Key 2 Care Limited

Derbyshire Care Services HQ

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Derbyshire Care Services HQ is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community in a supported living setting, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Previously the provider had two services registered with CQC: Derbyshire Care Services and Derbyshire Care Services Central and West. The last inspection of both services took place in June 2017. We rated both services overall as 'requires improvement'. We found two breaches of the regulations because both services were not always safe or well-led. We issued requirement notices in response to these. Both these services have been cancelled by the provider.

In April 2018 the provider registered a new service, known as Derbyshire Care Services HQ at a new address located in Derby city. The staff employed at this service have been transferred from Derbyshire Care Services and Derbyshire Care Services Central and West.

This inspection took place between 21 to 23 August 2018 and was announced.

At the time of our inspection visit 363 people were using the service and received a regulated activity; personal care.

A registered manager is a person who has registered with the Care Quality Commission 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.

System, processes and procedures were in place to promote people's safety. People were mostly protected from the risk of avoidable harm and abuse. Staff had been trained in safeguarding people and understood how to keep people safe. Staff followed the infection control procedures

The risks to people's health and wellbeing had been assessed. We found further improvement were needed to ensure specific risks to manage people's health conditions had been identified. Clearer guidance in the care would enable staff to follow the measures put in place to meet people's needs and to promote their safety and independence.

Staff recruitment procedures reduced the risks of employing staff unsuitable to work in care. There were enough staff to meet people's needs. People expressed concerns about poor time-keeping and lack of communication that increased the risk of people not receiving the care they needed at the agreed times. The registered manager had taken action and put systems and processes in place. The computerised

system used to plan rotas estimated the travel times between each visits and changes in management staff roles enabled them to monitor and improve communication with the care staff team and people using the service.

Staff were trained in safeguarding and other safety procedures to ensure people were safe and protected from avoidable harm. Staff understood their responsibilities to report concerns.

People were supported with their medicines in a safe way. People's nutritional needs were met and they were supported with their health care needs when required. The service worked with other organisations to ensure that people received coordinated care and support.

Care staff had not always been supported in their role. Supervisions and their observed practices were overdue. The registered manager had put systems in place to address this. The registered manager and the provider continue to monitor this.

The provider, registered manager and staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and gained people's consent before they were supported. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People and their family were involved in the development of their care and staff had a good understanding of people's needs. Care plans were different written in formats and required more details to reflect people's preferences, culture needs and lifestyles choices. People's care plans and risks had not been kept under review and the guidance for staff to follow varied. These had been identified by the registered manager and action taken. New risk assessments and care plans developed were more personalised and reflected people's preferences, daily routines, cultural needs and what was important to them. A system had been put in place to review people's care needs and transfer information to the new care plans. The registered manager and the provider continue to monitor this.

People and their relatives were happy with their regular care staff and had developed positive trusting relationships. People were treated with dignity and respect, and their rights to privacy were upheld. Staff respected people's backgrounds, faith and choice of lifestyle and promoted their impendence. People had the opportunity make decisions about their end of life care.

People, relatives and staff were encouraged to provide feedback about the service. People knew how to make a complaint. The provider had a process in place that ensure complaints and concerns were addressed in a timely manner.

The registered manager and provider were aware of their legal responsibilities and provided good leadership. The registered manager, management and staff team were committed to the provider's vision and values of providing good quality care.

People and relative's views about how well the service was manage were mixed however, all acknowledged there had been some improvements. Staff spoke positively about the registered manager and the changes that had been made to the service.

The provider's policies and procedures had been reviewed and updated. The provider had governance systems and processes but these were not used effectively, which meant some aspects were fragmented. The registered manager made changes within the service in relation to the management, changes in staff

roles and responsibilities, and introduced new systems and processes to improve the running of the service. There were arrangements in place for the service to make sure that action was taken and lessons learned when things went wrong, to improve safety across the service. The provider worked in partnership with other agencies and made improvement where required to meet people's needs.

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 safe not always safe.

