Dee's Domiciliary Care Services Limited

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Inspection report

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Date of inspection visit:
24 November 2016
25 November 2016

Date of publication:
30 December 2016

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 24 and 25 November 2016 and was announced. The provider was given 48 hours' notice because the location is a domiciliary care service and so we needed to be sure that key staff would be available at the office.

Dee's Domiciliary Care Services provides personal care, respite and domestic services to people in their own homes, some of whom are living with dementia or have complex health needs. The service operates mainly in the eastern part of the City of Southampton, where it is a preferred provider under the local authorities domiciliary care framework. The service also provides care to some people living in Hedge End, and the Bursledon, Netley and Hamble areas of Hampshire. There were 80 people using the service at the time of our inspection.

The service had a registered manager. 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.

People did not always have a care plan which provided detailed information about their needs and supported staff to deliver responsive care. The legal requirements of the Mental Capacity Act (MCA) 2005 were not being fully met. The provider had been asked to make improvements with regards to both these areas at our last inspection in July 2015. The required improvements had not been made.

Some risk assessments needed to be more robust and include more detailed guidance about how the identified risks were to be managed. More robust systems were needed to ensure that medicines were managed safely.

The provider had not notified CQC about significant events that had occurred within the service.

People told us the reliability of the service, particularly at weekends, needed to improve. Communication was sometimes poor. This impacted upon the confidence people had in the service and its leadership.

Staff had received training in safeguarding adults and had an understanding of the signs of abuse and neglect. Where concerns had been expressed about the care provided by Dee's Domiciliary, their senior staff were working effectively with the local authority to investigate and learn from these.

The induction for new staff was limited and was not mapped to nationally recognised standards. Staff did not receive regular supervision. This is important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities.

Improvements were being made to ensure that there were sufficient numbers of staff deployed to meet

people's needs. Recruitment practices were safe and the required checks had been completed before new staff members started work.

People were happy with the support they received to eat and drink and staff were able to describe to us the importance of protecting people from the risk of poor nutrition or hydration. Most people felt staff helped them to stay healthy and monitored their wellbeing.

People were treated with kindness. They felt that their privacy and dignity was respected. People felt at ease with their regular care workers who had developed positive caring relationships with them.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have asked the provider to take at the back 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 always safe.

Some risk assessments needed to be more robust and include more detailed guidance about how the identified risks were to be managed. More robust systems were needed to ensure that medicines were managed safely.

Improvements were being made to ensure that there were sufficient numbers of staff deployed to meet people's needs. Recruitment practices were safe and the required checks had been completed before new staff members started work.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect.

Is the service effective?

Requires Improvement

The service was not always effective.

The induction for new staff was limited and was not mapped to nationally recognised standards. Staff did not receive regular supervision.

The legal requirements of the Mental Capacity Act (MCA) 2005 were not being fully met.

People were supported with their health and nutritional needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness. They felt that their privacy and dignity was respected by their regular care workers with whom they had developed positive caring relationships.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have a care plan which provided detailed

information about their needs and supported staff to deliver responsive care.

The reliability of the service provided, particularly at weekends needed to improve.

People gave us mixed feedback about how well the service had managed complaints, although the complaints we viewed had been responded to in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had not notified CQC about significant events that had occurred within the service.

Communication was sometimes poor. This impacted upon the confidence people had in the service and its leadership.

Audits were not yet being fully effective at driving improvements.

Dee's Domiciliary Care Services Limited

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 was an announced inspection which took place over two days on 24 and 25 November 2016. The inspection team consisted of a lead inspector, a second inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. The lead inspector visited the organisation's office and spent time speaking with the registered manager and staff. The second inspector visited people in their homes. The expert by experience undertook phone calls to people using the service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the provider tells us about important issues and events which have happened at the service. The provider completed a provider information return. 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 used this information to help us decide what areas to focus on during our inspection. Prior to the inspection we also sent out questionnaires to 37 people, asking them for their views about aspects of the service they received. Sixteen questionnaires were returned and some of the feedback from these is also shared in this report.

