White Dove Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected White Dove Care on 7 August 2017 and it was an announced inspection.

White Dove Care is a domiciliary care agency providing personal care for people living with physical disabilities, dementia and mental health needs in their own homes. At the time of this inspection they were supporting 10 people.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (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.

At the last inspection on 5 September 2016 the service was rated requires improvement and had three breaches of regulation related to safe care and treatment, good governance and staffing. Following last inspection, we asked the provider to take action to make improvements to their processes in relation to risk assessments, staff supervision and auditing. At this inspection we found the service had only made improvements in relation to staff supervision; the other areas were in continuous breach, and we found two new breaches in relation to consent and safe recruitment.

There were policies in place in relation to safeguarding adults and whistleblowing procedures. Care workers understood these policies and said they would use them if needed. We identified two possible safeguarding concerns during our inspection related with unsafe moving and handling and the registered manager reported these to the local safeguarding team and CQC.

People's risks were not always assessed or the risk assessments in place did not have enough detail to minimise and manage those risks. We found recent incidents of people displaying behaviour that might challenge others were not being reported by care workers to the management or being identified during auditing.

New employees had some pre-employment checks completed prior to commencing employment however; these were not in line with the registered provider's own recruitment policy and did not always ensure safe recruitment.

People told us care workers turned up on time to provide care and there were enough care workers to support people.

The registered manager told us people were not supported with their medicines by care workers but we found some people were being verbally prompted by staff to take their prescribed medication and staff were applying prescribed creams. Staff's competency to carry on these tasks was not being checked and the registered manager was not conducting any medication audits.

Care workers completed an induction to ensure they were aware of their roles and duties. They were provided with regular supervisions to assess and monitor their performance and wellbeing.

People told us they were treated with respect and dignity. They said they were always given choice in relation to their care and care workers respected their decisions.

Care plans were personalised to people's care needs and preferences.

The registered manager was not able to explain their responsibilities under the Mental Capacity Act 2015; we did not find any mental capacity assessments for people who might require them. Consent was not always being sought from people who had the legal authority to provide it. We found one person's liberty was being restricted without the appropriate authorisation from the Court of Protection and the registered manager had not identified this.

People and their relatives told us they thought the service was well managed. We found the systems in place to monitor and improve the quality of the service provided were not robust. Some checks and audits were undertaken but these were not always documented and did not identify areas for improvement.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see the action we have told the provider to take at the end of this 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 consistently safe.

People's risks were not always assessed, risk assessments that were in place did not have enough detail to minimise and manage risk.

Recruitment process was not always robust.

The registered manager told us care workers were not supporting people with their medicines but we found evidences this was happening.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider was not working in line with the legislation to assess people's mental capacity and support their decision making.

People received the support they needed to eat and drink and people gave positive feedback about their meal experience.

Care staff had received support and training but this was not always effective.

Is the service caring?

Good

The service was caring.

People received consistent care from regular staff. People told us staff were kind and caring.

People had good relationships with those who supported them.

People's diversity was respected.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised to people's care needs and preferences.

People told us they were confident their concerns would be responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were quality assurance systems in place however, these were not always documented and did not identify areas for improvement.

Staff told us they were supported by their management.

The registered manager had not implemented the necessary changes to address all the breaches in regulation found during last inspection.

White Dove Care Ltd

Detailed findings

Background to this inspection

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

This inspection took place on 7 August 2017. The registered provider was given 48 hours' notice because the location provides care to people in their own homes and we needed to be sure the registered manager would be at the registered office. The inspection team consisted of one adult social care inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience caring for people with physical and learning disabilities and was fluent in Punjabi. Most of the people who used the service spoke Punjabi as their first language.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service. This included questionnaires completed by people, relatives and staff; as well as correspondence we had received and notifications submitted by the service. Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents.

We contacted local stakeholders to have their views on the care provided by White Dove Care. These included the local authority's safeguarding team, clinical commission group, fire service and local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not share any concerns with us.

During the inspection we spoke with three people who used the service and five relatives. We spoke with five staff members, including the registered manager and the branch manager and gathered the views of two community professionals. We looked at records in relation to three people's care, three staff records and other records which related to the management of the service, including policies and procedures, audits

and minutes of staff's meetings.