People mostly felt safe with the staff. Staff recruitment processes reduced the risk of employing unsuitable staff. Staff were trained to keep people safe from harm. There were enough staff to support people. However, systems needed to improve to ensure staff arrived at the agreed times.

Risks associated with people's needs were assessed. More detail was needed to ensure risks were managed and care plans provided clear guidance for staff to follow to monitor changes and to promote good health.

People received their medicines in a safe way. Staff followed infection control procedure.

Systems were in place to ensure that lessons were learnt from events.

Is the service effective?

Good

The service was effective.

Induction training ensured staff had the skills and knowledge required for their role. Improvements had been made to ensure staff were supported with ongoing training, support and supervision.

People's needs were assessed and care plans developed to ensure they received the support they needed. People made daily choices and decisions. Staff sought people's consent and understood people's rights. Capacity assessments had been put into place to identify the support people needed to make decisions.

People were supported to maintain their nutrition, and were supported to access health care support when they needed to.

Is the service caring?

Good

The service was caring.

People were cared for by staff that were caring, friendly and kind. People were supported to make decisions about how their care was provided. People were treated with dignity and respect, and staff ensured their privacy was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and they were involved in the development of their care plans. Some care plans were more detailed than others.

Further improvements were needed to ensure people received the support they needed that was personalised and responsive in line with their wishes. People's care needs and risks were not always kept under review or monitored. There has been ongoing action taken to address these issues.

People knew how to make a complaint. A complaint procedure was in place. Records showed complaints were not always addressed in a timely manner and effectively resolved.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager understood their role and responsibilities. They and the staff team had worked in accordance with the provider's visions and values to provide quality care.

The provider's governance system had not been used effectively. New care planning documentation, new systems and processes, and changes to staff's roles and responsibilities had been introduced to bring about changes. Although these systems have not been fully implemented there was some evidence of improvements.

People and staff's views about the service were sought and used to drive improvements. They were mostly confident that any concerns raised with the registered manager would be listened to and acted on.

Derbyshire Care Services HQ

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 checked 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 site visit took place on 21, 22 and 23 August 2018 and was announced. We gave the service 48 hours' notice of the inspection visit to be sure that they would be in.

The inspection was carried out by one inspector and two experts-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 experts-by-experience made telephone calls to people using the service and their relatives over the three days.

Before the inspection, we asked the provider to complete 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 the improvements they plan to make. This was returned to us by the provider and used to inform our judgement.

We reviewed the information we held about the service. This included the provider's statement of purpose and notifications we had been sent. A statement of purpose is a document containing information about the management, staff and a range of care and support services provided. Notifications are changes, events or incidents that providers must tell us about.

We looked at the information received from local authority commissioners. Commissioners are people who work to find appropriate package of care for people and fund the care provided. We contacted Derby Healthwatch; an independent consumer champion for people who use health and social care services, for

their views about the care provided. No information of concern was received about the provider.

We spoke with 17 people who used the service and 8 relatives of people who were using the service. We spoke with 27 members of staff in total. They included 13 care staff, four care co-ordinators, two seniors and a care manager. The management team that we spoke with included the human resources manager, training and development manager, a trainer and the business manager. We spoke with the registered manager and the providers who were present at the time of our inspection visit.

We looked at the care records of 13 people who used the service. These records included care plans, risk assessments and daily records of the support provided. We looked at 24 staff recruitment files and staff training records. We looked at records that showed how the provider monitored the quality of service, which included meeting minutes, complaints and a sample of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We found there were different formats of risk assessments which could increase the risk of people receiving unsafe care. These assessments looked at different aspects of the person's needs such as falls, medicines, mobility, capacity and risks within the home environment. However, these did not always take account of the person's health and living with a disability.

We found measures to manage risks were not always linked to the care plans and provided staff with clear guidance to reduce further deterioration and to promote people's good health. For example, one person's assessment had identified the risk of skin breakages. Any changes to their skin condition would indicate a deterioration in health and they would need medical treatment. However, the care plan lacked guidance for staff to monitor and report changes in the skin conditions such as breakages.