During the inspection we spoke nine people who used the service by telephone. We also visited five people in their homes and spoke with them about their care and support. We spoke with the registered manager, the performance and quality (PQA) manager, the office manager, a client liaison support officer and a call co-ordinator. We also spoke with 10 care workers. We reviewed the care records of ten people and four staff and other records relating to the management of the service such as audits, incidents, policies and staff

rotas.

Following the inspection we sought feedback from three health and social care professionals and asked their views about the care provided by the service.

The service was last inspected in July 2015 when we rated the service as requires improvement. We also found that the legal requirements were not being met in relation to consent and to the provision of person centred care.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when being supported by the care workers. One person said, "Yes I feel safe with all my carers". Another told us they felt safe because, "They [care workers] come in and make sure I'm ok". Whilst people told us they felt safe, we found that improvements were needed to the safety of the service being provided.

Risk assessments were not always sufficiently robust and lacked detail or clarity. For example, one person's care plan identified they had a history of overdosing on their medicines. There was no further information about this. We were told that another person was at risk of self-neglect. Their care plan documentation made no mention of this. Their moving and handling assessment said they had a known history of falls but there was no further information about this. There were similar concerns about the quality of information regarding risks in most of the care plans we viewed with moving and handling risk assessments not always reflecting the complexity of people's needs or taking in account the impact of pain for example. We noted that in another person's care plan, staff were being asked to prepare a drink and add thickener to this. Thickener is designed to easily thicken fluids for people who have difficulty swallowing due to a range of health conditions. It is important that the right amount of thickener is added so that the drink is made to the right consistency. The person's care plan did not however, describe how much thickener should be added. The care plan did not include a copy of the professional guidance relating to the modified diet. The staff we spoke with gave varied responses when asked how much thickener they added. The lack of detailed information about how the person's fluids should be prepared could have placed the person at risk of receiving inappropriate care.

The lack of appropriate risk assessments and risk management was a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risk assessments were in place. The assessments covered risks associated with the provision of care in people's own homes such as health and safety and fire risk assessments. Each person had a 'RAG' rating. This is a system of using the colours, red, amber and green to rate a person's level of dependency and need. In the event of there being an incident impacting on service delivery, the rating is used to identify those people at greatest need. Planning was also underway to ensure that there were going to be sufficient staff available to meet people's needs over the Christmas and New Year period. Each person had been given a poster confirming the contact numbers of the provider's out of hours or on call service.

Improvements were needed to ensure that key safe numbers were stored more securely and only known by staff that needed to know these. Key safes are devices that allow staff to enter people's home by using a code to gain access to a key. This system is often used when people cannot answer the door themselves or are perhaps cared for in bed. We observed that staff were provided with a list of key codes to each person's house, even when they did not visit this person. A health care professional told us they had needed to raise the issue of the security of key codes repeatedly with the service.

Some people using the service managed their own medicines or their relatives supported them to do this.

Where people did need support to manage their prescribed medicines, staff had received training for this and had their competency assessed. However, we found some improvements were needed. People told us there were occasions when they did not receive their medicines as prescribed because staff had not arrived on time. One person said, "They [The care workers] have arrived after I've already gone to bed because they're so late and they've woken me to give me my medicine…I have had to learn to take them myself, but I can't do my eye drops and they're important".

Once medicines had been administered, staff were required to record this on a 'Medication Record'. We reviewed the medication record for three of the five people we visited at home. In the case of one person, staff had sometimes recorded the administration of medicines on the medication record but on other occasions had recorded this in the person's daily notes. On other occasions we were not able to see that staff had made any record of having administered medicines. We could not be assured therefore that this person was receiving their medicines as prescribed. In the case of a second person, their medication record showed that staff were consistently administering eye drops once a day. The person told us the frequency with which they now needed their eye drops had increased and care workers were administering these every lunch and teatime. There was no record of this being the case in the person's medication record. The third person's medication record was complete. The provider's procedures stated that if medicines were refused or no longer needed, these should be disposed of by returning them to a pharmacy. Some staff told us they disposed of medicines by throwing them in the bin. For example, one care worker said, "I leave the tablets in an egg cup, if not taken by lunch; I chuck them in the bin". This is not a safe way to dispose of medicines. Staff did confirm they informed the office or on call if medicines were refused or not taken so that medical advice could be sought.