After our inspection, we asked the registered manager to send us additional information in relation to concerns identified during inspection and the actions taken to address those concerns. The registered manager sent us this information within the agreed timescales.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt safe with the care provided by White Dove Care. One person said, "I feel safe, and the carers are very helpful." Another person said, "Yes, I feel safe."

At our last inspection on 5 September 2016 it was unclear if staff should or should not be applying creams and if so, how this was being audited. At this inspection, the registered manager told us staff did not support people with any prescribed medicines however; in our conversations with people, relatives and staff we found otherwise. One relative said, "[Relative's] medication is next to [relative] so that [relative] can take it themselves, and carers remind [relative] to take it if it is not taken." One person said, "Yes, creams applied gently (by care workers)." Another person said, "Carer administers medication." We asked care workers if they applied any prescribed creams to people; one said, "No, never, just a little bit of oil sometimes;" another care worker said, "Yes, because [person] has [medical condition] in the legs and feet, [person] couldn't put it on, [person] cannot bend." We asked the care workers if they prompted or reminded people to take their medication; one said, "Just reminding sometimes [person 1] and [person 2]; [person 1] takes them in front of me, [person 1] needs them or they will be in pain." Another care worker said, "No, we don't do the medical side of the care, the family will."

Staff told us they had completed online medicines training as part of their induction. We confirmed this when we checked staff files and respective training certificates. However, staff's competence to administer prescribed medicines was not being assessed or monitored as recommended by the National Institute for Health and Care Excellence (NICE) guidelines in relation to administering people's medicines in the community. This meant people were not being supported by staff whose competence had been assessed and the registered manager was not assessing people's needs or auditing this aspect of their care.

We shared this information with the branch manager and they told us they had taken appropriate action. We asked the registered manager which alternatives and risks had been discussed with people that were previously being supported by care workers to have their prescribed medicines. The registered manager told us they were going to consider start administering medication from the 1 November 2017 and in the meantime people who were being supported by care workers were going to be supported by their families.

This meant the registered manager had not conducted the appropriate assessments and reviews in order to provide person centred care to people's needs. This demonstrated a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection we saw people's risks were being identified but not always assessed. At this inspection we found some risk assessments lacked detail in relation to how staff should support people to move and transfer in a safe way, how people's risk of falls should be managed and how best to support people whose behaviour might challenge others. For example, the moving and handling risk assessment for one person had a list of all the equipment needed and how to use it. The assessment recorded; "Staff should make sure bath stool is dry and not slipping; walking stick is always at hand." However, when we looked at another person's moving and handing risk assessment staff had recorded 'lifting a load or person in/out of

bath/bed'. No further details were given on how staff should do this. We asked staff how they supported this particular person; one said, "One carer holds [person], other carer puts the arm around [person's] waist, gently lifts [person] up, the wheelchair is there waiting." Another care worker said, "[Person] has bed rails on one side, [person] sits up, (we place) one arm around [person's] back, we lift [person] up gently, then [person] stands up." This information alarmed us as this manoeuvre is no longer considered good practice and can cause serious harm to both the person and staff. We discussed our concerns with the registered manager and branch manager. The branch manager told us they were not aware this was happening and assured us they would act on our findings. They said actions would include, refresher training for relevant staff, the person's moving and handling risk assessment would be reviewed by the registered manager and advice would be sought from the local authority's moving and handling team.

Another person's care plan stated, '[Person] walks with a walking stick; falls over often due to poor mobility. Staff should be aware of all training and manual handling.' There was no indication of how this risk of falls was being managed, if other healthcare professionals were involved and what staff should do in case of a fall. We spoke with the registered manager about this and they told us this person was prone to falls at night when care staff where not present and the family were seeking input from the appropriate health care professionals. However, this meant this person's risk assessment was not current and did not contain the level of detail that would enable care workers to respond to their needs in case of an emergency.

During our inspection, we identified two people were being supported by staff to move them in an unsafe way and this was a safeguarding concern. We discussed this with the registered manager and they assured us they would be taking immediate measures to address these concerns. The registered manager contacted the local safeguarding team and submitted a statutory notification to the CQC.

We asked staff what they would do if a person had a fall, one said, "I would call the family and report to manager." Another care worker said, "Make sure they were in a comfortable position, breathing areas were clear, make sure they are breathing, phone an ambulance, phone the family, if CPR (cardiopulmonary resuscitation) was needed, do it until ambulance arrives." This meant staff were confident in what actions to take in order to keep a person safe if they had a fall.