We found essential information was occasionally missed. For example, person had a 'Herbert protocol' in place because of there was a risk the person may abscond or going missing. This is a national scheme that encourages care providers to ensure vital information is available such as photograph of the person, their medication, communication needs and the places that they would visit. There was guidance about the action care staff should take but key information was missing including a photograph of the person.

We shared our findings and concerns with the registered manager. The registered manager had showed us the new risk assessments and care plans had been developed and were being used for all new packages of care requested by people. Following our inspection visit the registered manager confirmed that people's risks and care plans had been reviewed and updated.

People told us that risks to their health and wellbeing managed. One person said, "Well I haven't fallen so I am ok really. I do feel safe and I've got an [pendant] alarm around my neck." Another person told us they felt safe with the staff who had been supporting them for over a year. Care staff could describe to us how they supported people and knew what equipment needed to be used to move people. Some people had a key safe fitted. A key safe is a secure method of externally storing the keys to a person's home, which helps to maintain people's safety within their homes whilst enabling staff to enter and leave safely.

Records showed that the number of staff people needed for each visit was decided prior to their care commencing. For example, if people needed two staff to support them safely they were provided. However, people expressed concerns that care staff were often late which meant their needs were not met. One person told us there had been occasions when two care staff had not arrived at the same time and their relative was asked to help. This relative added, "They do send two carers but not at the same time. They arrive at different times; one carer ends up waiting for the other one."

Another person said, "It's not the care that's a problem the care is very good; it's the timings, [care staff] get very late at times but the care I can't fault that." That showed communication needed to improve.

Staff told us there were enough staff to meet people's needs but felt they did not always have enough time

to support people or had to rush people. Comments included, "There's no travel times between calls." "I start my first call early so that I can give [people] the care they need." "If you're on a double-up you could be waiting [for the second care staff] from five minutes up to an hour. You're supposed to wait outside and enter together. I don't know why they don't have double-up runs made up of a driver and a walker."

The registered manager was addressing the issue of no travel times between visits. The service had a computerised system to produce a rota and changes were being made to ensure adequate travel times were included. Staff were required to sign in on arrival by telephone. The office staff were alerted when care staff had not logged in to confirm their arrival at people's homes. We heard the care coordinators calling people to advise them that their care staff were due to be late.

The registered manager was aware of the challenges they faced to include travel times between each visit. A route planning system was used to plan routes so there were adequate travel times between each visit. In addition, new staff rotas were checked by the management team before they were sent out. A sample of the staff rota we looked at showed that travel times were included.

There were policies and procedures to promote people's safety. These included health and safety and safeguarding people from abuse. Systems were in place where the package of care included shopping calls and handling people's money. We saw all transactions were documented and regularly checked to ensure people's money was safe.

People's experiences of being protected from avoidable harm and abuse were mixed. The registered manager acted on concerns that we shared with them about people feeling unsafe. For example, a staff member was removed from providing further care to people to reduce the risk to people's safety. They also reported the concerns to the local safeguarding authority and an internal investigation was commenced.

Some people told us they felt safe with their regular care staff. Their comments included, "I've not been hurt." "Yes, I do feel safe. They come in day or night and always lock the inner door." And "[Staff name] is wonderful – [they are] part of the family."

Staff understood how to identify signs of abuse and preventable harm and knew how to report these; staff knowledge in safeguarding adults had been supported by training in this area. There were systems, procedures and practices to safeguard people from situations in which they may experience abuse. Records showed safeguarding alerts were raised with the local authority when required and appropriately investigated.

Staff recruitment procedures reduced the risks of employing staff unsuitable to work in care. One staff member said, "I have had a change of career. I was interviewed first. I couldn't start until they got all my references and Disclosures and Barring Services (DBS) check." A DBS check helps the employer make safe recruitment decisions. Staff files contained evidence that the necessary pre-employment checks had been completed before staff commenced work at the service.