The provider's procedures in relation to medicines management were not clear. The procedures did not clearly explain the difference between assisting people to take their own medicines and administering medicines to people, who otherwise, would not have been able to manage their own medicines. The procedures did not make it clear which of these care workers were authorised to do. Whilst people had a 'medication assessment', these did not always adequately describe the levels of support people needed to manage or take their medicines. The provider's procedures said, care workers 'must not administer tablets or capsules that are not in a monitored dosage system, blister pack, calendar pack or dosette box'. This was not in keeping with what care workers told us happened in practice.

The failure to safely manage people's medicines was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition to the registered manager and director, staff employed at the service included the performance and quality manager, a client liaison support manager, an office manager and an IT and administrative assistant. These staff were responsible for assessing new clients, drafting care plans, performing spot checks, supervisions and appraisals and reviews of people's needs. The remaining staff were care workers. Many of the care workers had been employed at the service for a number of years and knew people well. There had however been a period where staff sickness had been high and performance issues had led to the work force being reduced. This had impacted on service delivery at times and over the last year there had been a number of occasions when concerns had been raised with both CQC and commissioners of people's care about missed calls, care workers arriving late or only one care worker arriving when two were required. The feedback we received during this inspection indicated that people were still experiencing late calls and on occasion missed calls. They told us this was mostly a problem at weekends. Their comments included, "I'm thinking of hibernating at the weekend" , "The weekend is chaos", It's always the weekend, they rarely phone and I have difficulties phoning them because of my eye sight so I don't know what's happening" and "Quite often I don't have somebody on a Saturday". We were aware that there had been one missed call

during the week of our inspection. We were advised that this was due to a staff member not reading their rota correctly.

Staff gave us mixed feedback about whether there were enough staff to meet people's needs. Some staff were happy with the hours they worked and felt their schedules were realistic. Some care workers told us they felt under pressure to pick up extra calls when their colleagues called in sick or felt the need to rush when providing care. One care worker said, "Sickness is a problem, you have extra calls piled on, you feel you have to rush….you worry you may have missed something…sometimes I don't get a break between 7am and 5pm". This staff member told us it was, "A bit better than a year ago, but calls are still getting missed". We noted that many care workers' schedules did not include travelling time with one call being scheduled directly after the last. This meant that from the beginning of their round they were playing catch up.

Some people did however, tell us they were seeing improvements. For example, one person said, "Yes I have [had missed calls], but only one in the last few months". The recent satisfaction surveys also indicated that many people felt the service was improving. For example, one said, 'Staff in the field are excellent, weekends have improved' and another, 'Things go wrong when my normal carers are not working, but this is not often'. This was echoed by some of the staff we spoke with. One care worker said, "I am seeing an improvement, it's much better recently".

A number of measures had been put in place to help achieve these improvements. The number of people being supported by the provider had reduced. The management team were completing a weekly monitoring report which recorded the number of missed or late calls each week and the reasons why. The on call arrangements were being strengthened and where necessary staff performance and high sickness levels were being addressed through more robust human resource procedures. The registered manager was confident they currently had sufficient staff to support people, even if at times this might be later than planned. The registered manager was confident that the current number of staff was in line with the number of care hours they were currently delivering and sufficient to cover leave and staff sickness. They were clear that the service would not expand or accept new requests for care until they were confident they could manage this without compromising the quality of care. These improvements will need to be embedded in practice and sustained to ensure that there continues to be a reduction in the number of missed or late calls which could impact on people's safety.

