff and had reduced the risk of an unsuitable person being employed to work with vulnerable people.

We saw that any accidents and incidents were recorded and reviewed on a document, which indicated outcomes for each event. We saw this tracker had not identified any trends as yet, with the majority of recorded incidents constituting back injuries to staff. We reviewed the service's Moving and Handling policy and found it to be appropriate and informed by 'The Manual Handling Operations Regulations 1992' and 'The Lifting Operations and Lifting Equipment Regulations 1998'. We saw staff had been trained in moving and handling and that refresher training was planned on a rolling basis.

We found staffing levels to be sufficient to keep people safe, although there was a consensus that the timing of care calls required improvement. This is discussed in the Effective key question.

We saw the registered provider had recently initiated monthly training sessions delivered by the fire service in order that all staff in time had a greater understanding of the risks of fires and how best to manage associated risks.

People we spoke with confirmed staff used gloves and aprons when delivering personal care and we saw that infection control training formed part of the training in induction week for new starters. This meant the provider had in place arrangements to reduce the risk of infections.

Requires Improvement

Is the service effective?

Our findings

When asked whether care workers arrived on time, a significant proportion of people who used the service told us there were regular problems with regard to carers arriving at the agreed time. 20 out of the 65 people who used the service and their relatives we spoke with stated carers had arrived late, with a similar proportion of people (43% out of 14 respondents) stating carers did not arrive on time in questionnaires returned to CQC. Representative comments from people who used the service included, "They don't ring up when they are late, they just turn up whenever," and, "I can't say they turn up on time, no." When we spoke with care staff they confirmed there were regular instances of calls being delayed, whilst over half of staff who responded to CQC surveys did not feel they were given adequate time to arrive and stay for the agreed length of time. Likewise, commissioning, safeguarding and social care professionals we spoke with all agreed delayed calls were a concern of theirs.

We saw the registered manager had recently implemented systems to try and reduce the regularity of delayed or missed calls. For example, they had installed a large monitor in the office which displayed which carers had not 'logged on' (by way of telephoning the office) to a care call, meaning care co-ordinators could follow up with these individual carers. We saw the service had also introduced an additional three 'on call' care staff available at weekends, whose role it was to cover for staff who may call in sick. The impact of these systems had yet to be measured at the time of our inspection.

Specific examples of late calls included a carer arriving for one person's call at 9.45pm, when the agreed time had been 8pm, and one person having to telephone the office when their carer, due to arrive at 9am, had not arrived by 10:30am. Another person who used the service required painkilling medicines to be administered every four hours and, due to their visits being delayed, this was not adhered to, meaning they were at heightened risk of pain. People who used the service were at risk of harm through a failure of the registered provider to ensure staff were able to attend calls on time.

Linked to this pattern of late calls we found there was a lack of continuity of care, particularly on weekends. One person said, "The weekends are awful – you never know who's coming," whilst another said, "It works perfectly until [Carer] goes on holiday – the office do not inform me if changes are made to the times of visits." One staff member said, "My rota is good and consistent, except for on a weekend. We always have to cover for people." These comments were not an isolated minority but representative of a third of people we spoke with. Guidance issued by the National Institute for Health and Social Care Excellence (NICE) recommended that providers should, "Prioritise continuity of care by ensuring the person is supported by the same home care worker(s) so they can become familiar with them" ('Home care: delivering personal care and practical support to older people living in their own homes', September 2015). Whilst we found the registered manager had, for the most part, ensured this happened during the week, people who received care at a weekend experienced poor levels of continuity and often did not know who would be caring for them in advance.

We reviewed training policies and procedures and found the majority of staff to have a range of training delivered as part of their induction week. This consisted of 21 modules, including safeguarding, dementia

awareness, diabetes awareness, first aid, moving and handling, medicines, fire safety, equality and diversity and dignity training. We found however that some staff who started working for the company in December 2014 had yet to undergo training the provider considered mandatory. For example, we found three members of care staff who provided care to people living with dementia had been given no dementia awareness training. When we spoke with two commissioning professionals independently of each other, they told us the lack of dementia awareness of some carers was a cause for concern.

