Miss Linda Deazle

D R & C Private Home Care Limited

Inspection report

Shakespeare House
17 Wellington Street
Leicester
Leicestershire
LE1 6HH

Tel: 01162555560
Website: www.drcprivatehomecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
D R & C Private Home Care Limited is a domiciliary care service providing personal care. The service provides support for children 0 – 18 years, younger adults, people with a learning disability and autistic people, physical disabilities, people with mental health needs, older people and people living with dementia. At the time of our inspection there were 6 people using the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Right Support: People were placed at potential risk of harm as staff training practices were not robust. Staff references from current or previous employers were not always sought. Staff shortages meant the manager and sometimes people's relatives were providing support and care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People's individual care and support needs and any known risk had been assessed and planned for. Staff understood people's individual care needs and associated risks. People where required were supported with their medicines. Accidents and incidents were reviewed.

Right Care: People's relatives were positive about the care and support provided to their family member and were involved in discussions and decisions about the care and support. Relatives were positive about the quality of the care, which was provided by a small team of staff, who knew the person well. Staff were introduced to people, and worked alongside experienced staff or the person's relatives so they could get to know people and gain their trust and confidence.

Right Culture: Systems and practices for oversight and governance of the service were insufficient to monitor the quality and safety of the service provided. The system of auditing had failed to identify improvements were need in the recruitment and training of staff. People's views as to the quality of the service were sought, however the focus of feedback was limited to the person's package of care, and did not provide opportunities to seek people's views in order to shape and develop the service.

Relatives spoke positively of the service their relative received, and the person centred care provided. Relatives and staff spoke positively of the manager, and were aware of the challenges brought about due to

insufficient staffing, and the action being taken by the manager to recruit staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 3 May 2018).

Why we inspected
We undertook this focused inspection as part of a random selection of services rated good and outstanding.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for D R & C Private Home Care Limited on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to the oversight and monitoring of the service, staff shortages, and insufficient staff training.

Please see the action we have told the provider to take at the end of this report.

We have made a recommendation that the provider reviews and updates the staff recruitment policy to meet the requirements set out in law so as to support safer recruitment practices and decisions.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

D R & C Private Home Care Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 1 inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 13 November 2023 and ended on 16 November 2023. We visited the location's office on 13 and 16 November 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 5 relatives about the experience of the care provided. We spoke with the manager in person, and 3 members of staff by telephone.

We reviewed a range of records. This included 3 people's care records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including quality monitoring, policies and procedures, and the staff training matrix.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- There were not always sufficient staff employed to meet people's assessed needs and provide their agreed packages of care.
- Relatives were aware of the staff shortages. A relative said, "At the moment we haven't got a carer for 1 day of the week, I know the manager is actively looking for someone." Some relatives had agreed to work with staff as the second carer to support their family member, to ensure their needs were met.
- A majority of staff had not undertaken training to promote people's safety, this placed people at potential risk of harm.
- The staff training matrix showed significant gaps in training. For example, only 24% staff had completed training in moving and handling people, 34% in basic first aid, 31% in food hygiene, and 35% in health and safety.

There were not sufficient numbers of suitably trained staff to meet people's needs. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was actively recruiting additional staff to meet the specific needs of individuals and were themselves providing support and care in response to the shortage of staff.
- The manager had followed the provider's policy for staff recruitment. However, the policy did not fully reflect the requirements as documented in law. This meant, staff records did not contain all the necessary documents and evidence to support robust recruitment practices.
- Satisfactory evidence of conduct in previous employment within the field of health and social care had not been requested. The provider had relied on character references.

We recommend the provider reviews and updates the policy for the recruitment of staff, so as to include and refer to the information required for candidates as set out in Schedule 3 of the regulations which must be confirmed prior to employment.

- Disclosure and Barring Service (DBS) checks had been undertaken. These checks provide information including details about convictions and cautions and held on the Police National Computer. The information helps employers make safer recruitment decisions.
- People were supported by a small team of consistent staff who had been introduced to the person, and their wider family. A relative said, "We have 2 main, regular carers [staff] who have knowledge of autism and sensory deprivation, which is really good."