New staff completed safeguarding training during their induction and this was then refreshed on an annual basis. Staff were able to describe the nature and types of abuse they might encounter and described how they would ensure any concerns were shared with the management team. We saw a number of incident forms which demonstrated that staff had escalated concerns about people's safety to Southampton City Council. However, we also received feedback from one healthcare professional who raised some concerns about the ability of staff to recognise and report upon potential safeguarding concerns or signs of self-neglect. They felt that in one instance this had led to a delay in one person's needs and support being reviewed. The relevant reporting procedures were detailed in the provider's safeguarding policy, but we noted that the service did not have a copy of the local multi-agency safeguarding procedures available at the time of the inspection. This is important as it supports providers to follow local procedures and provides detailed information for all those who have a role to play in adult safeguarding adults from harm. The provider was also not aware that they are required to notify CQC when allegations of abuse or neglect were made about the service provided by Dee's Domiciliary. This is important as it allows us to monitor that appropriate action has been taken in response to concerns to ensure people are safe.

Appropriate recruitment checks had been undertaken. Records showed staff completed an application form

and had a formal interview as part of their recruitment although we did note that the interview was not detailed or competency based. Checks had been made with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Until the DBS checks were returned new staff only worked supervised in people's homes.

Staff were provided with personal protective equipment (PPE) and received training in infection control measures. The majority of people we spoke with told us staff used gloves and aprons when providing personal care and spot checks were undertaken by the management team to ensure this practice was embedded. This is important to prevent the spread of and control of infectious diseases.

Requires Improvement

Is the service effective?

Our findings

Overall, people told us they were generally satisfied with the skills and knowledge of their regular care workers. People told us their regular care workers understood their needs and met these effectively. Their comments included, "They do a good job", "They are very professional" and "They give me a service that I require". Whilst people generally felt they received effective care, we found improvements were required.

At our last inspection in July 2015, we found that the legal requirements regarding consent were not being met and staff were not acting in accordance with the principles of the Mental Capacity Act (MCA) 2005. The (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. This inspection found that some improvements had been made. Most of the care plans we viewed in the office did include a signed consent form. However, where people were unable to give consent, the registered person was not able to demonstrate that they were acting in accordance with the MCA 2005. For example, we were told that two people lacked capacity to make decisions regarding their care and support but their care plans did not include an assessment of their capacity. There was no evidence that an appropriate consultation had been undertaken with relevant people, to ensure that the care plan being delivered was in the person's best interests. Staff had undertaken training on the MCA 2005, but still lacked confidence with regards their responsibilities under the Act and its associated Code of Practice. The provider's action plan following our last inspection stated that staff would receive supervision around the MCA 2005 to demonstrate they understood the key principles of the Act. This had not taken place. The leadership team did not have a copy of the Mental Capacity Act 2005 Code of Practice which is statutory guidance and describes in detail the responsibilities those caring for adults who lack capacity have when making decisions on their behalf.

Further improvements were needed to ensure that the legal requirements regarding consent were being fully met. This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported, were encouraged to undertake training and understood the requirements of their role. New staff undertook a basic induction which provided a basic overview of areas such as infection control, safeguarding people from harm and understanding the role of the carer. We were also advised that new staff were given opportunities to shadow more experienced staff. Whilst we were able to see certificates which stated that staff had completed an induction, we were not able to see workbooks or competency assessments which demonstrated how the provider had checked the new care workers skills, knowledge and understanding. The induction was also not fully mapped to the Care Certificate. The Care Quality Commission expect that providers demonstrate that staff have or are working toward the skills laid out in the Care Certificate which was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. We were advised that a member of the leadership team was shortly undertaking additional training which would enable them to

effectively implement the Care Certificate within the service.

At our last inspection in July 2015, we had noted that whilst senior staff carried out some spot checks or observations of care workers, staff did not receive any other formal supervision. Supervision is important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The provider had recognised that this was an area where improvements were required; however, they were only just implementing their new supervision structure. The aim of the new structure was to ensure all staff received supervision every two months which supported them with dealing with issues such as decision making, accountability and workload management. This new structure will need to be embedded to ensure that staff receive regular and effective supervision which ensures their competence and skills are being maintained. Records showed that some staff had received an appraisal within the last 12 months. These had been used as an opportunity to discuss their development needs.

