Dolphin Care (IOW) Limited

Dolphin Care (IOW) Limited

Inspection report

Willowbrook House
Appuldurcombe Road, Wroxall
Ventnor
Isle of Wight
PO38 3EN

Tel: 01983853478

Date of inspection visit:
10 March 2017
20 March 2017
21 March 2017

Date of publication:
19 October 2017

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

Summary of findings

Overall summary

Dolphin Care (IOW) Limited is registered to provide personal care and the treatment of disease, disorder and injury to people living in their own homes. At the time of our inspection they were supporting 33 people.

The inspection was announced and was carried out between the 10 March 2017 and the 21 March 2017 by two inspectors. The provider was given two days' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

There was a registered manager in place at the service, who was also one of the providers. 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.

People and their relatives told us they felt safe while being supported by care staff. However we found that the risks relating to people's health and wellbeing, such as the risk of falls or pressure injury sores had not been documented to help staff understand those risks and the action they should take to help reduce them. Risks relating to people's home environment were also not always identified and documented.

People's medicines were not managed safely. The records relating to peoples medicines were not always accurate and up to date and staff did not always follow best practice guidance in respect of administering topical creams.

There were insufficient staff to meet people's needs. This led to staff not staying with people for the length of time they had been assessed as needing. For calls where a person had been assessed as requiring two members of staff, there were occasions when only one staff member attended to support the person. The registered manager/provider did not have a robust recruitment process in place to ensure staff were suitable to support the people using the service.

The registered manager/provider failed to identify safeguarding concerns relating to people using the service and to notify the appropriate authority. Health professionals were not always called when concerns were raised in respect of people's health and wellbeing.

The care provided to people using the service did not always reflect their preferences and individual care needs. Care records did not contain information about people's likes, dislikes or how staff should support them in an individual way or how they preferred. Risks relating to people's food and drink needs were not always managed effectively

People's records of care and the records regarding the management of the service were not always accurate or up to date.

The registered manager/provider did not have an effective system in place to monitor the quality and safety of the service provided.

The registered manager/provider did not fully understand their responsibilities under their registration with CQC as a registered manager.

The registered manager/provider did not always take action to ensure that people felt supported and valued.

Staff developed caring and positive relationships with people and treated them with dignity and respect. Staff understood the importance of respecting people's choices and their privacy.

Staff received an appropriate induction and on-going training. However, training was not always available to enable staff to meet the specific needs of people using the service.

Staff sought verbal consent from people before providing care and were aware of legislation designed to protect people's rights.

People and when appropriate their families were involved in planning their care.

The provider sought feedback from people or their families and had arrangements in place to deal with complaints.

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.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During our inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks relating to people's health, wellbeing and their environment were not documented and action to reduce those risks were not identified.

People's medicines were not managed safely and staff did not follow best practice guidance in respect of administering topical creams.

There was insufficient staff to meet people's needs leading to shortened calls and only one staff member attending calls where two care staff are required. The recruitment process was not robust.

The registered manager/provider failed to identify safeguarding concerns relating to people using the service and to notify the appropriate authority.

Is the service effective?

Inadequate

The service was not effective.

People's food and drink needs were not always managed effectively and health professionals were not always called when health related concerns were raised.

Staff were not always protected from risks when providing a service to people in their homes.

Staff received an appropriate induction and on-going training. However, training was not always available to enable staff to meet the specific needs of people using the service.

Staff sought verbal consent from people before providing care and were aware of legislation designed to protect people's rights.

Is the service caring?

Requires Improvement

The service was not always caring.

The registered manager/provider did not always take action to ensure that people felt supported and valued.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices, their privacy and helping them to remain as independent as possible.

People and when appropriate their families were involved in planning their care.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not received care that had been assessed to meet their individual needs. Care records did not contain information about people's likes, dislikes or how staff should support them in an individual way.

The provider sought feedback from people or their families and had arrangements in place to deal with complaints.

Is the service well-led?

Inadequate

The service was not well-led

People's records of care were not always accurate or up to date. Records regarding the management of the service were not always accurate or up to date

The registered manager/provider did not have an effective system in place to monitor the quality and safety of the service provided

The registered manager/provider did not fully understand their responsibilities under their registration with CQC as a registered person.

Dolphin Care (IOW) Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was announced and was carried out between 10 March 2017 and the 21 March 2017 by two inspectors. The provider was given 2 days' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

Before the inspection we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also received feedback about the service from a stakeholder.

During the inspection we visited and spoke with four people using the service and with three of their relatives and a friend. We spoke with six members of the care staff, the deputy manager and the registered manager who is also the provider.

We looked at the office based care plans and associated records for 10 people using the service and four care plans in people's homes. We also looked at four staff duty records, records of complaints, and records relating to the running of the service.

The home was last inspected in July 2014, when no concerns were identified.

Inadequate

Is the service safe?

