Derbyshire County Council

Dales and North West Derbyshire Home Care

Inspection report

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Date of inspection visit:
03 February 2020
04 February 2020
06 February 2020
07 February 2020

Date of publication:
14 May 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Dales and North West Derbyshire Homecare is a domiciliary care agency. It provides care to people living in their own houses and flats and within two extra care facilities in the Dales, High Peaks and North West Derbyshire. The service supports younger adults, older people, people living with dementia and people with physical disabilities living in their own homes. Some people received a short-term service following a period of hospitalisation. At the time of this inspection 258 people were 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
The provider did not have a clear overview of the service provided and quality checks were not always completed to improve the service. Quality monitoring was inconsistent and had not identified all the risks to people to ensure people's health and wellbeing. The provider did not always understand the requirements of their registration and had been operating the service from a different address to the registered office.

Some staff had not had the opportunity to undertake the training they needed in order to care for people safely when they were discharged from hospital. Care plans and risk assessments had not always been reviewed to describe the actual care people received. People could retain their independence and manage their medicines. However, where support was given, accurate records were not always maintained to record the level of support people needed.

When people received short term care, care plans were completed from professionals outside of the service. Senior staff did not always review the suitability of their care in a timely manner to ensure this was effective in their home.

People's health needs were met, and they had access to health care and social care services when necessary. People were happy with the staff that currently provided their care and had developed positive and caring relationships with people they clearly knew well. People were concerned the changes within the service would change this.

People made decisions about their care and were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests. People and staff were concerned the new changes would mean established relationships would not be maintained.
Staff had been trained in how to safeguard people from avoidable harm and were knowledgeable about the potential risks and signs of abuse. Safe and effective recruitment practices were followed to help make sure that all staff were of good character and suitable for the roles they performed at the service. The provider

had a complaint's policy and procedure and people were confident they knew how to raise any concerns. There were regular meetings for staff to share their opinions about the service.

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 Requires Improvement (Published 6 March 2019) and there were two breaches of regulation. The provider completed an action plan to show what they would do and by when to improve. At this inspection we found sufficient improvements had not been made.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Enforcement
We have identified breaches in relation to how the provider and the oversight of the service. Quality and safety checks were not always carried out.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Dales and North West Derbyshire Home Care

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 Care Act 2014.

Inspection team
Three inspectors carried out this inspection 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 including supporting older people.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short notice period of the inspection to seek consent from people to a home visit or a telephone call from an inspector. Inspection activity started on 4 February 2020 and ended on 7 February 2020. We visited the office location on 7 February 2020.

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 and professionals who work with the service. We used the information the provider

sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 13 people who used the service and four relatives about their experience of the care provided on the telephone and we visited five people in their homes. We spoke with ten members of staff, seven domiciliary support officers, who organise and review care and are based within the office.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two staff files in relation to recruitment and a variety of records relating to the management of the service.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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.

At our last inspection the provider had failed to ensure staff were suitable trained and administered medicines were recorded accurately. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection we found improvements had been made with how medicines were managed, however further improvements were still needed.

Using medicines safely

● People felt the staff supported them to take their prescribed medicines and applied creams when these were needed. People could choose to manage their medicines and retained independence in this area. However, care plans did not always clearly record who was responsible for administering medicines. For example, one relative told us they were responsible for administering medicines, however, the care plan recorded staff needed to administer these.

● Where people needed prompting to take their medicines, information about the prescribed medicines and support was not recorded. This meant best practice guidance regarding administration and recording of medicines were not followed.

● People had opportunities to have their medicines reviewed. One relative told us, "They've had a medicine review with the nurse practitioner, so we have the right medicines." They told us following the review, their medicines were changed, and new medicine records were provided to ensure staff knew what medicines to administer.

●Where people need support to apply creams, the medicine records included a body map which showed staff where people's creams needed to be applied.