Staff completed training in safeguarding people from harm, the Mental Capacity Act (MCA) 2005, infection control, (which we were told included food hygiene), moving and positioning and medicines. This training was generally up to date. A small number of staff opted to complete additional training relevant to the needs of people. For example, 15 staff had completed training in caring for people living with dementia and most had completed training in the use and care of artificial feeding devices. Training was being rolled out on the early warning signs which might indicate a person was self-neglecting. We did note that only 13 staff had current first aid training and records showed that only five staff had training on dignity in care. We were advised that first aid training was due to take place in December 2016 and would include all those staff who did not have current training. The provider's improvement plan identified there were plans to employ a full time training manager who would be responsible for spot checks and training delivery. All of the staff we spoke with felt the training provided equipped them with the skills they needed for the role. Overall the feedback from people was that their regular care workers were adequately trained to meet their needs.

People were happy with the support they received to eat and drink. One person told us, "They [the care workers] make me a cup of tea and then leave me jugs of water". Staff were able to describe to us the importance of protecting people from the risk of poor nutrition or hydration. Where people were known to be at risk of not eating well, food charts were put in place so that this could be monitored and concerns raised where necessary with relevant professionals.

Most people felt staff helped them to stay healthy and monitored their wellbeing. For example, one person said, "Yes I have on-going problems and they ask me if I'm alright, if I want a doctor". Another person said, "I had an incident when I fell over and banged my head, I phoned Dee's instead of an ambulance and they came straight away". A third person said, "I've not been seriously ill, but she [their care worker] would definitely notice". The registered manager told us that staff were kept informed via a group message system about changes to people's health or wellbeing which staff told us worked well. This might include informing staff that a person was on a course of antibiotics or had been prescribed a new cream. We saw evidence that staff worked alongside other healthcare professionals such as occupational therapists, to ensure people had suitable equipment in place for their moving and positioning needs. A member of the management team told us that the relationship with the community nursing team could at times be strained, but they were now taking part in a working group of local health care professionals to discuss issues such as medicines delays, sharing information and anticipatory care plans. It was hoped that this would help to improve how the services worked together to meet people's healthcare needs.

Good

Is the service caring?

Our findings

People told us their care workers were kind and caring. One person called them "Angels". Another person said, "Yes they are kind and caring, they come in and chat to me, you couldn't wish for a better lot really". A third person said, "They are all chatty and kind, I've had no problems whatsoever". A relative had sent a compliment to the service saying, "A big thank you to your girls for being so kind and loving to [the person] and myself, I will never forget their kindness". A health care professional told us, "The individual carers are often very caring".

One care worker told us their colleagues were "All kind and caring, if not I will ring the office and tell them, 100% [the registered manager] would act". This was echoed by another care worker who said, "I have no loyalty to anyone other than the clients".

Most people told us they had developed positive relationships with their regular care workers. One person said, "I always pull people's legs and I'm happy for them to do that with me and then I feel comfortable". Staff told us how they tried to make time to chat with the person they were supporting and tried to display empathy with them. One staff member said, "We do the same people most days, we know them really well, we try to get as close as we can…we may as well move in, we are like one of the family". Another care worker said, "We talk to them as we go along, have some banter". The registered manager told us how staff were encouraged to care not only for the person but to support and show concern for all those around them including the person's family members and informal carers.

We saw evidence that people had been supported to express their views about how they would like their care to be provided. When people first started receiving the service, they were visited at home so that their care plan could be drafted. Together with the person, staff identified the care that was to be provided and the tasks that were to be completed at each visit, this helped to ensure that people had control over their care. One person said, "Yes I had a meeting here with social services and someone from Dee's and we discussed what I wanted".

Care workers understood the importance of encouraging people to remain independent. One care worker said, "Independence is important, I encourage them to do as much as possible". A person told us, "They'll just give me a hand when I want them, like taking tops off, but they'll let me wash my face and that". Another said, "They ask me what I can do, not what I can't". Care workers also talked about the importance of supporting people to follow their interests and take part in social activities, for example, one care worker said, "I encourage [the person] to go the day centre as much as they can, if I am doing shopping, I encourage them to go too".