Our findings

People told us they felt safe while being supported by care staff. One person said they felt, "safe, bless their hearts; like having friends and neighbours". Another person told us, "I feel safe when [member of staff] is there. She knows what she is doing". A third person told us they felt safe and "When they [staff] come round they shout 'only me' so we know they are here". A family member said they felt their relative was safe. They added, "If I didn't think she was safe I would report it".

However, people did not always experience safe care and treatment because risks to people's health and wellbeing were not always identified and managed safely. People's risks were not always documented and available to support staff in understanding those risks and how to manage them. For example, the care checklist for one person was ticked to show they had poor balance, under 'action to be taken' it stated 'Parkinson's aware'. There was no information in the rest of the care records, including the person's plan of care to help staff understand how to support this person safely. A family member told us, "[My relative] has a habit of falling on the floor in the morning as he can be a bit wobbly". We looked at this person's care plan which contained no information regarding his mobility or his risk of falling. Their care plan 'falls assessment' had not been completed and there was no falls risk assessment in place. A member of staff described how they supported this person to mobilise. They confirmed that the information was not in the person's care plan and said, they "just do it due to personal experience". They then told us they were aware that the person had had a number of falls, "because of what his wife tells me and he tells me and the book [entries other staff had made in the daily record of care book]".

The records for another person who was cared for in bed contained no risk assessments. We identified that this person was vulnerable and at risk of developing pressure injuries; risks related to the use of bedrails; and of developing urinary tract infections. The records of care provided no information to identify these risks or help staff to understand how to manage them. There was also no environmental risk assessment for the person's home. The registered manager/provider told us the person had [wild] mice running loose in their home and because the person "liked them"; staff put corn in the kitchen for them so they will leave the rest of the food alone. The registered manager/provider told us they felt "there was no health risk".

We also found that risk assessments were not in place for other people who were also at risk of falls, pressure injuries and the risks related to the use of bedrails. We raised our concerns regarding the lack of documented risk assessments with both the deputy manager and the registered manager/provider. The deputy manager told us "We do risk assessments but I don't write them down". They added staff were aware of all of the risks, "Because I've told them". The registered manager/provider told us that all staff had been given a copy of 'pressure area care guide for patients'. They also said that staff had been directed to a poster on the wall of the office in respect of managing risks related to bedrails. We saw this poster was by the Medicines and Healthcare Products Regulatory Agency dated 2008. Since the inspection we have confirmed this poster was out of date with the latest version being published in 2013.

Where staff identified a concern they documented it in the daily record of care book and contacted the office. These books were text book size and kept in people's homes until they were full. The registered

manager/provider told us it can take up to nine months before the book is returned to the office. We raised the concern that people could be left at risk because the member of staff may not have informed the office. The registered manager/provider told us that they were confident that their staff would always inform her of a concern. They added that they and the deputy manager always checked the books when they were attending a person's home to provide care but they were unable to evidence this practice.

The failure to ensure that risks to people's health and wellbeing were identified and acted upon; and the failure to ensure risk assessments relating to people's health, safety and welfare were completed is a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the support they received from staff to take their medicines. One person said, "They [care staff] know the medication I need and exactly what I want".

However, the management of people's medicines by the service did not always ensure that they received their medicines safely. Care staff who supported people with their medicines and administered topical creams had received appropriate training, however their competency to support people with their medicines had not been fully assessed to ensure their practice was safe. We raised this with the deputy manager who was unable to provide any evidence that staff competency to support people with their medicines had been assessed. They told us the assessment was part of the training, which was classroom based.

Staff used a 'Medication Monitoring Diary' to indicate when staff had supported people to take their medicines or when topical creams were applied. Staff were required to tick a box when they had supported a person to take their medicine or applied topical cream and then initial the sheet to confirm the entry was correct. All of the 'Medication Monitoring Diary' forms we looked at had gaps which were not signed. This meant the registered manager/provider could not be assured whether the person had taken their medicine or had cream applied. We raised this with the registered manager/provider and the deputy manager who told us the gaps were where family members had given the medicines or applied the creams.

The deputy manager told us they did not carry out any medicine audits and the spot checks of staff delivering care did not include how they supported people with their medicines. We identified the risk of care staff failing to correctly fill out the 'Medication Monitoring Diary' when they had supported the person to take their medicines or administered a topical cream and the registered manager told us, "I know my staff and they wouldn't do that". We looked at the 'Medication Monitoring Diary' for one person who had just received care. We found that on the day prior to our visit the Diary had been ticked to show creams had been applied but not initialled to confirm the entry was correct. The diary entry for the day of our visit was blank. We spoke with the person who told us care staff had applied all of their creams.