Assessing risk, safety monitoring and management

● Where people received a short-term care package to assist with reablement following discharge from hospital, assessments were completed by the community health or social care professional. One community care worker explained this process supported people being able to move home in a timely manner and avoid delayed discharges. We saw the provider received a copy of the assessment, which care staff told us they collected prior to people starting to receive a service. Arrangements were not in place to re-assess each person to ensure the service could meet their needs. Domiciliary support officers told us it was not possible to visit people within the first three days due to the volume of their work. This meant people may be at greater risk of receiving unsuitable care.

● Where people received a long-term care package we saw potential risks to people's health and well-being was assessed and the care plans recorded the measures to mitigate these. We saw where people needed

equipment to help them to maintain a safe position when sleeping, dignified photographs had been taken to ensure the equipment was used correctly.

Learning lessons when things go wrong

● Staff knew how to record and report accidents or incidents. Accidents and incidents were reviewed to ensure any themes or trends could be identified to keep people safe.

● Contingency plans were in place to ensure the service continued even in adverse weather. The provider had assessed which services for people were critical, in order that these were prioritised in such events. Staff explained that due to the rural location of some people's homes, they had identified where the weather could impact on care delivery and contingency plan were in place.

Systems and processes to safeguard people from the risk of abuse

● The staff had received training and understood how to report their safeguarding concerns to prevent the risk of future harm. Where concerns had been identified, these were documented, and referrals made to the local safeguarding team. This meant these could be suitably investigated and measures put in place to ensure people's safety.

● The registered manager notified us of where potential safeguarding concerns had been raised, as required.

Staffing and recruitment

● People, their relatives and staff felt there were enough staff available to meet people's needs. Where people received a long-term care package, they told us they currently received their care from a small team of staff who they knew well.

● Recruitment checks were completed to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service.

Preventing and controlling infection

● Staff understood how to maintain suitable infection control standards. People told us the staff used protective clothing and equipment when providing their care and disposed of these following each use.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The service was being developed to provide people with care following a period of hospital care. Staff explained this reablement care meant supporting people to regain skills to be more independent and supporting them during recovery. Not all staff had received reablement training care to have the necessary skills and knowledge to keep people safe and staff were concerned that this had an impact on the care they provided. Staff also felt that training to enable them to use the new work phones was not sufficient and some staff were not confident when using these.
- New staff completed an induction at the start of their employment which included training about how the service was managed. They shadowed experienced staff before working alone. Staff told us this meant they could gain confidence and the management team could check they could work alone safely.
- The staff felt supported and told us they received regular supervision meetings. The meetings provided feedback about their performance and had opportunities to discuss their performance and training needs.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Where people needed support for a long-term care package, we saw their needs and choices were assessed before they started to receive a service. People told us they were involved with developing their care plan which included information about how they wanted to receive their care, to ensure staff understood how they wanted to be supported to stay safe.
- Assessments of people's needs included information about protected characteristics under the Equality Act 2010. For example, people's marital status, religion and ethnicity was recorded. This was important information to ensure people did not experience any discrimination.

Supporting people to eat and drink enough to maintain a balanced diet

- People retained responsibility for shopping and staff supported people to prepare and eat meals. Where it had been agreed as part of the care package, people's care plans contained information regarding how they needed to be supported.
- People felt the staff supported them to eat with care and staff had the necessary skills to prepare their meals. A record of meals served was maintained to ensure checks were made that people had eaten any meals and drinks that were left for them between visits.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The staff worked in partnership with people, their family and professionals to ensure where people needed

equipment to support them to move, an assessment was completed, and necessary equipment provided. A moving and handling assessment was completed, and staff told us this was reviewed to ensure it matched how people wanted to be supported.

● Where people's needs changed, the staff liaised with relevant health care professionals and people told us there was good communication.

● When people were unwell , the staff sought emergency care and stayed with them. Systems were in place for staff to alert the office so future support calls could be reorganised. Staff told us they were able to stay with people until emergency medical treatment had been sought.

