Doves Care Services Ltd

Doves Care Services

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Doves Care Services is a domiciliary agency which provides care and support to people who live in their own homes. The agency was registered with the Care Quality Commission (CQC) in February 2015. At the time of this inspection the service was supporting 16 people.

The service was previously inspected in September 2015 when it was rated 'good' overall, with the key question of well-led rated as 'requires improvement'. We identified a breach of Regulation 17 (good governance) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection the provider sent us a plan detailing the actions they were taking to improve. At the time of the inspection in September 2015 the service was supporting five people.
You can read the reports from our previous inspections, by selecting the 'all reports' link Doves Care Services Ltd on our website at www.cqc.org.uk.
This announced inspection was undertaken on 12 and 17 May 2017. The inspection was undertaken by one adult social care inspector.

The registered provider also held the role of 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 provider was not managing the service in a way that protected people from the risk of harm from unsafe care. Systems in place had not been effectively implemented to ensure people received safe and responsive care and support. Staff recruitment practices were not safe and staff did not receive training in relation to their role and to support their understanding of people's care needs. Insufficient staff were recruited to ensure people received support from staff in a timely way and at times staff were working excessive hours to provide care. Care plans and risk assessments were insufficiently detailed to provide guidance and information to staff about people's care needs and how to mitigate risks to their health and safety.

The provider did not have an understating of their legal requirements relating to their registration with the Care Quality Commission. The provider was not aware of the implementation of the Health and Social Care Act 2008 which came into force in April 2015. This meant the provider did not have an understanding of the requirements of this Act and where they were in breach. The provider had given misleading information to CQC during the registration process.

Prior to this inspection, in May 2017 we had received information from the local authority's safeguarding team that the service's recruitment practices were unsafe. The provider was in consultation with the safeguarding team as well as the commissioning authorities responsible for arranging people's care as they were seeking assurances the service could provide safe care and support to people.

Following the inspection we received confirmation from the local authority that they had ceased contracting

with Doves Care Services Ltd. All those people supported by the service had been provided with alternative care services. The provider gave us assurances they would not provide a service to any new service users until they had made improvements. They told us they would confirm this in writing however they failed to do so.

At the time of this inspection, the provider employed four care staff and two administrative staff. We reviewed the service's recruitment practices for staff currently employed and for staff previously employed by the service but were no longer working for them. None of these staff had been recruited safely and the necessary pre-employment checks to ensure staff wee suitable to work with people who might be vulnerable had not been undertaken. None of the staff had current disclosure and barring checks (police checks) and references from previous employers had not been sought for six out of the seven staff files reviewed.

The provider was unable to provide us with evidence that staff had received induction training or training in relation the needs of the people they would be supporting. Staff had not received supervision or had their competence to work safely assessed. For example, staff had not received training or had their competence checked in the safe use of a hoist needed to assist one person with transferring from their bed to their chair or for another person, with the administration of eye drops. Staff were not provided with supervision and the provider had not undertaken spot checks to ensure staff were working safety and in line with people's preferences.

Insufficient staff were employed at the service to ensure people received care in a timely way. The provider told us they undertook care visits when staff were on holiday or sick. However, both the office staff told us they had undertaken care visits due to staff shortages. Neither of these staff had received training or had been introduced to any of the people receiving support. People told us that although they had not had any missed visits, sometime their visits were very late. We looked at the duty rota for one person for the week following the inspection and saw they were working seven days that week. For five of those days they were working from 06:45 to 21:00 providing up to 14 visits, with three breaks between visits. Due to staff shortages, one member of staff told us they had been told by the provider they had to work despite being unwell.

At the previous inspection in September 2017 we identified the provider had not maintained accurate, complete and contemporaneous records in relation to each person receiving a service. At this inspection in May 2017 we found improvements had not been made. Records relating to people's care needs and any associated risks were poorly recorded and did not provide an accurate or detailed description to ensure staff could provide safe care and support. The findings of risk assessments had not been included in people's care plans. Staff were not provided with clear information about people's specific care needs and how they should offer support. In addition, the support people required to maintain their health and the impact of health conditions on people's support needs were not recorded in care plans. This placed people at risk of receiving unsafe care.