The provider's business continuity plan had been reviewed to ensure the management team and staff had information about the action to take in the event of an unforeseen emergency. These measures supported people's safety.

People who needed support with their medicines, had care plans which included information about the support they needed. We asked one person if they were supported with their medicines, they said, "Yes, I would say they are on time; [tablets] are in blister pack from the chemist. And they watch me take them."

Records showed care staff were trained in medicines administration and regularly assessed to help ensure they supported people with their medicines safely, and in line with the provider's policies and procedures. Care plans had instructions for staff to follow, for example, where the medicines were kept, how the person preferred to take their medicines and the records needed to be completed. Records confirmed that care staff documented when people were supported with their medicines in a safe way.

People told us that staff protected them from the risk of infection. A person said, "Yes, they wash [their hands] wear [disposable] gloves and aprons." Staff were trained in infection control procedures and had a good supply of disposable gloves, aprons and antibacterial gels.

The provider had systems in place to enable care staff to record and report all incidents and accidents. Staff understood their responsibilities and had reported incidents when required. Records showed the registered manager had analysed these events to identify the causes and actions needed. Any lessons to be learnt from these events and from internal and external audits and inspections were shared with the management and staff team. For example, staff were trained to prepare snacks such as a cheese toasty and omelette in response to people's feedback. We saw that the staff disciplinary procedure had been used effectively when there were concerns about care staff performance. We found the registered manager took action in response to the issues identified during our inspection visit to ensure people received safe care.

Good

Is the service effective?

Our findings

People had mixed views about care staff knowledge and training completed to support them. One person said, "[Care staff] seem to me to be well trained, they know what they're doing. I don't have any concerns." Another person said, "I am hoisted for the toilet and personal care and some of them don't even know the equipment [to be used]. Before they send [new care staff] they should shadow sometimes."

The training and development manager showed us the systems in place to ensure care staff were trained for their role. Management staff were also trained to provider personal care and support. There was a rolling programme of induction for new staff and training updates for existing staff. Care staff practices were checked before they could work on their own. At the time of our inspection visit a trainer was delivering safeguarding training to two care staff. The training was adapted to suit care staff learning needs.

Staff spoke positively and were enthusiastic about their training. A new care staff told us their induction was office based and included practical training to use equipment such as a hoist. They said, "I shadowed another [experienced] carer so I got to learn first-hand how to help people." One care staff said, "We do get a lot of training and told when we need to have updates."

Records showed staff had completed an induction training and host of essential courses including moving and handling, first aid, fire safety, safeguarding and various health and safety topics. Staff had received specialist training to enable them to support people's health conditions such as dementia awareness and behaviours that challenge services. Care staff were encouraged to complete nationally recognised training such as the care certificate and accredited professional qualifications in health and social care.

Supervision is one way to develop consistent staff practice and ensure training is targeted to each member of staff. The registered manager told us that staff supervisions and appraisals had not taken place regularly. Systems had been put in place and there were changes in the management staff roles and responsibilities to address this. One staff member said, "Supervisions and team meetings are happening now. I've had a supervision meeting where I can say how I feel and if I need any training. I do feel more valued and listened to." Records viewed confirmed this.

People's needs were assessed prior to them using the service. Records showed assessment processes were in line with current legislation and standards. This enabled the provider to be assured that they could meet the person's needs and had the staff with the right skills mix to provide the care and support. One person said, "I had an assessment and I said yes to what they wrote down. They asked me questions and I told them what I wanted." This person's assessment and care plan was a new format. This included information about their personal preferences such as female care staff, their physical and emotional needs and their social interests, cultural and spiritual wishes.

People's dietary needs were met and they were supported to stay healthy. One [care worker] prepares my tea and puts it in the fridge for later. I have a yoghurt or fruit put at the side of me for when it's time for tea I have a flask of semi-skimmed milk and a glass of water to take my tablets; it's all in front of me now."

Another person said, "[Care staff] makes snack-type meals in three quarters of an hour and makes a drink [for me] as soon as [they] come in.