Ensuring consent to care and treatment in line with law and guidance

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 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People made decisions about their care and told us the staff listened to what they said and respected their wishes. Staff explained that people currently using the service had capacity to make decisions and a record of their involvement was recorded within the care plans.

● Where people lacked capacity, staff understood how to act to ensure decisions were made in their best interests. Assessments were available to complete; staff understood these would be decision specific and would involve relevant people to any outcome and decisions to ensure these were made in people's interests.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Care plans and effective management systems were not in place to ensure people had safe effective care. We have taken this into consideration when considering the rating in this area.
- Where people received a long-term care package, they told us they received care from a consistent team of staff who they knew well and had developed close relationships with. One person told us, "They are like family. We are very happy with the service." However,

the provider was in the process of changing how support calls were arranged; a dedicated scheduling team now organised people support visits and staff and people were concerned this would have an impact on the consistency of the staff who provided their care. Staff explained that scheduling used to be patch based but the patch boundaries were no longer used and scheduling was across a wider area.

- People felt the staff who currently provided their care, were kind and caring and nothing was too much trouble for them. One relative told us, "It doesn't matter what you want, they are always happy to do anything."
- People spoke positively about the support they received and the relationships they had developed with staff. One person told us, "The staff are always happy, not miserable and it's lovely to hear them singing together." A relative told us, "The staff are caring, professional and friendly. You can always hear laughter when they are together."

Respecting and promoting people's privacy, dignity and independence

- People were encouraged to remain as independent as possible. For people receiving short term care, they told us their main aim was to regain their independence and continue to live in their own home. The service was changing to focus on providing short term care. However, staff were not always confident they had the skills they needed to support people when they left hospital.
- People felt the staff respected their dignity and respected their right to privacy
- Staff respected people's homes and personal property and had the necessary equipment to enhance their independence.

Supporting people to express their views and be involved in making decisions about their care

- When organising support, the provider considered people's preferences. The provider had an equality policy and staff understood that people's support was based on their individual needs. For example, people were asked about the gender preferences of staff when providing people's personal care, and their wishes were respected.
- The staff listened to any decisions people made about their care and understood when people wanted

help and support.

● When people received long term care, they told us new staff were introduced to them and they were able to decide whether they wanted to receive their support. People told us this helped develop good relationships with staff who they trusted and could express their views.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Some people continued to use the service following the short-term care arrangements. and their care was not always reviewed. People had a short-term care plan following discharge from hospital; however we saw after a period of reablement, this did not always reflect the care people needed and the care plan had not been reviewed to reflect people's current support.
- With the introduction of the news scheduling system, people told us they had not received a care roster. This meant they did not always know who would be providing their support and when.
- People were included in developing their care plans and where reviews took place, they felt that staff listened to them and their views were reflected in the care plan. People told us they discussed the support requested, and the times of the support visits was agreed with them.
- A new system had been developed which monitored whether staff arrived to deliver people's care. Where there was a delay of over thirty minutes, checks were made to ensure staff were safe and to potentially organise additional support for people who were waiting for a service.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care plans contained information about people's communication needs. The provider was knowledgeable about their responsibilities to ensure information was provided to people was in an appropriate format, to enable them to read and review it. Information about the service was available in different formats, including easy read and could be translated to different languages to ensure all people had this information in an accessible format.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to pursue activities and interests that were important to them or were helped with their shopping and cleaning. The provider arranged services for people to be supported with their interests or to support people when out; for example, when shopping.
- Care plans included information about when people needed support to go out or needed assistance to travel to appointments. One relative explained that staff helped them to meet with friends, go the doctors and hospital appointments and appreciated their support.

Improving care quality in response to complaints or concerns

● People were confident their concerns would be responded to and knew how to make complaints if needed. One person told us, "If anything was wrong, I'd get in touch with the office staff and they'd sort it." Another person told us, "I don't think anything could be any better. I'm really happy."

● Systems were in place to manage and respond to complaints. Where any complaint was received, these were investigated, and people were advised of the outcome an any changes or improvements.