Each person receiving support was provided with a Service User Handbook and Guide. This handbook provided people with information about the service's key policies and procedures. However, other than a reference to having access to a formal complaints procedure, people were not provided with information about how to make a complaint. Those people we spoke with said they felt they could raise concerns with the provider should they have any. Two people told us they had raised concerns and the issues had been resolved and dealt with to their satisfaction. However, the provider had failed to record these concerns in line with their own policies and procedures.

The service had a policy regarding internal quality audits. These included reviewing whether risk

assessments and care plans been fully completed. However, the use of these audits had not identified the concerns we raised during this inspection and provided information that was inaccurate. For example, the internal audit identified nutritional reviews had been undertaken every three months or when significant changes occurred. However, we found that no nutritional assessment had been undertaken for one person identified at risk of not eating enough to maintain his health. Shortly before this inspection, the local authority had provided support to the service through its Quality Assurance and Improvement Team (QAIT). A service improvement plan had been developed which detailed the actions required by the provider to address the shortfalls in the management systems. The provider said they were reviewing their systems to ensure they were used more effectively.

People told us the communication from the service was not always good, although this had improved since the appointment of two office staff. Records showed this was a concern raised by people in the service's quality survey sent to people in August 2016. The provider had failed to act upon people's feedback to improve their service. However they were now confident that with office staff in place this issue would be resolved. Other comments included in the surveys showed people's satisfaction with the service. One person said, "Happy with the service" and another said, "The girls do a marvellous job."

People told us they were happy with the care staff who supported an assisted them. One person said the staff were kind and polite. Another praised the staff saying they were "good at their job". They said, "They have a sense of humour and we have a laugh." They told us how much they enjoyed having a conversation with the staff when they visited. The relative we spoke said his relative "likes them [the staff] very much."

Staff spoke about the people they supported with kindness. One member of staff said, "They're all really lovely." Another recognised how importance their visits were to people as many people lived alone and were lonely.

We made four recommendations and identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result we placed a condition on the provider's registration that the registered person must not admit any service user to Doves Care Services without the prior written agreement of the Care Quality Commission. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff recruitment practices were unsafe. The provider could not be assured people were being supported by staff who were suitable to provide care in people's homes.

Risks to people's health and safety were not appropriately assessed or mitigated against.

Staff competence to use equipment necessary in people's care and to safely administer eye drops had not been assessed.

Insufficient staff were employed by the service to ensure people received care visits in a timely way

Is the service effective?

Inadequate

The service was not effective.

People were supported by staff who had not received the training they required to understand people's care needs and perform their roles.

Staff were not provided with the information they needed to support people to maintain their health.

People's consent to care was not recorded in line with legislation and guidance.

Is the service caring?

Requires Improvement

The service was not always caring.

People could not be assured they would receive care that respected their preferences and what is important to them.

People's involvement in planning their care was not recorded.

People were supported by kind and caring staff.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not support people to received personalised care. People's care needs and how they wished to be supported were not fully recorded.

The service did not record complaints or the action taken to resolve people's concerns.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance systems had failed to identify and address issues with the quality and safety of the services provided.

The provider was not aware of their legal responsibilities in relation to their registration with the Care Quality Commission.

Communication between the provider and the people receiving support was poor. People were not informed of events that affected their care.

Doves Care Services

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 took place on 12 and 17 May 2017 and was announced. The provider was given 48 hours' notice because the service is a small a domiciliary care agency and we wanted to be sure the people using the service, the provider and staff would be available to speak to us. One adult social care inspection undertook this inspection.

Prior to the inspection we received information from the local authority's safeguarding team that recruitment practices within the service were not safe. Before the inspection we also reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the registered provider is legally obliged to send us within required timescales. During this inspection, we spoke with four members of the staff, the provider, four people who used the service and a relative. We reviewed the care records and risk assessments of the three people. We also looked at seven staff recruitment files, including three for previously employed staff who no longer worked for the service. We also looked at the training records for the staff currently employed by the service. We reviewed records in relation to how the service was being managed and how the quality of the service was monitored.