Assessing risk, safety monitoring and management
● Risks were assessed to ensure people were safe. Staff took action to mitigate any identified risks.
● Relative's expressed their confidence in staff's knowledge of their family member to promote their safety where risks had been identified. A relative told us, "Staff are very observant, if [family members] skin is of concern, they let me know and get it dealt with by the doctor or a nurse. They are very diligent with that."
● Staff supported people when they became anxious or distressed, by following the person's support plan, which identified known triggers for increasing anxiety and how to reduce these.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA.
● People were supported to make daily decisions and choices about their care. A relative spoke of their involvement in the assessment of their family member's needs and development of the care plan, which meant their decisions and choices influenced the care provided.
● Staff were knowledgeable as to people's needs, which meant they were able to understand and respond to people's gestures and facial expressions, which indicated the person's consent to care and respond to their specific requests. For example, a staff member told us how a person picked up a book, and handed it to them, indicating they wanted the staff member to read the story to them.

Using medicines safely
● Where staff were required to provide support with medicines this was documented in their care records. Staff signed a medication administration record when medicine was administered. A relative said, "Staff do the medicines, and that's okay."
● Staff were provided with guidance signed by a health professional and training where they were required to administer medicine in response to specific medical conditions. For example, the administration of medicine when a person had an epileptic seizure.

Preventing and controlling infection
● People were protected from the risk of infection.
● Relatives told us staff wore protective aprons and gloves when providing personal care to their family member. A relative told us, "The staff do wear their PPE (gloves and aprons) and are very careful in what they do."

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
●People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so.
● Staff had completed training on how to recognise and report abuse and they knew how to apply it.
● Staff raised concerns about people's wellbeing and recorded incidents and near misses to the manager, this helped keep people safe.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Systems to monitor the quality and safety of the service needed to be enhanced to ensure all aspects of the service were appraised to support its continuous development.
- The lack of systems to monitor and audit the service meant the manager had failed to meet their legal requirements by ensuring there were sufficient numbers of staff with the required skills and training.
- The provider had not ensured its policy for staff recruitment reflected requirements set out in law to ensure its processes were robust.
- In response to staff shortages the manager was providing personal care and support to people. This restricted the time available to them to monitor the quality and safety of the service.
- People's views and that of their relatives were sought, however the scope and range of questions asked was limited. This restricted opportunities for people to fully comment upon the quality and experience of the care provided and to make suggestions as to how the service could be improved.

Systems and processes had not been sufficiently developed to ensure the effective assessment and monitoring of the service. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Audits had been undertaken in some key areas related to people's care, which included people's care and support plans, medication administration records and accident and incidents. Any shortfalls were identified and action taken to address these. For example, care and support plans had been reviewed.
- The manager had advertised for staff, including an administrative assistant, which they said would enable them to focus upon the management and oversight of the service.
- The manager was receptive throughout the inspection process and spoke of their commitment to improve the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People's care and support was person centred. Staff mostly worked in small teams providing care to 1 or 2 people. Staff's knowledge of people's needs had positive impact on people's experiences of care. A relative told us, "Staff ask what [family member] is having for tea when they come in, so they can talk to them about it whilst they are working." This was of significance as the person they supported was very focused on food,

and what was on the menu.
● Relatives were positive about the quality of the service provided. A relative told us, "It's excellent care, I can't fault it. I am not over praising them; staff do go that extra mile and make sure everything is done."
● A majority of relatives said they felt reassured by the knowledge and understanding staff had about their family member, and the positive relationships which had developed. A family member said, "Staff have learnt to understand [family member], staff take their time, I hear staff laughing and joking with them, they have a nice relaxing way with [family member]."
● The manager had regular contact with staff, and in some instances worked alongside them which provided opportunity for them to review the attitude and behaviour of staff within their work.
● Staff regularly liaised with the manager as to a person's needs, including any concerns or changes in their wellbeing.
● Systems were in place to monitor staffs day to day delivery of care through observed practice undertaken by the manager. Staff said they had opportunities to talk with the manager, and received feedback about their quality of their work. A staff member told us, "The manager is always available if we need support, they're very approachable and supportive."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The manager was aware of their responsibility to keep people informed of actions taken following incidents in line with the duty of candour. They were aware of their legal duties to send notifications when appropriate to the local authority and the CQC (Care Quality Commission).

Working in partnership with others
● The manager worked with local authorities in relation to the assessment and reviewing of people's needs, including children and adult services.
● The manager worked with relatives, to support in the assessment, planning and provision of their family members care.
● The manager had attended seminars about future regulation provided by the CQC.
● The manager had attended provider forums led by the local authority, who provide support and guidance.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems and processes, underpinned by robust policies and procedures were in place to effectively monitor the quality and safety of the service provided.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of staff to meet people's needs. The provider had failed to ensure staff undertook training in a timely manner in topics related to the promotion of people's health, safety and wellbeing.