Care staff had a good understanding of how to ensure that people were respected and their dignity maintained. Care workers said they were mindful to ensure that when supporting people with personal care, bathroom doors and curtains were kept closed. A care worker said, "Dignity is important, I establish before I start what they want me to do". One person told us their care workers were "Very good and respectful". Another said "They do treat me with dignity and respect. They make sure my curtains are closed before they

get me up or put me to bed".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2015, we found that people did not always have a care plan which was person centred and informed care workers how to meet people's needs. This is important as although people told us that their regular care workers had a good understanding of their needs and how to meet these, at times, people were being supported by new staff or staff not familiar with their needs. The provider told us that all existing care plans would be reviewed and updated by the end of November 2015 with new care plans being audited within seven to ten days to ensure they provided a clear and personalised plan of care designed to meet people's needs. This inspection found that the required improvements in relation to care planning had not yet been met.

Some people's care plans still did not contain a sufficient amount of detail to enable all staff to meet their needs appropriately and in a person centred manner. For example, people were noted to be living with conditions such as Alzheimer's disease or Huntington's Disease, but there was no further information about how this affected them. A number of people required prescribed topical creams to be applied but their care plans lacked information about where these needed to be applied. One person needed thickener to be added to their drinks due to swallowing problems but the guidance provided in relation to dietary needs just said, 'soft and replacement drinks'. One person we visited did not have a care plan in their house. This person had been receiving a service from Dee's Domiciliary for some months. The provider was not able to explain why this was the case.

Some care plans were not accurate. For example, due to nutritional risks, staff were completing fluid charts to monitor how much one person was drinking. The requirement to do this was not referenced in the person's care plan. Staff were assisting one person with catheter care, but this was not reflected in the list of tasks to be completed at each visit. Another person's plan said they were unable to 'weight bear' but staff were in fact supporting the person to walk short distances each morning.

Whilst we did see some care plans which were more detailed and provided some information on people's likes/dislikes/preferences, this was not consistent across all people's records. Care plans continued to use a confusing format of answering 'True' or 'False' to questions. For example, in response to questions such as 'Is there a risk of falls' staff had answered 'True' but there was no further information about what this meant for the person and how this need was being met. A care plan recorded that it was 'True' another person was often in pain, but again gave no further information about where the pain might be and the implications it might have for providing the person's care. We saw very little reference to people's preferences as to whether they had a male or female care worker. None of the care plans viewed reflected people's choices and wishes regarding their end of life care and did not record whether people had a 'Do Not Resuscitate' document in place.

The failure to design and make available a suitably detailed and person centre plan of care for all people using the service was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views about the timeliness of their visits was mixed, however, there was evidence to suggest that the reasons for people's dissatisfaction with the timing of their care visits partly stemmed from the way in which the local authority commissioning framework had been set up. This stated that care visits did not have to be time specific but then when the package started, people were unhappy with this which meant that the relationship between people and the provider did not always start well.

People were generally happy with the consistency of care they received during the week but many felt that at weekends, they were often sent care workers who were not familiar and did not understand their needs. For example, one person said, "I normally get the same [care worker] each morning and lunch-time, tea time can vary and the evening call is consistent, it's just the weekend". Another person told us "Everything fell apart" when their usual care worker was on holiday.

Overall feedback from people indicated that during the week care workers stayed for the correct amount of time and provided the right amount of support to meet their needs. One person said, "They do all that is necessary before they leave" and another said, "They [the care workers] are very good that way…if they finish early they'll sit and have a chat". However again people were less confident that this was the case at weekends. One person said, "Monday to Friday, they do everything I ask them to do and they'll ask me if there's anything I want doing, but at the weekend its different, I will always get a shower if I want one, buts it's sort of 'do I really need that' attitude". This view was echoed by a number of people we spoke with.

People told us they did not know when their visits were meant to be as they did not get a weekly schedule. They felt this was an area which needed to improve. A member of the management team told us sending weekly schedules led to people becoming unsettled if this had to be changed or a different care worker sent. In an attempt to address this issue, each person had been sent a letter informing them of the routine or planned time their visits should take place.