We spoke with the training manager, who, whilst able to show us that all staff were due to complete relevant training by the end of July 2016, acknowledged staff had not as yet been trained appropriately in line with company policy. NICE's 'Home care: delivering personal care and practical support to older people living in their own homes', September 2015, states registered providers should, "Ensure home care workers are able to recognise and respond to: common conditions, such as dementia."

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 saw that policies reflected the five principles of the MCA but, when we spoke to some members of staff we found their knowledge of mental capacity considerations to be lacking. We reviewed training records and found a number of staff had not undergone mental capacity training. This demonstrated that not all members of care staff had been sufficiently trained to provide care to meet people's assessed needs. As above, we saw this training was mapped on a training matrix and due to be delivered but, at the time of inspection, there was a risk people were receiving care from staff who were not sufficiently trained to meet their needs.

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

The service was well positioned to build on its current training provision. We saw the service had a specific training room equipped with lifting equipment to enable face-to-face training. The registered manager was a qualified and experienced trainer, supported by the training manager and another member of staff. The latter two staff members had both been trained to deliver first aid training and moving and handling training, meaning future refresher training could be delivered to staff on site and face-to-face.

We saw staff were also trained in subjects specific to the individual needs of people who used the service, for example catheter care, stroke awareness training and percutaneous endoscopic gastrostomy (PEG) feeding training. A PEG is a tube passed into a patient's stomach through the abdominal wall as a means of feeding when oral intake is not possible or adequate. We also saw one member of the training team was due to shadow a MacMillan nurse with a view to sharing learning regarding end of life care as part of the provider's dignity training package.

People who used the service were largely positive about the knowledge and experience of the staff who cared for them. People told us, "They're always doing training. I've had the same carer and they know me really well", "They are efficient and good at what they do," and, "They are experienced and trained to used the hoist." When we spoke with external health and social care professionals, their responses were mixed with regard to experiences working with Dale Care staff. One professional told us about uniformly positive experiences whilst another stated they found Dale Care could communicate with them more effectively.

They did not cite concerns regarding people's safety, but rather they thought more consistent and effective communication from Dale Care would, "Allow them to provide a better service to people". They qualified their comment by stating, "The knowledge on the ground and with the care co-ordinators is good and they are prepared to go the extra mile."

People's needs were met through liaison with a range of external healthcare professionals, such as GPs, chiropody practitioners, opticians and dentists. We saw this was documented and care plans updated appropriately. For example, one person had previously been reluctant to attend diabetes clinics. We saw they had been successfully encouraged to regularly attend these clinics by a member of staff and the person subsequently experienced positive outcomes regarding their health and wellbeing.

With regard to nutrition and hydration people told us, for example, "They make my meals and I get what I want," "They do the meals and they are fine – they always leave [Relative] with a drink," and, "If I'm not eating then they'll say, 'Should I leave something out for you for later."

All staff we spoke with confirmed they had received supervision and appraisals and that they felt supported by their manager. Representative comments included, "There is an open door here and it's one of the reasons I feel I've been able to progress in the company." Another staff member said, "Whenever I've a problem, they help and sort it out," and, "I get good support from the management". Staff confirmed they were subject to regular observations by development officers and we saw evidence of this in the personnel files we reviewed.

The majority of staff told us their relationship with care co-ordinators in the office was positive and that they could rely on support should they need guidance whilst on a care call. One member of care staff said, "I get on great with the office staff – we have a co-ordinator who's specific to the area so they know the area and the people." Care co-ordinators likewise reported they felt the recent changes in the office had brought about improvements in their ability to meet people's needs.
We saw the organisation had grown significantly since the last inspection and the registered manager had put in place staffing changes to try and manage this growth.