Inadequate

Is the service safe?

Our findings

People who used the service could not be assured they would receive safe care and support. Recruitment practices used within the service were unsafe. Risks to people's health and safely had not been well documented and staff were not provided with guidance or training to mitigate these risks.

Prior to this inspection we had received information from the local authority's safeguarding team that the service's recruitment practices were unsafe: staff were providing personal care to people without the necessary pre-employment checks being undertaken. The provider was in consultation with the safeguarding team as well as the commissioning authorities responsible for arranging people's care as they were seeking assurances the service could provide safe care and support to people.

At the time of this inspection in May 2017, the provider employed four care staff and two administrative staff. We reviewed the service's recruitment practices for staff currently employed and for staff previously employed by the service but were no longer working for them. We looked at seven staff recruitment files: three of which were for staff who had been previously employed.

None of the seven files contained evidence the service had obtained current disclosure and barring checks (DBS) prior to commencing the staffs' employment. The disclosure and barring service helps employers make safer recruitment decisions and helps to prevent unsuitable people from working with people who may be vulnerable. The provider has a legal responsibility to obtain these checks prior to staff undertaking care duties. One file contained a reference to a DBS check obtained by the member of staff, prior to being employed at this service. The provider told us the member of staff subscribed to the DBS update service which ensured their DBS status was always up to date. However, the provider was unable to show us evidence they had checked the current DBS status for this member of staff. One member of staff told us they knew they should not have started to work prior to the DBS check being returned but said the provider had told them it "would be alright". Prior to this inspection the local authority had asked the provider to obtain DBS checks for all their staff. The provider told us these had been requested and they were waiting for the results.

Five of the seven files examined did not contain references that related to their past employment history or their character. One file contained photocopies of two references from the staff member's previous employers. However, these were not written on the employers' headed notepaper and were undated. There was no evidence the provider had made enquires with the previous employers to be assured these references were genuine. The provider was unable to show us evidence they had made contact with any of the staffs' previous employers to gain references. On the first day of the inspection, we asked the provider to seek references for the staff currently undertaking care duties and who did not have references. On the second day of the inspection, the provider had not obtained these.

Records did not show that the provider had explored staff members' employment history and none of the applications forms provided clear information about staffs' employment dates. One member of staff's records held contradictory information about where they worked and where they lived. The provider had

noted on the interview checklist that there were no issues arising from this staff member's application form. This showed the provider had not properly reviewed this member of staff's application form.

We spoke to the provider about the lack of records in these files. They said they had employed an administrator, who no longer worked for the service, to oversee people's recruitment. The provider had not checked they were following the service's own polices and procedures with regard to recruitment. However, the provider had a responsibility to review each prospective member of staff's documentation prior to their interview and prior to confirming their employment. The provider was unable to show us evidence that staff were suitable to provide care to people in their own homes.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Insufficient staff were employed at the service to ensure people received care in a timely way. At the time of this inspection the service employed four care staff to undertake visits to 16 people. The provider told us they also undertook care visits when staff were on holiday or sick. However, both the office staff told us they had undertaken care visits due to staff shortages. Neither of these staff had received training or had been introduced to any of the people receiving support. We looked at the duty rota for one person for the week following the inspection and saw they were working seven days that week. For five of those days they were working from 06:45 to 21:00 providing up to 14 visits, with three breaks between visits. Due to staff shortages, one member of staff told us they had been told by the provider they had to work despite being unwell.

People told us that although they had not had any missed visits, sometime their visits were very late. Staff told us that prior to the week before this inspection, travel time had not been included in their duty rotas. This meant they often cut short people's visits by arriving late or leaving early. Two people said they were not routinely informed if visits were going to be late, and at times had been kept waiting for several hours. People told us this had disrupted their day but no-one said they had been unduly affected. They said the service endeavoured to send a member of staff even if this was much later than planned.