Improvements were needed to ensure that updated care plans were placed in people's homes following reviews. Care reviews were carried out by the management team every six months. We were advised that care plans were then updated as necessary to ensure they continued to reflect people's needs. However each of the care plans we viewed during our visits to people in their homes were over one year old and contained out of date information. We spoke with the management team about this. They confirmed that reviews had taken place, but for some reason the updated care plans had not been placed in the person's home. They told us this would be done the next day. We received feedback from a healthcare professional who told us, "Very outdated care plans are often in the home…despite several discussions to update it". Daily records were completed and those viewed were generally detailed and reflected the care that had been provided. The records showed that staff appeared to know people well and were attentive to needs such as nail and foot care.

The service had a complaints policy and information about how to raise concerns or complaints about the quality of care provided was included in the service user guide that people received when they first started using the service. Some people told us they had never needed to raise a concern or a complaint. Those that had gave us mixed feedback about how well the service had managed these. Some felt the service had responded well. For example, one person told us how they complained when a care worker kept 'interfering with their tablets'. They said Dees had "Talked it through with me and she [the care worker] didn't visit again". Others told us they had needed to follow up concerns to get a satisfactory response. One person told us Dee's had not dealt with their concern very well, they said, "They don't really know what I need and what I want". A second person told us how they had asked for a particular care worker not to return following some issues with their care. They told us, "They did come back and I had to phone Dee's again to ask her not to come".

A number of people had contacted CQC over the last 12 months to share their complaints about the service, many of these expressed a view that the service had not taken action to address and resolve their concerns which was why they were contacting the Commission. This indicated that people did not always have confidence in the provider's complaints system. The registered manager and performance and quality manager expressed a commitment to continue to use complaints to drive improvements. The complaints we viewed had been responded to in line with the provider's policy and further improvements were also planned such as a portal on the provider's new website which would allow people to directly comment on the quality of service they received. It was hoped this would be in place by January 2017.

Requires Improvement

Is the service well-led?

Our findings

People's feedback about the leadership of the service was generally positive. One person said, "I know [the registered manager], she's approachable". Another person said, "They are a good firm". However, people gave us mixed views about whether they would recommend the service to others. One person said, "Yeah, I would. I had no trouble with them; they've been really good to me" and another said, "Well I can't compare it to others but better the devil you know". However, other people were less positive. One person said, "No [I would not recommend the service] at weekends you don't get treated right, it's always late or missed calls". Another said, "If they got the weekend running well, yes I would, but not otherwise".

Staff were positive about the registered manager. One care worker said, "They are really good, very flexible with hours, understanding". Another described them as a "Good leader, firm but extremely fair". They told us the registered manager was approachable and supportive and tried to address any concerns they might have. Team meetings were occasionally held and were an opportunity to discuss matters such as rotas, training and general working practices and documentation. Most care workers said that staff morale was generally good. The management team had recently held a team building day which it was reported staff really enjoyed. One staff member said, "I do feel it is improving, we are getting on with each other, it's a good team". Another care worker said, "I love my job, the clients are lovely, you can't fault them, it's a much better place than before, my only gripe if the lack of staff sometimes". The registered manager said, "We had a recent training day, there was a better atmosphere, it was jolly, happier, there was a buzz".

We found that some areas of how the service was led required improvement. Registered managers and providers are required to send statutory notifications to the Care Quality Commission (CQC) when a significant event occurs. One type of significant event is when an allegation of abuse or a safeguarding incident occurs. The registered manager had failed to inform CQC of a number of such safeguarding incidents. The safeguarding concerns had been appropriately reported to the local authority and investigated to ensure remedial actions were put in place to prevent similar incidents; however not ensuring that a notification was sent to CQC is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