Staff were trained in good food hygiene procedures and understood the importance of providing a daily balanced and healthy diet. A care staff, "You ask what they would like to eat for breakfast or lunch. Its's usually cereal, toast with a cup of tea for breakfast and microwave meals for dinners I always make sure they have a drink left before I go."

People's nutritional needs had been assessed. Any dietary needs and support required such as cultural diets or sugar free drinks were documented within care plans. There was information to help care staff recognise the signs and symptoms that would indicate risks of malnutrition and dehydration. Records showed that people had been referred to the dietician or their GP for further advice. This helped staff to monitor that people had enough to eat and drink.

A person told us they could stand up and no longer wanted to use the hoist. This was reported to the registered manager. They later told us that an occupational therapist had visited to assess the person's ability to move and had ordered new equipment to support them. Records confirmed that a physiotherapist was also involved in meeting their on-going health needs

One person told us their care worker was interested in their wellbeing and they were confident that their GP would be called if required. Another person said, "I was bleeding; when [care worker] came and they just rang the doctors number and said, 'this is urgent', so the GP came and said dial 999 and get [person's name] to hospital."

People's care records had information about their health conditions and other health care professionals involved in their care such as the dietitian or community nurse. This showed people were supported to live healthier lives by receiving on-going healthcare support and medical support when required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection.

We found the service was working with the MCA principles. The MCA policy set out how staff were to meet MCA legal requirements. The registered manager and staff team understood their responsibilities to protect people and alert other agencies if they felt a person's rights were being compromised. Records showed people's capacity had been assessed and their consent had been sought about the care to be provided. No application had been made to the Court of Protection.

People and relatives confirmed that care staff sought consent and explained how they could help them. One person said, "[Care worker] does ask before [they] doing anything." Staff told us they offered people choices, sought consent and respected people's decisions. When people declined the support care staff documented it.

Staff ensured that people's home environment and layout where care and support would be provided was suitable and documented in their care plans. Staff told us they always checked equipment used to support

people was in good working order and condition. Where required staff ensured the person had the emergency pendant alarms close by before they left, should they need to call for assistance.

Good

Is the service caring?

Our findings

People and relatives told us that their regular care staff were kind, caring and treated them with respect. Comments included, "I have three ladies who are very good exceptional". "The regular ones are very nice." And "They help me with washing and they get me dressed, ready for the nurse. They're all very polite and I have no qualms about any of them. Some of them are marvellous and we have a good laugh and if my special carer is off they always send another one they know I like."

People told us they had developed positive caring relationships with the care staff. One person described the caring approach of a care staff who had gone the 'extra mile'. They explained that the care staff stayed with them until the ambulance arrived when they became unwell. When the person returned home from the hospital they found their home had been cleaned, dusted and the floors were vacuumed and mopped which had not been included in the agreed package of care. This meant the person could recover without the worry of doing the domestic chores.

A relative told us the regular staff helped to promote their family member's independence. They said, "Carer passes stuff to my [family member] so [they] can do what [they] can for themselves to stay independent." Another relative told us they liked that staff ensured their family member had everything they needed before leaving and were unobtrusive in the family home, which demonstrated respect for other family members.

People told us they were involved in making decisions about their care. Some people had supportive relatives. All those who we spoke with said they had been involved in the development of their care plans and felt their opinion had been listened to. Advocacy information was available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

Care plans included information about people's wishes, preferences and life history. Staff demonstrated they knew people's needs and wishes, and ensured they had supported the person with everything they needed before they left. Staff knew people's communication methods. For example, a staff member described how they recognised and responded to signs and gestures used by a person who used non-verbal communication. This helped the person to express emotions and participate in choices about their day to day care. Information was available in formats that people could understand.