The mental health risk assessment for a person who was living with dementia recorded '[Person] has dementia. This makes [person] forgetful, will shout, make demands and sometimes be anxious. Staff should remain calm and patient. Follow training.' When we looked at this person's daily records of care dated July 2017 we found two instances where behaviour considered as challenging had occurred. One entry stated; 'We took [person] to the bathroom, [person] was aggressive, [person] was hitting me, didn't want clothes on, then after a bit [person] was ok, was put to bed.' Another entry indicated, "We took [person] to bathroom, [person] scratched one of the carers then [person] calmed down and was put to bed." It was not documented what action the care workers had taken following these incidents. When we asked the staff who supported this person what they would do if this person displayed behaviours that might challenge others, one said, "We talk with [person] gently, if [person] is not ready we wait." This meant risks related with people's mental health were not being acted upon in a timely fashion and there were no evidence care workers were managing these risks according with people's current needs. We spoke with the registered manager about our concerns. The registered manager told us they were not aware of the incidents but would take appropriate action to ensure this person was having the appropriate support and by staff with the appropriate skills and knowledge.

During our inspection, we identified one person was being supported by a care worker with financial transactions however, there was no risk assessment in the person's care folder in relation to this particular support. We spoke with the registered manager and they told us they were aware this support was

sporadically provided and it had been agreed with the care worker that every time this happened they had to send a photo of the transaction's receipt to the branch manager. We asked how the registered manager was monitoring this support in order to prevent any situations of financial abuse or allegations against staff. They had regular telephone contacts with the person; we could not evidence this by looking this person's daily records. The registered manager also told us they would put in place an appropriate care plan and a document for staff to record financial transactions which they said would be audited monthly.

These examples demonstrate people's risks were not always being identified or managed properly; this meant the registered provider was in continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment.

We checked systems were in place to protect people from harm and abuse. We found, the registered manager and branch manager were knowledgeable in identifying abuse and they said if a safeguarding concern was raised to them, they would follow their safeguarding policy. Care workers we spoke with were able to identify main types and signs of abuse and said they would report any concerns to their line manager. One care worker said, "If I saw (any safeguarding concern) I would tell my manager." Another care worker told us, "I would report to my manager, if nothing happens I would go to the other manager, to the council or the police." The care workers we spoke with were aware of the whistleblowing policy and said they were confident to use it if they needed. A whistle blower is someone employed by the registered provider who reports concerns where there is harm, or the risk of harm, to people. One carer said, "I have raised a few issues with my managers as some colleagues were coming a bit late; the manager responded." This meant staff had the knowledge of how to protect people from abuse, neglect and poor practice however we could not be certain they would always identify and act on it as the unsafe manual handling we identified during this inspection had not been previously noted.

We looked at the personnel files for three staff who had been recruited since our last inspection. We found the registered manager was not consistently following their own recruitment policy in relation to recruitment checks to ensure staff suitability to work with vulnerable adults. The registered manager told us before the appointment of a new staff member, they were offered an interview and if successful, Disclosure and Baring checks (DBS) were done and a minimum of two references were requested, one being from the latest employer. DBS checks were undertaken to check if prospective staff had any criminal offences. In the three files sampled we saw gaps in worker's employment history had not been investigated. For example, the interview notes for one staff member stated their most recent employment was an office administrator however, this was not indicated in their job application and no references had been requested from this employer. All the references present in the staff's files we sampled were personal references. We discussed this with the registered manager and they told us these particular workers had been out of employment for a while and therefore, had been given a choice of providing two personal references. We asked the registered manager if they had requested information from other professionals who knew the applicants and could comment on their conduct, they said no.

This meant the necessary recruitment checks to ensure staff suitability to work were not being followed and this constituted a breach Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to fit and proper persons employed.

We checked how the service ensured there were sufficient numbers of staff to keep people safe and meet their needs. People and relatives told us there were no missed or late calls. One person said, "If on the odd occasion (care worker) is running late, I receive a call to say (care worker) will be five or ten minutes late due to traffic." Every person we spoke with told us the care workers stayed during the agreed time and care was provided by regular care workers.