The senior care co-ordinator now focussed solely on supporting and guiding the other care co-ordinators, rather than covering their own set of calls. Since taking on the role, we saw the senior care co-ordinator held twice-weekly meetings with each care co-ordinator to ensure they were on course to plan all care calls. The registered manager had also introduced a phone call 'triage' system, with three members of staff taking initial phone calls from people who used the service, professionals and colleagues, either dealing with the query or relayed the call accordingly. The intention was to free up more care co-ordinator time by ensuring triage staff dealt with administrative/staffing queries. At the time of inspection it was too early to tell if these changes had any impact on people's experience of care but it demonstrated the registered manager was trying new ways of ensuring staffing resources were best placed to meet people's needs.

We spoke with care co-ordinators who displayed a good knowledge of the people who used the service in their area. Care coordinators we spoke with had experience in providing personal care and had also recently shadowed members of care staff when completing calls.

We saw that staff meetings happened regularly and were organised by geographical location. We saw these meetings were not mandatory and, as such, were not always well attended. Communication with staff was through a combination of these team meetings, telephone calls, emails and text message updates from office staff. We found there was an opportunity to implement a more effective means of communicating key messages on a regular basis to staff.

Good

Is the service caring?

Our findings

People we spoke with and their relatives agreed that care staff were respectful, caring, dedicated and treated people with dignity. We found, through a range of responses from people who used the service, that they had built positive relationships with carers, particularly where that continuity of care had been sustained. People who used the service told us, "My carers are lovely and I look forward to them coming in," "We are happy with our care and get looked after – they are a friend not just a carer," and, "They are not like my carers they are more like my sisters." A small number of people we spoke with told us they sometimes noted carers were rushed whilst visiting them but attributed this to the organisation of shifts rather than the fault or attitude of individual care staff. We noted that those people who expressed concerns about experiences of delayed calls made a point of telling us that individual carers were, "Good at their caring job," "They are very respectful and very obliging," and, "You can't fault them – the girls would do anything for us."

Some people we spoke we told us care staff, "Went above and beyond," stating, for example, "They usually ask if there is anything else they can do after they have finished, like making the bed as they know things are difficult for me." People gave examples of care staff treating them with dignity and respect when providing personal care. One person said, "They are very respectful when they help me shower," and another, "They are very nice in my home and yes they treat it with respect and listen to me." One person said, "They sit and have a chat. They treat me like a person."

Questionnaires returned to CQC from people who used the service demonstrated that all respondents either agreed or strongly agreed with the statement, "I am happy with the care and support I receive" and, "My care and support workers are caring and kind." These results, alongside our conversations with people who used the service and their relatives, demonstrated that staff behaved kindly and compassionately when supporting people. This also demonstrated the registered manager had ensured staff adhered to the caring ethos of the organisation, as set out in company literature.

We asked people about their involvement in care planning and, again, there was a consensus that people were involved in their care. One person told us, "I feel in control" and other people and relatives we spoke with confirmed they had a copy of their care plan, knew what it contained and felt part of the care planning and review process.

Concerns regarding the continuity of care, particularly at weekends and as discussed in detail in the Effective section, were also highlighted in questionnaires returned to CQC, with the majority of people disagreeing with the statement, "I am always introduced to my care and support workers before they provide care." People we spoke with commented, "You never know who is coming," and, "They keep changing – I never know who will turn up." We noted the majority of these concerns were regarding weekend care calls and that the majority of people we spoke with on the telephone were positive about levels of continuity. One person said, "I've got to know them and they me," "It's usually the same carer," "It's the same girls who come," and, "They've got to know me as a person." Similarly, those people who expressed concerns about not always knowing which carer would arrive, did make the point that staff, consistent or otherwise, were caring and treated them as individuals. Whilst it was evident that the continuity of care was

an area the service had achieved some positive outcomes, it was an area the registered provider needed to improve.

We saw the service had received a range of compliments, which provided further evidence of the caring approach of staff. Comments included, "The family are extremely grateful for the brilliant care he received from the carers," "The best carer I have ever had: dependable, attention to detail, kind and altogether delightful," and, "Fantastic – I don't know where I would be without them."

With regard to promoting dignity, respect and autonomy at the end of people's lives, we saw the service had arranged for a member of staff to shadow a MacMillan nurse for two days, with a view to sharing lessons learned as part of the organisation's dignity refresher training programme.