Organisation and communication needed to improve. People told us the service was not always reliable and that they were not always informed if, for example, their call was going to be late. This impacted upon the confidence people had in the service and its leadership. One person told us they often had problems with their calls at weekends, they said, "I've got to ring them every time and it's costing me a fortune". Another person said, "They sometimes ring to say someone else is coming out but normally I have to ring to find out what is going on". One of the people who responded to our questionnaires said, "When trying to contact [the service] they don't answer the phone, when asked about this, their answer was would you prefer office staff to go out and see clients or stay and answer the phone". A healthcare professional also expressed frustration that upon contacting the office, there was often only one staff member who was able to give information about people, which meant that could be a delay in information being shared when that person was on leave or out of the office. The providers improvement plan has identified a number of actions that moving forward will help to improve communication between people and the service, but also between the

service and commissioners and other health and social care professionals. This included plans to ensure that accurate records were maintained of any verbal information shared regarding the care and support of people. These improvements will need to be embedded and sustained to ensure that there is effective and open communication with people, their relatives and staff.

People were being encouraged to provide feedback about the service they received through the use of twice yearly satisfaction surveys. We reviewed the feedback from the most recent questionnaires, these were largely positive. Comments included, "We feel very lucky to have the girls looking after mum" and "We are very happy with the normal carers". As discussed elsewhere in this report some areas for improvement were also noted and these included better reliability and communication about changes to visits or late calls. Again some people noted that the quality of care and service provided seemed to be improving. The performance and quality manager told us they would be analysing the feedback and drawing up an action plan to address the areas when improvements were needed. The provider was also considering whether to expand this feedback service to staff so that they also had formal opportunities to comment on the quality of the service.

Spot checks or observations of care workers were undertaken to ensure they were delivering appropriate care, wearing the correct uniform and following correct infection control procedures. When care records were returned from people's homes, these were checked to review whether the call duration was the right length. Daily records were checked to ensure staff were keeping a detailed record of the support that had been provided at each visit. An action plan was produced as a result of these checks. This considered what changes might be needed both from a care worker perspective and to improve the care experience for the person. There was however, no evidence that the actions had been completed. Medicines records were also audited.

However, whilst there were quality assurance systems in place, these were not yet being fully effective at driving improvements. For example, the provider's quality assurance systems had not identified the continuing concerns we found with regards to the quality of care plans and the lack of robust risk assessments. Whilst incidents and accidents and complaints had been investigated, the provider did not undertake an analysis of these to assist in identifying any themes or trends.

The provider demonstrated a good understanding of the challenges faced by the service. The PQA manager had developed a very detailed service improvement plan which laid out the actions needed to develop and improve the service. Some of these had already been completed such as strengthening the on call arrangements and undertaking quality surveys with people. Staff sickness was reducing which in turn meant better consistency of care for people. Future plans included the need to develop a website, recruit and train a team of senior carers or team leaders that could support the management team and take over responsibility for areas such as spot checks or reviews. Whilst there was a plan to increase in size there was a recognition that this needed to be done slowly and be in correlation with a growth in the staff team and their skills and knowledge. Throughout the inspection, the registered manager and management team were receptive to feedback and clearly demonstrated a commitment to openness and transparency. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way and to provide people with a written apology when things go wrong or the quality and safety of care is compromised.

The registered manager had a passion for providing person centred care and told us they were committed to making sure people received the very best care possible. They told us, "I don't believe in getting too big, I want to provide a person centred service, I want to know every client and each carer". The registered manager said they were proud of her management team and how they were working effectively with the

local authorities to make improvements. They said, "We are proud of how we are developing…the customer facing side is pretty good". They were confident that structural and administrative improvements would continue to support this.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the Care Quality Commission of any abuse or allegation of abuse in relation to service users. Regulation (2) (e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Further improvements were needed to ensure that people had a suitably detailed and person centre plan. Regulation 9 (3) (b).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Further improvements were needed to ensure that the legal requirements regarding consent were being fully met. Regulation 11 (2).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always have a suitably detailed risk assessment. Risk assessments did not always describe the measures that staff should take to mitigate identified risks. Regulation 12(2) (a)(b). The provider had failed to ensure the proper

and safe use of medicines. Regulation 12 (2) (g).