There was an on call system and the registered manager or branch manager were available to support care workers and people, if required. This meant the registered manager had systems in place to ensure people were having their care visits and any concerns would be dealt with promptly.

Requires Improvement

Is the service effective?

Our findings

We asked people if care workers asked their consent and respected their choices, all said they did. One person said, "Anything I want, they will do."

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) and whether any applications had been made to the Court of Protection to legally deprive someone of their liberty.

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.

The registered manager told us the people they supported had mental capacity to make relevant decisions regarding their care, however, after reviewing people's records and speaking with relatives and staff, we found this was not always the case. For example, one person's mental health care plan stated, "[Person] has a diagnosis of dementia. In [person's] confusion, [person] may demand to go out or even go home." When we looked at this person's care records there was no evidence the registered provider had assessed this person's mental capacity in relation to their care.

Staff's understanding of the MCA and it importance to their work was not consistent. We asked staff about the MCA and its impact on their practice. One care worker said, "Mental capacity is like we need to treat them all the same, talk with them with respect"; another care worker said, "Everybody has the right to make their own decisions; if they lack capacity we help them by making a best decision for them." These answers show that the care workers were assuming capacity and treating people respectfully as per legislation and good practice. We also asked how care workers would know if someone lacked the capacity, one said "For example, if it's raining and they don't want to put the coat on;" another care worker said, "The outlook and personality tells you a lot about what people can and can't do." These answers showed that it was not clear to care workers the difference between lacking capacity and making an unwise decision or having particular individual characteristics which meant staff was not always following the principles of the MCA.

We asked the registered manager what was their understanding of their duties under the MCA while providing care to people. The registered manager did not show a sound understanding of how and when to assess people's mental capacity and what to do if someone was assessed as lacking capacity to make decisions in relation to their welfare or finances. The registered manager told us they would rely on the local authorities' initial assessment of a person's capacity and if someone's capacity deteriorated they would ask the local authority to assess again. This was not in line with current legislation and good practice which states mental capacity assessments should be decision specific and carried on by the ones closest to the decision.

We asked the registered manager what they would do if someone was assessed as lacking the capacity to

make particular decisions regarding their care. They told us they would ask a family member with the legal authority to make the relevant decision however, we did not find any evidence of this in the files sampled. A relative told us they had lasting power of attorney (LPA) but they said the registered provider had never asked about this. An LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you are no longer able to or if you no longer want to make your own decisions. LPA's can be registered for property and finance or health and welfare. This meant people who lacked capacity to make decisions about their care could not be reassured these would be made following the best interests process and consent sought by those with the legal authority to do so.

During our inspection we identified one person who had difficulty making decisions about their care, was under constant supervision and had their access to the community restricted. This person's care plan stated, '[Person] will try to get out. Family want doors locked at all times.' According to the information provided, this decision seemed to be done in the person's best interests however, there was no Court of Protection order in place giving authorisation for this restriction and the registered manager had not identified this before our inspection. This meant care staff were restricting someone's liberty without the appropriate authorisations in place. We discussed this with the registered manager and they told us they would be in contact with this person's social worker so the appropriate assessments could be done to initiate an application to the Court of Protection if appropriate.

This evidence demonstrates a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered manager was not ensuring consent was sought from people with the legal authority to give it and mental capacity assessments were not being completed.

We asked people and their relatives if they felt care workers had the appropriate training and knew them well. One person said, "Yes, they know what I need." Other person commented, "Yes, they are very careful when they dress me as I cannot lift my arms much due to my (medical condition)."

We checked if there was support in place for new care workers and if they had a period of induction where they could learn their new role and familiarise themselves with people's needs. The registered manager told us all care workers had an induction period which included completing online and classroom training in line with the Care Certificate, as well as shadowing experienced members of the team. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers should follow in order to provide high quality care. We confirmed this was being done when we spoke with care workers and looked at staff's files. One care worker said, "Yes, I had training online, manual handling in a classroom; the (branch manager) showed me and guided me on how to do this for the first three times, we worked like a team." Another care worker said, "Yes, online training, it was explained what the job is, I shadowed for one day and then was checked if I was doing the work." This meant that new staff were being supported to learn how to deliver safe and effective care appropriate to people's needs.