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

Risks to people's health and safety were not being managed well. People's care files did not contain information and guidance for staff about risks or how to manage these risks safely. For example, one person had their care needs assessed by the local authority prior to being supported by Doves Care Services Ltd. This assessment identified them as being at risk of choking and they required 'fork mashable' food. They also had developed pressure ulcers and were at risk of further skin breakdown. They had a chronic medical condition, needs relating to continence management and required the use of a hoist to transfer from their bed to their chair. The provider had undertaken their own assessment of this person's needs which did not reflect all the risks and care needs identified in the local authority's assessment.

The measures in place to mitigate risks to this person's health and safety were poorly described in their care plan. The information did not reflect either of the assessments undertaken and some information was contradictory. The care plan held no reference to this person's risk of choking. One page in the person's care plan identified their family would be supporting them with meals, while another page identified staff were to assist with diet and fluids. This meant that if staff were to assist this person with eating they had not been provided with important information about how to keep this person safe.

In relation to managing the person's risk of skin breakdown the care plan referred to their need to have their

position changed: it stated, "Family between visits. Carers during visits". There was no guidance for staff about how often the person should be having their position changed and no guidance about what action to take should they have concerns over the person's skin condition. With regard to the person's mobility needs the care plans stated "N/A" and gave staff no information about the use of the hoist. A separate document entitled, "Service user needs overview" referred to the use of a hoist but gave staff no further instruction about how to support the person safely.

Records showed staff had not received training in relation to this person's care needs and there was no evidence staff had been assessed as competent to use a hoist. We spoke with the provider about this lack of guidance and training for staff. They said the person's family guided staff about how to care for the person.

Another person's care plan described them as "not very steady on my feet" and "quite dizzy when I am up and about". Their care plan did not guide staff about how to support the person to walk safely or when assisting them with their personal care.

At the time of the inspection the provider told us staff were not assisting anyone with their medicines. However they were supporting people with the application of topical creams and the administration of eye drops. The care plans provided staff with no guidance about how these creams and eye drops should be applied or administered. For example, one person's care plan stated, "He requires help with drying, creaming and dressing as well as eye drop in both eyes". There was no evidence staff had been provided with training or had their competence checked to ensure they were applying creams appropriately and administering eye drops safely.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe with their care workers and had no concerns. Care staff knew they must report any concerns over people's welfare to the provider or local authority. People and staff told us they felt confident the provider would take appropriate action if someone was at risk. However, records showed none of the staff currently employed at the service had received training in safeguarding adults.

We recommend the service seeks guidance from a reputable source to provide staff with training in safeguarding adults who might be vulnerable due to their circumstances.

Inadequate

Is the service effective?

Our findings

People did not receive care and support from staff who had received the necessary training to carry out their role. Staff competencies and work performance had not been monitored to ensure they understood people's care needs and provided care in line with people's preferences.

Records were insufficiently detailed to identify whether staff had received induction training at the start of their employment or ongoing training to ensure they remained up to date. Two care staff told us they had worked alongside the provider to be introduced to the people they would be supporting but there was no record of this in their files. The provider said they trained staff using presentations and training booklets. One document identified staff had received training in 23 care topics on the same day. The provider said this was incorrect and that was the list of all training provided for staff; however they were unable to confirm what training staff had received. Training topics did not include common health conditions that staff might expect older people to need support with. For example, there was no training in relation to continence management, skin care, nutrition and dehydration or health issues such as diabetes or Parkinson's Disease. The provider was unable to provide evidence staff had received supervision or had their work performance observed and assessed since they had started to work with the service. Staff had not received training in safeguarding people.

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

The provider told us they contacted people's families, GP or the community nurses if they had any concerns over people's health care needs. However, the support people required to maintain their health and the impact of health conditions on people's support needs were not recorded in care plans. For example, one person's care plan identified they had a number of chronic health conditions and was unable to meet their nutritional needs. The care plan gave staff no other information about these health conditions and what to be observant for or what action to take should the person's health deteriorate. The plan described the person prepared their meals themselves and staff were not guided about how to support this person to ensure they ate enough to maintain their health.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rights were not always protected as the provider was not meeting their responsibilities under the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decision 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 interest and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. People told us the provider and staff asked them for their consent during each care visit. However, none of the care plans we looked at held evidence that people had been consulted over their care or given their consent to

receive the care.