Staff understood the importance of promoting equality and diversity, respecting people's religious beliefs, their personal preferences and choices. Some people did not have English as a first language and liked to speak in their native language where possible. Some of the staff were multilingual. Staff told us that where possible they supported those people and could converse with them in the language of their choice. One person told us they were supported by staff from different ethnic backgrounds. They said "A [care staff name] is lovely, efficient and listens [to me]." They explained that a system had been set up with their regular carers so they knew how they wished to be supported with regards to their personal care needs.

People were treated with dignity and their privacy was respected by staff. A person told us that care staff

"Always respected their privacy and dignity." A relative said, "When [my family member] has a full body wash they always cover [them] up; [their] privacy and they are always respectful towards [them]. They have staff on either side of the bed and one [care staff] washes [my family member] and the other dries [them]. [My family member] is always left clean and fresh."

Staff were trained to promote people's dignity and understood the importance of respecting people's privacy. They gave examples of how they promoted and respected people's dignity and privacy. Comments included, "I use two towels; one used to cover waist down and the other used to dry them" and "I make sure the curtains are drawn and the door is closed. I would give them the flannel to wash and offer to help if I saw they were struggling to wash themselves." All care staff were registered for the dignity champion training. A dignity champion promotes treating people with dignity, acts as a good role model and challenges poor care.

People's information was kept secure. The provider had complied with General Data Protection Regulation, (GDPR) that relates to how people's personal information is managed. Staff understood that information was only shared on a need to know basis.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed and they were involved in the development of their care plans. People's decisions made about their care were documented and used to form the basis of their care plan. People could have access to an advocate if they felt they needed support to make decisions, or if they felt they were being discriminated against under the Equality Act, when making care and support choices. The registered manager gave a person information about advocacy support and offered to contact them on their behalf if required.

People and their relatives told us they mostly received a service that was personalised and responsive to their needs. One person said, "[Care staff] is punctual, doesn't rush me and always goes at my pace. When I come out of the shower, [they] say gently help me to sit so I relax, [care staff] is like an angel." Care staff knew people well and could describe how they supported people. One care staff said, "Before I go to someone new, [office staff] tell me what they need help with. I read the care plan in the house and ask the person, just to be sure."

People expressed concerns about the number of different care staff, poor time-keeping and communication from the office staff when care staff were due to be late. A person said, "It's not very satisfactory. It's early stages but so far, I have had at least 20 different [staff] coming on different days. They come in and I ask who they are." We shared this with the registered manager who confirmed there were 12 different staff not 20, which was still unacceptable.

Another person said, "[Carer] is alright; [they] come in the afternoons and we're quite comfortable with the regular ones. But if they're away you have to tell the new [care staff] everything." However, another person told us there was a lack of continuity in care and no consistency in the record keeping. This person's care plan lacked guidance for care staff to follow including what signs or symptoms to look for to monitor their health such as skin condition and breakages. We were unable to check the daily logs completed by care staff as had not been returned to the office.

We shared the feedback and concerns received with the registered manager. They assured us that travel times were being estimated between each visit using the computerised systems to plan staff rota. In additional care staff team had been established to work in geographical areas, so that people and their relatives would know. We were told that the assessors had arranged home visits to review people's care in a planned way and in response the concerns people shared with us.

The care plans we sampled were different formats. Some care plans were more detailed than others. The registered manager was in the process of transferring the assessment of needs and care plans to the new format that supported personalised care. The new care plans included detailed information about people's background, cultural and religious needs, hobbies and interests, family members who were important to them and their preferences with regards to their care needs. Routines that care staff should follow were detailed for each visit. In some instances, there was information about specific needs relating to living with a disability, health conditions such as diabetes, photographs that showed staff step by step actions to follow

when using equipment to move people. People's preferences were noted for example, how care staff should greet the person and in what order people liked their support to be provided.

One person's care plan included pictures and symbols that they understood and used to make decisions. That showed the provider was complying with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

We received mixed responses when we asked people if they had been involved in the review of their care. Comments included, "I've had no questionnaire, no phone call, no visit from the office. A lad used to come out three years ago, but since then nobody." "I haven't had a review not yet. It's [my care needs] just the same." And "The office rang once three months ago and asked how I was getting on with the carers and I said alright." A relative said "I don't deal with the office. I saw one person six or seven weeks ago, [they] came here to see if [my family member] was okay."