We saw people's personal sensitive information was securely stored on a password protected IT system that was backed up daily in the event of any system error. We also saw instances of disciplinary action taken when a member of staff had spoken about confidential information on social media. This demonstrated the registered manager took people's right to a private life seriously and adhered to the confidentiality policy to ensure people's information was respected. Similarly, we saw the organisation's pre-assessment of people's needs focussed on the importance of their consent to care, as per respective policies. One person told us, "They always ask me what I want," whilst another said, "I have a full file with all their details in and I am involved." People we spoke with confirmed they were asked for their consent before being given care and we saw people had signed to give consent to care plans.

When we spoke with staff they demonstrated a good knowledge of people's needs, interests, likes and dislikes. Staff we spoke with were passionate about people receiving good quality care. For example, we saw one person, who had been living in unsuitable accommodation prior to receiving support from Dale Care, who had been at risk of financial harm, and had since seen significant improvements in their wellbeing due to the actions of Dale Care staff. One member of staff had supported them to achieve the positive outcome of a new council tenancy, whilst putting in place care plans and risk assessments that supported the person to be able to engage in their interests (for example, putting a bet on a horse race) without exposing them to unnecessary risk.

Good

Is the service responsive?

Our findings

We received a range of opinions from people who used the service, relatives, social care professionals and commissioners regarding the ability of individual staff and the service as a whole to respond to people's changing needs. Feedback was mixed, although the majority of people who used the service and relatives we spoke with (59 out of 65) indicated they were confident in the ability of staff to identify and meet their changing needs. Six people expressed concerns about the responsiveness of office staff and their ability to resolve concerns quickly. One person said, "Ringing the office is a dead loss," whilst another said, "When I rang nothing happened – I had to push and push."

We saw this was an area the registered manager was aware of and, five weeks prior to the inspection visit, had implemented a new 'triage' team to screen telephone calls to the organisation. This team was made up of staff with care experience and the intention was that they deal with a high proportion of calls rather than passing the call through to care coordinators, whose time was focussed on ensuring care calls were arranged for people in advance. Evidence was anecdotal but staff we spoke with told us they had noticed improvements, giving examples of being able to change shifts or book holidays more quickly. Care co-ordinators also told us the system meant they were spending less time focussing on calls from staff about such issues and were able to focus on organising people's care.

The majority of people we spoke with were complimentary about the ability of individual staff and the service as a whole to meet their changing needs. People told us, "They are flexible and I would recommend them," and, "When my needs change they change my care plan." One person gave an example of how they on occasion needed to change the timing of their morning call, and that this had not proved a problem. Other people we spoke with told us, "If you ring the office they are excellent – they sort it out straight away," and, "You can contact them at any time and there is always a person to talk to – not a machine."

We found care plans generally to be comprehensive and easy to follow, with copies of risk assessments and care plans scanned onto the computer system and a copy kept in people's houses. We saw reviews were undertaken regularly and brought forward where people's needs changed. Where advice had been sought from external healthcare professionals we saw this was documented on the computer system. Care plans were person centred and contained a sufficient amount of information to give staff the necessary details to provide care to that person. When we spoke with staff we found they had a good knowledge of people's interests. For example, one staff member told us about a person's interest in Scrabble, and how important it was to them to take part. Other carers were able to tell us about people's hobbies, such as following horse racing and gardening.

One external healthcare professional was extremely positive about the working relationship staff had formed with them and cited examples of this leading to positive outcomes for people who used the service. They gave specific examples of people who required help with mobility, stating, "They (Dale Care) try things and if something doesn't work they will try something else." They stated their work involved people's transition from respite care or hospitals back home and that they found carer knowledge and application of the use of, for example, stand aids, to be good. They expressed confidence in the ability of development

officer staff to liaise with them and other healthcare professionals to ensure people experience a smooth transition between services. We saw in other instances advice had been sought from, for example, the Speech and Language Therapy Team (SALT), physiotherapists, district nurses and bariatric specialists.

The registered manager told us they encouraged complaints as a means of ensuring the service could improve. We saw evidence of this in the service user welcome pack and in company policy. When we spoke with people who used the service and their relatives, they knew how to make a complaint.