We recommend the service ensures people's consent to receive care and support is documented in their care files.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection in September 2017 we identified that some of the care plans did not contain information about people's past history or their interests. At this inspection we found that this information was still not recorded in people's care pans. Staff were not provider with information about people's religious or cultural needs. Information about people's past history and culture is important for staff when building relationships with people and providing care to people that recognises and respects their wishes and what is important to them.

We recommend the service records people's past social history and interests, cultural and religious needs as well as their involvement in planning their care.

People told us staff asked them about their care needs and how they wished to be supported when they visited. However, care plans did not reflect peoples' involvement. There was no evidence the provider had reviewed people's care plans with them. People's agreement the care and support tasks identified in the care plans had not been recorded.

We recommend the service ensures people consent to receive care and support as described in their care plans is sought and recorded.

People told us their privacy and dignity were respected when receiving personal care and staff were respectful towards them. Although records showed that 'individuality and human rights' was a training topic available to staff, there was no record staff had received this training or been provided with information about treating people with respect and protecting their dignity.

People told us they were happy with the care staff who supported an assisted them. One person said the staff were kind and polite. Another praised the staff saying they were "good at their job". They said, "They have a sense of humour and we have a laugh." They told us how much they enjoyed having a conversation with the staff when they visited. The relative we spoke said his relative "likes them [the staff] very much."

Staff spoke about the people they supported with kindness. One member of staff said, "They're all really lovely." Another recognised how importance their visits were to people as many people lived alone and were lonely.

Inadequate

Is the service responsive?

Our findings

At the previous inspection of this service in September 2015, we rated this key question as 'requires improvement' as the service was in breach of Regulation 17, good governance. The provider had failed to maintain an accurate, complete or contemporaneous record in respect of each service user. At this inspection in May 2017, we found the service remained in breach of Regulation 17 and, in addition, we identified two further breaches of the regulations in relation to this key question.

People told us they received care in the way they preferred as they were able to guide staff about how they wished to be supported. One person said, "They do all they are supposed to do." However, staff were not provided with sufficient information to ensure people received the care and support they needed in a consistent and safe way and in line with their preferences. People's care plans did not describe people's care needs, what care tasks they were able to do themselves and how staff should provide support. People's preferences with regard to their care had not been recorded. Care plans were undated and there was no evidence people had been involved in developing the plan.

This is a continued breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans included a one page summary of each person's care needs. However these contained little information to guide staff. For example, one person's summary said, "(name has various medical needs… which considerably affect his ability to manage day to day activities". The summary did not describe what activities the person required assistance with. This person's care plan lacked detail and contained limited information to inform staff how they wished to be supported. For example, with regard to assistance with personal care, it stated, "I need support in the shower to wash my back and legs as I cannot balance." The timetable for this person detailing what care tasks staff should undertake at each visit stated, "Assist with personal care. Able to make own breakfast" for the morning visit, and "Support in getting ready for bed" for the evening visit. There was no guidance for staff about how the person should be supported safely or what their preferences were.

Another person's care plan sated, "Due to [name's] health conditions he is unable to meet his personal care needs". Staff were provided with little information about how they should assist this person. Their care plan stated, "While showering [name] requires help with washing his back." The plan did state how much the person was able to do for themselves or how they should be supported safely in the shower.

This is a breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection, the local authority had undertaken a review of people's satisfaction with the service they were receiving. Some people had raised concerns over their care and their relationship with the provider. These concerns were being looked into by the local authority outside of this inspection.