A person who had used the service for a week expressed concerns about their package of care and told us that they needed advocacy support. We shared the concern with the registered manager. They contacted the person to review their care and provided an advocate to support them. The registered manager told us that one of the improvements made because of our inspection was that they would review all new people's package of care within seven days of their service starting instead of the 28 days set out in the provider's procedures.

We saw different methods were used to monitor and review people's care. Reviews were triggered either from concerns reported by care staff or unannounced spot checks on care staff practices or quality monitoring telephone calls. Records showed some people had had their care needs and risks reviewed and their care plans had been amended when their needs had changed. However, this was not the case for everyone. The registered manager had identified this from an internal care plan audit. The registered manager and management team had begun the process of reviewing people's care initially with quality check telephone calls with people, and home visits where people reported that their needs had changed.

The provider had systems and policy in place about how to support people at the end of their lives. Staff had access to end of life training. Information about end of life care, bereavement and counselling services was available to care staff, people using the service and relatives. Records showed people had the opportunity to express their wishes and decisions made about their end of life care. No one was receiving end of life care at the time of our inspection.

People and relatives knew how to report concerns. One person said, "My concerns are sorted out because I don't give up. I have to go back [to the office], too many times!" A relative said, "I mentioned to the office that carers were speaking on their phones whilst caring for mum, they were speaking in their own language. I don't believe it's happened again." Another relative told us there had been some improvements since they made a complaint about poor time-keeping and the issue of only second care staff arriving late had reduced.

The provider had a procedure to respond to complaints. Information and contact details for the local advocacy agency, the local authority and the local government ombudsman was included should people need support or remain dissatisfied with how their complaint was handled. An advocate speaks up on behalf of a person, who may need support to make their wishes known.

The PIR stated that the provider had received 101, of which 74 had been resolved within the 28 days.

Records showed complaints had been investigated and where possible action taken. The complaints themes supported the feedback we received from people who used the service and their relatives. The registered manager had put systems in place to address the ongoing issue of travel times, continuity of care and increased the frequency of unannounced spot checks on care staff to check their practices. Some complaints had taken longer to resolve; therefore, a tracking system was put in place to check that complaints were dealt with in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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 and provider's vision and values was to promote people's independence and enable them to have a happy quality of life. They understood their role and were aware of the legal responsibilities in notifying the CQC of significant events and incidents within the service. They were aware of the legal requirement to display the registration certificate and rating from this inspection. Management staff and care staff felt the registered manager provided good leadership and had made some changes to improve the organisation and how it operated.

The registered manager, management team and care staff had a good understanding of providing quality care and had people at the heart of the service. Staff told us there had been some improvements. Comments included, "Things are improving. You couldn't get through [on the telephone] before. Now you can because there are more [telephone] lines." "[Senior carer name] came out when I reported concerns about someone's needs. That never happened before." And "I found [registered manager] was really helpful but didn't know who she was until after. She was actually interested in what I had to say."

Some staff spoke positively about the changes that had been introduced by the registered manager and felt they were kept informed. A staff member said, "I've called the office for advice by telephone and in person. They do text me if there's been any changes to my rota." However, this was not the case for all. Other care staff felt less confident to contact the office staff. We shared this with the registered manager who assured us this information would be included in the next staff newsletter. In addition, text messages would be sent to all care staff with the names and contact details of coordinators should they need to report potential late visits.

People and relatives, we spoke with had mixed views about the service. One person said, "Three good things about the service are: it's just nice to have a service as I can't manage without it, it's not bad, and they give me the girls I like if possible." Another person said, "Overall, this is a very inconsistent service, with some people happy and others continually stressed."