We reviewed the complaints tracker, which documented all complaints received and the outcomes for each complaint. We saw that, where people formally made a complaint about the organisation, a response was provided by the registered manager or complaints manager. We saw numerous instances of the registered manager or complaints officer apologising where there had been an error. We saw they had adhered to their own complaints policy and had shared information with relevant external professionals where appropriate. Half the people who returned pre-inspection questionnaires to CQC stated they felt complaints were not responded to well, whilst one external professional told us, "The attitude of management towards complaints can be rather skewed in that they will often blame the client or family." We found, on occasion, the tone of responses to complaints was focussed on defending errors made rather than focussing on the needs of the person involved. We spoke with the registered manager about this and they acknowledged they would be more mindful of the need for all complaints responses to be handled more sensitively.
We saw evidence of people who used the service and their relatives being involved in reviews of their care plan. We reviewed questionnaire responses returned to CQC by people who used the service and saw all 11 respondents strongly agreed with the statement, "I am involved in decision-making about my care and support needs." All 11 respondents also either agreed or strongly agreed with the statement, "If I want them to, the care agency will involve the people I choose in important decisions." This demonstrated the registered provider ensured care was provided with the preferences of people who used the service in mind.

We saw the service routinely gathered people's opinions about their care through an annual survey. We saw there were 268 responses to the last survey, with 91% of respondents expressing satisfaction with the care provided.

We saw a high proportion of calls the service provided were shorter calls to help with personal care or complete household tasks. We saw examples of people supported to maintain levels of independence. For instance, we saw that one person had been at risk of self-neglect. We saw staff had liaised with a range of agencies to make sure they were mindful of this person's needs and saw they had encouraged the person to access the community more regularly. This demonstrated people were supported to achieve and maintain independence by staff who had regard to their rights.

Requires Improvement

Is the service well-led?

Our findings

We found the registered provider had not always notified CQC of relevant incidents. For example, we found evidence of people being put at risk of harm through three repeated medicines errors. Whilst we saw the registered provider had ensured responses to these incidents involved corrective actions and discussions with the people involved, their family members and local authority safeguarding teams, they did not notify the CQC of the incidents. Failing to ensure a person receives the right medicine by way of staff making the same error repeatedly is an example of abuse by neglect. Where medicines errors involve the potential for abuse by way of neglect, these instances should be notified to CQC. This is so CQC can ensure the registered provider remains accountable for such errors and to use this information to determine whether there are any recurrent patterns of concern with a provider. These instances should have been notified to the CQC in order for the regulator to have a clear oversight of the types of potentially serious medicines errors occurring.

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

We reviewed 20 care plans and found in three of them information that was not accurate. For example, two people's care plans clearly stated they had diabetes. A separate information page, used by care co-ordinators to identify and allocate care workers to meet people's needs, indicated they did not have diabetes. This meant there was a risk of staff being tasked with caring for people they were not appropriately trained to support. The registered manager acknowledged this and undertook to rectify the information immediately. We also found one person's care plan to be lacking up-to-date information regarding their history of falls and the subsequent support put in place. The person had suffered a fall previously and we saw the journal section of the care plan indicated a carer had highlighted concerns with an item of equipment in the person's house. When we analysed the next full review of the person's needs we saw this information had not been incorporated. This meant that any carer accessing this information would not have up to date information regarding whether the equipment had been replaced, deemed suitable or that the risk had been otherwise managed. Again, the registered manager undertook to rectify the inaccuracy. This meant the person had been supported through being supported by an occupational therapist but that the service's information was not accurate.

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

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager displayed a good knowledge of people who used the service and the organisation's systems and processes. One external health care professional told us, "They have a working knowledge of people's needs." The registered manager had been in the role since January 2016 but had 26 years' experience working with the company and had supported the previous registered manager. They had extensive experience in health and social care and had until recently been the training manager.