During this inspection we looked at the registered provider's training matrix which showed staff training was up to date. Training had been provided on subjects such as duty of care, working in a person centred way, fluids and nutrition, awareness of mental health and dementia, safeguarding adults, fire safety, first aid and safer people handling. When we looked in staff's file we saw certificates of training completed. However, we could not be reassured the training was always effective as during our inspection we identified unsafe manual handling and care worker's knowledge of the MCA was not robust. This meant people could not be reassured they were being supported by staff with the appropriate skills and knowledge.

At our last inspection we found supervisions and appraisals were not robust as not all staff knew what supervisions were and were unclear when they had been in receipt of these. During this inspection we found

the registered provider had made improvements in this area and was no longer in breach of regulation. We asked staff if and when they had supervision, one told us, "Yes, every month or two;" and other commented "Yes, every three months." This was in line with the registered provider's own policy. We also asked staff what was discussed during supervisions and if they found them beneficial, one staff member said, "We upgrade our training, discuss any issues we have, any issues with clients." Anther mentioned, "Workplace, clients, the work we do, if we need one before we can ring them (managers)." When we looked at supervision records we could corroborate these meetings were taking place at regular intervals and were meaningful conversations used to support and develop staff's skills and career progression. This meant staff were supported to perform in their roles and maintain their skills.

Staff were knowledgeable about people's needs. One person's mobility care plan stated, '[Person] struggles a lot in the morning due to pain'; this person's regular care worker confirmed this was the case and explained us how they supported the person to maintain their wellbeing. One relative told us, "They do things according to [relative's] pace and choice. [Relative] has shower only once per week because [relative] says their bones hurt more when they have a shower. [Relative] likes oil on their head so carers give gentle head message and then comb [relative's] hair every day." We spoke with one care worker who supported this person and they gave us a similar description of the care provided.

We asked people who used the service about their experience when being supported by staff to have their meals and they were all positive about this. One person said, "Yes, they know what I need and how I want my food"; another person said, "Sometimes I ask for pasta instead of usual dall & roti." The registered manager told us they assessed people's nutritional needs and preferences before commencement of the service and they catered for specific meals as halal and diabetic meals. When we looked at people's care plan we confirmed this was documented. For example, one person's care plan stated, 'Halal diet; has a very sweet tooth.' Staff were able to tell us about people's preferences and how they offered choice. One care worker said, "I ask [person] what [person] wants, sometimes it is curry, others fish and chips; I make [person their] breakfast and leave something made in the microwave."

We saw evidence people received the input of external healthcare professionals. We spoke with one person who told us they had broken their toe and they said the, "Carer called the GP for a home visit." We spoke with a healthcare professional who told us they had only received one referral from White Dove. This same professional also told us that management and care workers had "Responded well to information given."

Good

Is the service caring?

Our findings

We asked people who used the service and their relatives if staff were kind to them. One person said, "[Care worker] is very good and helpful, without their help I couldn't manage". One relative commented, "Carers are very respectful and engage with [relative] very nicely. They are also very nice to the family too and work according to the care plan, which is good because you don't want anyone who is unfriendly to the family."

We considered if people's privacy and dignity was being respected. Care workers could describe how they respected people's privacy whilst providing care. One said, "When I am changing people I close the door; if their pad need to be changed I take it out straight away." Another care worker commented, "I always respect them; I always keep secret, I do not discuss with family if [person] tells me things about their [other relatives]." People also told us staff were respecting their privacy. One person said their carer got them ready and waited outside while this person took their shower. This meant staff provided care in a respectful and considerate manner. During our inspection, we saw people's files with confidential and sensitive information were stored securely in the office.

The registered manager told us people's cultural needs and preferences were assessed before commencement of the service. The registered manager also told us their company's ethos and practice respected people's diversity and they were proud of their ability to match people and carers with similar linguistic and cultural characteristics. The registered manager said they were specialised in providing care workers who could speak Punjabi and Urdu. This feature of the service was appreciated by people and relatives. One person said, "Because the carers speak my language, they can understand me much better." Other relative said, "[Relative] struggles with English, therefore, we asked for a bilingual carer, which we got." When we looked at people's care records we saw their cultural preferences were documented. One care plan stated, "[Person] likes to stay clean for prayer. Eats only halal."