End of life care and support

● There were no people receiving end of life care, however, people were supported to express their views about how they wanted to be supported towards the end of the life. Care plans included information about people's references including, their wishes following their death.

Inadequate

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to embed suitable systems to ensure the service was reviewed and identify where improvements could be made. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Quality monitoring systems were not effective. The registered manager was aware of their responsibility to enter management information into the provider's electronic system in relation to audits. However, there was insufficient oversight of this information. Concerns had been raised by us in other services managed by the provider; we saw there was not an agreed approach to reviewing and comparing management information across the provider's locations to identify risk and areas for development.
- Suitable systems were not always in place to review how people received their care. We saw care plans were not always reviewed and did not reflect the care people needed. People did not always receive care for the agreed amount of time. Staff recorded when they started and finished supporting people, although this was not always monitored to ensure people received the care they were commissioned to receive.
- The provider had introduced a new system to schedule calls. The system had been operating alongside the old system to ensure this was effective. However, the new scheduling system was introduced on the day of our inspection, and we saw this was not effective. Staff were unaware of who they needed to support the following day and office staff were needing to reorganise and duplicate care support rotas to ensure people received their care. In addition, the new systems were internet based; some staff lived in rural parts of Derbyshire and had limited or no access to a reliable internet connection and could not access this information on their new work phones.
- People told us they hadn't had a roster detailing which staff would be providing their care over the last weeks; this meant they hadn't known what time their visit was planned for and which staff would be supporting them.
- Staff did not feel confident that they understood how to use new equipment and felt the training and support from the provider had not given them the skills and knowledge needed to understand how to

access to their care roster. One member of staff told us, "It's very chaotic and the service doesn't feel ready for the changes."

● Medicine management systems had not been sufficiently developed to ensure best practice guidelines were followed and a comprehensive record of medicines were recorded.

● Concerns were raised that where people had received care from consistent staff, this may not continue to be provided as the new scheduling system did not consider local knowledge of rural locations when planning people's care. One member of staff told us, "The rotas don't make sense as the schedulers don't know the area. We have to keep swapping with colleagues, then rearrange and contact the scheduler."

● The provider had reviewed their service provision and was moving towards providing more short-term care for people following a hospital stay. However, they had not provided staff with the necessary training to understand how they should provide this support effectively.

● Systems were not in place to ensure care packages were reviewed in a timely manner following discharge from hospital to ensure people's safety.

● The provider and registered manager were not always clear about regulatory requirements. We found that the service had been operated from different offices to the office that was registered with us. The provider acknowledged this and has now made arrangement to change the registration of the service to ensure it is correctly and suitable registered.

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

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

● People had been informed of changes within the organisation and knew that services may change. Where people had received long term care from consistent staff, people were concerned about the potential impact on the care they would receive.

● The staff felt supported by local office staff and the registered manager. However, staff were concerned that the provider had not listened to their views about not receiving reablement training or confirmed how confident they were to use new equipment. Although the new systems had been used alongside existing systems, staff felt the timing was not suitable and assurance had not been made that the new system was suitable.

● The registered manager understood their responsibility to inform us of significant events, such as safety incidents, in accordance with the requirements of their registration.

● Staff meetings were held to discuss people's care needs and to make suggestions for improving their care. Staff felt the registered manager and domically care officers listened to their views and provided continuous support.

Working in partnership with others

● The registered manager and staff worked in partnership with other agencies when services were provided. One community professional told us there was good communication when people were discharged from hospital to ensure people were able to return home.

● Where people received support from health care professionals, staff communicated any changes to ensure new equipment could be provided to keep people safe.

● A new dementia support group was being organised to support people living with dementia in the community. Staff explained they had been liaising with community groups to develop links and make arrangements for people to use community service to prevent social isolation and for people and their family to receive emotional support and guidance.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established or operated effectively to ensure the registered person assessed, monitored, and improved the quality of the services provided.

The enforcement action we took:

We issued a warning notice.