Each person receiving support was provided with a Service User Handbook and Guide. This handbook provided people with information about the service's key policies and procedures. However, other than a reference to having access to a formal complaints procedure, people were not provided with information about how to make a complaint. Those people we spoke with said they had a good relationship with the provider and felt they could raise concerns should they have any. One person said, "There is nothing I'm worried about." Two people told us they had raised concerns and the issues had been resolved and dealt with to their satisfaction. We asked the provider to show us how they recorded concerns and complaints. They told us they had not received any. When we asked about the concerns raised by the two people we spoke with, the provider said they did not consider these to be complaints and therefore had not recorded them.

In the service's Statement of Purpose, the document detailing its aims and objectives and the services it provides, it makes reference to making a complaint. It sates, "We do not wish to confine complaints to major issues. We encourage service users to comment when relatively minor matters are a problem…It is our policy that all matter which disturb or upset a service user should be reported, recorded and corrective action should be taken." This means the provider was failing to record concerns raised by service users in adherence with their own policy.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the previous inspection of this service the provider told us they were planning to expand the service and had made management plans to support this. They had systems in place to support staff induction and training; planning visits for a larger staff team; care plan and risk assessment reviews and the management of complaints as well as quality audits. We found these systems had not been put in place prior to the service expanding, or were not sufficiently robust. We found a number of breaches of regulations

The provider did not have an understating of their legal requirements relating to their registration with the Care Quality Commission. The provider was not aware of the implementation of the Health and Social Care Act 2008 which came into force in April 2015. This meant the provider did not have an understanding of the requirements of this Act and where they were in breach. In addition, the provider had given misleading information to the Commission during their application process to register the service.

This is a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection in May 2017, we found the provider was not managing the service in a way that protected people from the risk of harm or from unsafe care. Systems in place had not been effectively implemented to ensure people received safe and responsive care and support. Staff recruitment practices were not safe and staff did not receive training in relation to their role and to support their understanding of people's care needs. Insufficient staff were recruited to ensure people received support from staff in a timely way and at times staff were working excessive hours to provide care. Care plans and risk assessments were insufficiently detailed to provide guidance and information to staff about people's care needs and how to mitigate risks to their health and safety.

Following this inspection we received confirmation from the local authority that they had ceased contracting with Doves Care Services Ltd. All those people supported by the service had been provided with alternative care services. The provider gave us assurances they would not provide a service to any new service users until they had made improvements. They told us they would confirm this in writing however they failed to do so.

The service had a policy regarding internal quality audits. These included reviewing whether risk assessments and care plans been fully completed. We looked at the audit for one of the care plans we reviewed. This audit was last undertaken in April 2016. It showed the care plan had been completed in line with the service's policies and procedures. The provider showed us an audit undertaken in June 2016 of care related issues, such as nutritional, pressure area care and continence reviews as well as risk assessments and care planning. The service assessed itself against a score of 1-5, however there was no indication whether was the lowest score and 5 highest score. The service had scored 5 in all but two of the 28 areas under review and comments made indicated action had been completed to meet all of the requirements. These audits did not identify the issues we found during this inspection with the lack of information and guidance for staff. For example, the internal audit identified nutritional reviews had been undertaken every

three months or when significant changes occurred. We found that no nutritional assessment had been undertaken for the person identified at risk of not eating enough to maintain his health. This meant the internal auditing system was not used effectively to assess the quality of the service and to promote improvement.

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

Shortly before this inspection, the local authority had provided support to the service through its Quality Assurance and Improvement Team (QAIT). They had visited the service to assess and guide the provider about their management practices and quality audits. As a result they developed a service improvement plan which detailed the actions required by the provider to address the shortfalls in the management systems. The provider said they were reviewing their systems to ensure they were used more effectively.

People told us the communication from the service was not always good, although this had improved since the appointment of two office staff. They said at times they not been told when staff were going to be very late and often they did not receive a rota informing them of which care staff were coming to them. The service used surveys to gain people's views about the quality of the service and this issue was raised in the most recently received survey results (August 2016). This showed the provider had failed to act upon people's feedback to improve their service. The provider was confident that with office staff now in place this issue would be resolved. Other comments included un the questionnaires showed people's satisfaction with the service. One person said, "Happy with the service" and another said, "The girls do a marvellous job."