The majority of people we spoke with were positive about the impression they had of the management of the organisation. One person said, "The managers come out from time to time to see how things are going," whilst another said, "Someone has called me up on a couple of occasions to make sure everything is okay." One staff member we spoke with said, "The company cares and takes personal ownership." Whilst this opinion was not unanimous, the majority of people who used the service we spoke with were positive about the management of the service. When we spoke with external health, social care, safeguarding and commissioning professionals, they raised some concerns about the registered provider's ability to maintain good standards of care for such high numbers of people but acknowledged the provider had the systems in place to be able to do this.

We reviewed auditing and quality assurance practices and found there to be a range of systems in place, with the registered manager, complaints manager and human resources manager undertaking auditing. For example, we saw medicines audits identified individual errors and put in place corrective actions such as retraining, supervision, messages in the staff meetings. Likewise, we saw care plan audits that identified areas of poor practice in care plan completion and rectified the problem. In both of these instances however, auditing was unable to identify a means of stopping recurrent errors and this was an area the registered manager and other staff agreed to improve through trialling new solutions.

We saw the organisation held large amounts of information that could be better directed to ensuring people's personal care experiences were improved over time and that recurrent errors were phased out. For example, the computer system was able to generate a report indicating who had accessed the care plan system and when. Interrogating this would have given management clear information about whether care staff were failing to read updated care plans prior to giving personal care. At the time of inspection, this function of the computer system had not been utilised but the registered manager told us they would incorporate it into improving how they monitor, assess and improve service delivery.

We saw the registered manager did take steps to encourage and enforce individual accountability for people's safety and the standards expected of staff. We saw, for example, staff who had not adequately performed during the probation period, or staff who had made repeated errors and failed to improve despite support, were subject to the formal disciplinary process and had their employment terminated. We saw these processes had adhered to the disciplinary policy. We also saw examples of messages being communicated to care staff from the registered manager and that key messages were also shared at team meetings. The training manager acknowledged that staff meetings were not mandatory, whilst the registered manager acknowledged there was a need to ensure messages, particularly with regard to people's changing care needs, were read by staff to avoid a recurrence of errors.

We found staff morale in the office to be positive and, when we spoke with members of care staff, only one out of nine lodged concerns about their confidence in the ability of their managers to sustain and maintain improvements to people's care. They stated this was specifically in relation to the volumes of late calls caused by the lack of travelling time, and the recurrence of medicines errors. We reviewed the results of the latest staff survey and found, of 176 responses, 2% were not happy working for the company.

We saw management instructions to staff when medicines audits identified individual errors on MARs. These instructions were to the individual staff member involved and the registered manager could improve the manner in which individual errors and the lessons learned from those are shared more widely with staff in a systematic, consistent fashion.

Policies and procedures we reviewed had been recently reviewed and were informed by relevant aspects of best practice, such as the Royal Pharmaceutical Society and local authority guidance.

We found the registered manager to have a clear understanding of the areas that required improvement in the service. We found they had planned improvements to service provision through further implementation of recognised systems but had yet to put these ideas into practice. For example, the registered manager told us they had achieved International Organisation for Standardisation 9001(ISO) accreditation in 2014. ISO accreditation is an internationally recognised certification of an organisation's consistency of policy. We saw the service had previously achieved the Contractors Health & Safety Assessment Scheme (CHAS) certification. CHAS is a recognition of a service's approach to managing health and safety. The registered manager also stated they planned to sign up to the social care commitment, which is a promise by social care providers to ensure people receive high quality care services by committing to and meeting seven 'I will' statements. The registered manager stated they hoped to sign up to the commitment imminently.

We saw staff had raised funds for a range of local and national charities through events such as coffee mornings and sponsored walks. We also saw positive working relationships had been formed with local agencies, such as the Tyne and Wear Care Alliance, which was a source of additional training, for example, continence care awareness training.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We found the provider did not notify CQC of alleged instances of abuse by way of medicines errors.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found the provider did not ensure the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found the provider did not ensure there was an accurate, complete and contemporaneous record in respect of each service user

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found the provider did not ensure there were sufficient numbers of staff deployed to meet people's needs through the implementation of an effective rota system.

We found the provider had not protected people against the risks of having staff in place who had not received appropriate training.