During our inspection, we checked if staff were supporting people to retain their independence and we confirmed this was being promoted by staff. One staff member said, "First, if they can do something they should do; if we do everything for them, their body will stop." One relative commented, "They do things according to [relative's] pace and choice."

The registered manager told us no one was using advocacy services but they were aware who to contact to obtain the services of an advocate. The registered manager explained they would refer people for advocacy if the person needed help with making decisions. This meant people could be supported to put forward their views if this support was required.

Good

Is the service responsive?

Our findings

Most of the people and relatives we talked with felt they received a reliable service. They told us their care workers were usually on time, stayed for the agreed visit duration, and completed the care and tasks they required. Comments included, "They are very good, they help a lot".

The registered manager told us they assessed people's needs prior to the commencement of service. When we looked at people's care plans we saw information documented during initial assessment seemed limited but care plans then detailed people's needs and preferences. This meant the service was assessing people's needs and the service's capacity to meet those needs before taking on new clients.

When we looked at people's care plans we found they were well organised and divided in different sections such as service contract, rota, staff's duties during person's care visit, assessment, care plan, spot checks, list of contacts in case of emergency, client reports, reviews and accidents and incidents.

Examples of care plans included personal contacts, professional contacts, religion, social needs and relationships, mental health, personal care, mobility and communication. For example, one person's care plan noted 'Speaks only in Punjabi; hard of hearing; no hearing aid' and informed staff they should 'speak loudly and in Punjabi, use any means needed, for example, hand gestures, ask [person] to repeat again.' Another person's care plan stated '[Person] suffers from anxiety; does not to go out alone or like meeting new people. Staff should interact with [person] and make [person] comfortable and at ease.' Another person's care plan specified, 'When [person] is not wearing hearing aid gets confused about what is being said; hearing aid must be worn and switched on.' This meant that information in the care plans had been designed to help staff meet people's specific care needs by providing staff with detailed guidance.

We asked staff what it meant to them providing person centred care, in particular for people living with dementia or people who might display behaviour that challenged others. The branch manager told us person centred care was about, "Making sure the person has the best possible care for their needs" and "Care is about the person." One staff member commented, "Good dementia care is about listening, say ok." Another two staff members said that if people were displaying behaviour considered challenging to others, they would "Give [people] time, do something else and then return, be patient." We spoke with one relative who confirmed this was happening, they said, "[Relative] has dementia, and carers respond to [relative's] needs really well. For example, when [relative] has one of their turns and refuses to have a bath, carers speak to [relative] slowly and gentle until [relative] is ready. Carers are very patient with [relative]; they are never in a rush and always come on time."

We checked if people and their relatives were being involved in planning and reviewing their care.

The registered manager and branch manager explained they contacted people on a regular basis to review their care and overall satisfaction with the service provided. Most care plans were being reviewed on a monthly basis, the provider called this the client report. When we looked at people's care plan we confirmed these conversations were being documented however, it was not always clear how and who was conducting

the reviews as these were not signed. We asked the registered manager and they told us these reviews were mainly done by the branch manager through telephone conversations. From the files sampled we saw evidence that some people's care preferences were being revised and when needed, changes were done however; others had very limited information. One client report recorded, 'Family would like evening shift to be later as the days are getting bigger and it takes [person] longer to settle at night. Shift change will be organised.' Another person's client report noted, '[Person] is happy with carer, rota and service.' When we spoke with people and relatives they confirmed the registered and branch manager contacted them in person or on the phone and they were satisfied with the service provided. One relative said, "The agency rings from time to time, to see if we are happy with the service or if there are any issues." This meant people and their relative's views were frequently consulted and reviewed to ensure care was provided according with people's preferences and needs.

During our inspection, we asked if people and their relatives knew how to raise a concern or make a complaint. None of those contacted said they had ever had reason to formally complain and the registered provider confirmed they had not received any complaints so we unable to assess the responsiveness of the registered provider in relation to responding to complaints. However, one person said, "If I had any concerns I would call the manager who listens and responds straightway." One relative commented, "If something is difficult or not possible then the manager will explain nicely the reason. For example, extra hours or flexibility in the hours required during the week." Another relative stated, "If anything is worrying us, we can phone the manager and they always listen to the concerns and address them accordingly."

The registered manager was able to explain to us which steps they would take if they received a complaint, these included gathering information, documenting what had been agreed and actions taken. This was in line with their complaints policy. This showed people and their relatives could voice their concerns and be reassured that these would be valued and acted upon.