The registered manager was passionate and committed to improving the service. They welcomed feedback from people using the service, relatives and staff. They shared the challenges faced to merge the two previously registered services to become Derbyshire Care Services HQ. There were changes to the management structures and new staff had been appointed to improve the functions of the different departments such as human resources, training and care management. Staff roles and responsibilities had also been clarified. The provider had also invested in new systems and processes to support these changes. This included the new assessments and care planning documentation and the management of staff training.

The provider's governance systems had been reviewed because they were not used effectively to bring about improvements. The new systems and processes had not been fully implemented which meant some aspects were fragmented. For example, staff rotas did not include travel times between each visit and people were not always made aware of any delays. The unannounced spot checks on staff practices were also overdue. People told us that continuity of care would be improved if they had a regular team of care staff who knew and understood how they liked to be supported. This would ensure people received personalised and responsive care and support. The registered manager and provider continue to monitor this.

The registered manager had identified through management meetings and internal audits that improvements were needed to people's care records and care reviews were overdue. A new assessment and care planning documentation had been developed and used for all new people who needed care and support. Care coordinators and assessors had responsibilities to systematically review people's care needs and transfer the information to the new care plans. As we shared new concerns, risks and changes in people's needs or health concerns with the registered manager some people's reviews were brought forward. Whilst this showed the service was being responsive, other people's reviews were delayed as a result.

We found the systems to ensure staff were trained, supervised and supported in their role needed to improve. Some staff's training was overdue. The training manager had addressed this by providing training to staff individually and in small groups. A system in place to ensure staff training was planned and ad-hoc training was available to address unsafe staff practices.

Some staff told us they felt supported and were supervised and had their practices observed through the unannounced spot checks. The registered manager had identified that staff supervisions and their observed practices were overdue and had put plans in place to address this. Records showed staff supervisions had taken place following unannounced spot checks. A schedule showed that supervisions had been planned to follow staff observed practices.

We saw the minutes of management and care staff meetings, which showed the management provided updates and information about any proposed organisational changes and new systems, general concerns about care issues and training information. A staff newsletter provided updates and reminders about infection control procedures and using disposable gloves and aprons, time-keeping, reporting concerns and included a policy of the month such as social media and safeguarding procedures.

The provider used a range of ways to encourage people using the service, relatives and staff to share their views and influence the development of the service. These included individual comments through review meetings, quality check telephone calls, complaints and compliments. One person told us that someone had called from the office to ask for their views about the service. Records of the quality telephone calls showed that people views had been documented and action was taken when concerns were reported. Compliments, cards and letters of thanks were received about the service from people who used the service, relatives and professionals.

The provider had carried out a survey of people's and relatives' views in July 2018. The results showed most of the respondents felt safe and well-cared for and said they were treated with dignity and respect. Written comments included, "Very big improvement. I like that my carer speaks the same language as me" and "We are lucky to have a settled team that know me well."

The registered manager had introduced a 'you said – we did' updates, which were sent to people using the

service. The latest update covered topics such as continuity of care, time-keeping and customer care and the action being taken to address these issues. That showed people's views were being listened to and plans put in place to address them.

There were staff initiatives and incentives such as pay structures and 'carer of the month'. That showed the provider and registered manager valued the staff team. People who used the service and staff were encouraged to nominate care staff for the 'carer of the month.'

Records showed internal audits had been carried out on records such as staff recruitment files and people's care records. The registered manager had introduced other monitoring systems to ensure quality of care and risks were understood and managed. For example, they monitored significant events such as incidents and accidents and looked at ways to reduce them. Systems were in place to track the progress of complaints to ensure those were resolved in a timely manner and identify if any lessons could be learned. Records in relation to the day-to-day management were kept up-to-date. The registered manager showed us the action plan produced from the audits, internal and external inspection. Following our inspection visit they sent us updates in response to the concerns that were raised about people's care. That showed concerns had been acted on and they continued to monitor and develop the service

The provider worked in partnership with commissioners and other agencies in an open, honest and transparent way that ensured that people received a joined-up approach to their care and support. The feedback from the local authority at their visits showed the manager had engaged in the process and was working to put in place the processes they were asked to.