Requires Improvement

Is the service well-led?

Our findings

We asked people and relatives if they felt the service was well managed and all comments were positive. One person said the management team were nice and understanding. Another comment included, "Happy with everything, no problems."

There was a registered manager in post at the service who was also the registered provider and had been managing the service since its registration in 2012.

During our last inspection in September 2016 we identified the registered provider was not compliant with regulations which related to safe care and treatment, good governance and staffing. Following our last inspection, we asked the registered manager to send us an action plan outlining the actions they were going to take to meet the regulations and improve the quality at the service. During this inspection, we asked the registered manager if they felt their action plan had been successfully completed and they told us it had. However, at this inspection we found the service had only made improvements in relation to staff's supervision; the registered provider remained in breach in relation to safe care and treatment and good governance, and we found two new breaches in relation to consent and safe recruitment. This meant not enough improvements had been made since last inspection.

On this visit, we looked and found some checks and audits were undertaken but these weren't always documented and did not identify areas for development. The registered manager told us they did announced and unannounced spot checks on staff. These checks were recorded on a yes/no list that included care worker's activity on arrival, for example, 'arrives at service user home on time, alerts service user on arrival, checks service user care plan on arrival'. It also included if care workers had followed hygiene control procedures, meal preparation, domestic tasks, manual handling and personal care performed. We looked at some of the spot checks and we could see these were done regularly however, the records only showed if a particular task had been completed or not and did not detail how it had been done. For example, one spot check recorded the care worker's ability to support with the bath aid/stair lift had been assessed but it was not detailed how this was done, if the care worker had followed correct procedures and if any actions were taken to improve the care worker's performance. This meant the registered manager could not evidence their oversight of the staff's competence and continuous improvement to perform their role.

We asked the registered manager if they monitored the quality of care plans, daily notes and staff files. They told us due to White Dove Care being a small company they were able to maintain a close oversight of staff's files and these were checked on a regular basis but they did not document these checks. The registered manager also told us they read people's daily notes in order to maintain an oversight and identify any concerns but they did not document these checks. However, during our inspection we found two incidents in the one person's daily notes that had not been reported or noted by the registered manager. The registered manager told us they had not had the time to examine those notes as they related to July 2017. This meant the registered manager's oversight could not be evidenced and their checks were not identifying and addressing the issues found at this inspection.

The evidence above demonstrates a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015, registered providers have a legal duty to display the ratings of CQC inspections prominently in both the office and on their websites. On our arrival at the office the ratings from last inspection were not displayed; we reminded the registered manager of their duty to display. Before the end of our inspection, we reminded the registered manager once again and when we left the premises the ratings were on display in the registered manager's office.

The registered manager told us they sent surveys to people to gather their views of the overall quality of the service. None of the people we spoke with could recall being asked for feedback through a survey, but some people said that during their reviews they had been asked for their views on the quality of the service. We saw four completed surveys however these were not dated. Comments included, 'never let down' in relation to timekeeping and 'would like to have online information.' The branch manager told us they were planning to set up a website and provide information by email following this last comment.

There were systems to ensure effective communication including text messages, phone calls and staff meetings to update staff regarding changes to individual's wellbeing and any other relevant updates. During this inspection, we could see regular staff meetings were taking place. We read some meeting minutes and saw the themes discussed included updates on people's needs, rotas and training. Care workers we spoke with confirmed that team meetings were happening on a monthly basis and were productive.

Care workers spoke positively about their working environment and the management of the service. We asked care workers if they felt the management team was supportive and approachable; one care worker said, "Yes;" another care worker said, "[Registered manager] is a good manager; he will sort it out." In relation to their working environment, a care worker's comments included, "I am happy with my job;" "It's a nice little company to work for;" "It's a steady ship, steadily improving" and "It's a good place to work." This meant people were supported by staff who felt motivated and supported to do their job.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. During our inspection we found the registered manager was meeting their responsibilities in relation to notifications.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had not always conducting the appropriate assessments and reviews in order to provide person centred care to people's needs, in particular in relation to medication.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager was not using consistently ensuring that consent was sought from people with the legal authority to give it and mental capacity assessments were not being completed.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The necessary recruitment checks to ensure staff suitability to work were not being followed.