The registered manager/provider told us that care staff supported people by applying unprescribed topical creams if they were asked to do so by the person or their family, without seeking medical or pharmacy advice. One elderly person's care plan stated that they required two topical creams to be applied. However, their 'Medication Monitoring Diary' for February 2017 identified that staff were applying four different creams, including one cream which had been hand written on their 'Medication Monitoring Diary'. We asked the registered manager/provider about this cream, which was a local analgesic with the warning 'to talk to your doctor before using if elderly'. They told us they had suggested the cream to the person because the person was complaining of painful joints. The registered manager/provider was not able to confirm whether they had sought advice from a pharmacist or medical professional before using the cream and told us they had suggested it, "because it had worked for me". The 'Medication Monitoring Diary' confirmed that staff had been administering the cream regularly since at least the 03 February 2017. An entry in the care history

for this person dated 27 February 2017 following a visit to the person by a GP stated '[name of cream] will now be put on prescription'. The registered manager/provider had also recommended the same cream to another person; the registered manager/provider told us they had, "tried [name of cream] for a few days [on the person] to see if [the person] any reactions or if allergic [to it]". They said, they had continued to use it in this way until it was prescribed by their GP. A member of care staff said, "Yes I would put creams on even if they are not prescribed if they ask me to; cream they or their family have brought". They added "I did just that this morning with [named person]". They also told us, "If I am not sure [which cream to use] I will ask [the deputy manager]. Last week I asked [the deputy manager] which cream was best for a rash and she said sudocrem". They added, "If [a medicine] is not on their medication [record] and [their relative] asks me to give them a tablet, you do. Then write it in the book". People were at risk of being treated with medicines or creams that were not safe for them to use because the service had not in all cases checked they were appropriate to use by speaking with medical professionals or ensuring they were prescribed.

Records relating to people's medicines were not always accurate and up to date. Staff supported one person to take two medicines during their morning visit. The care records for that person contained a 'Client Medication Information Chart' dated 2013. This form listed six difference medicines four of which had been discontinued for over a year. The person's care records did not contain any information in respect of the two medicines staff were supporting them to take.

Three members of staff had been trained by a nurse to give a person an injection. However, there was no risk assessment or information in the person's care records regarding this injection. For example, details of when and where on the person the injection should be given; any special information such as to be given before or after food; or any possible side effects. We raised this with the registered manager/provider who told us that would have been covered during the training. By the second day of our inspection they had obtained a patient information leaflet for the medicine from the person.

The failure to ensure that medicines were managed safely is a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was insufficient staff to meet people's needs. We looked at the staffing schedule for 6 March 2017 and identified eight occasions where staff were allocated no travel time between calls. We checked people's addresses on the internet which identified a travel time of up to 14 minutes between calls. This pattern was reflected on other days during the week. This meant that staff were continually late to some calls and always rushing. One member of staff told us, "Don't always give travel time and that is an issue. If you have to go far away, you're chasing your tail all the time. So it's a problem I try to remain calm, but if you have lots of traffic lights and roadworks can be stressful". Another member of staff said, "Sometimes the time with a client isn't long enough and some you can finish early; that's where you get the overlaps". A relative said, "Sometimes they [staff] can be late; it's the traffic. If they are going to be late they let us know". We also identified a significant number of occasions where staff did not stay the full amount of time people had been assessed as needing. For example one person was assessed as requiring staff to support him for an hour to ensure his needs were met. We found a number of occasions when staff had been scheduled to attend for less than the assessed time. The person's relative also gave us other examples where staff had left early. The said, "Some days they [staff] just flit in and out. When they are busy or someone goes sick; you have to accept that". We identified an occasion from the person's record of care when staff had left after 30 minutes. The relative told us, "I know they were having problems someone had gone sick". They added "Yes that was a bad day". We looked at the daily record of care for another person where staff had recorded 'During putting on [continence] pad tore [right] side so put pad underneath to protect area where torn as not enough time to put on new pad'.

The schedule also identified a number of occasions where a person had been assessed as needing the support from two staff, where only one member of staff was scheduled to attend or one of the members of staff was scheduled to leave early. On another occasion a member of staff had been allocated to attend two different people at exactly the same time. A member of staff told us there was, "Not enough staff; lots of pressure to cover extra calls". They added "Some calls should be two people but where they are short can quite often cut down to one person to cover call". They gave an example of one person who had mobility problems and told us, "She is supposed to be a two carer call but often you are on your own".

Both the deputy manager and the registered manager/provider are regularly involved in providing care, which takes them away from the management side of their roles. The registered manager/provider told us that staff absence was mainly covered by themselves and the deputy manager. They added "Occasionally staff will do overtime". The registered manager/provider told us that some staff would be leaving in April with the loss of 60 hours which would have to be covered by themselves and the deputy manager until they could recruit additional staff. A member of staff told us, "There is a good team of girls but the office isn't always good. Sometimes management is overworked. They are out doing care so things don't get done". Another member of staff said the registered manager/provider was, "still taking on extra calls, spreading them self too thin. I'm like please don't take on any extra clients". During the inspection we observed the registered manager/provider discussing "squeezing them in" during the afternoon period with potential clients.

We raised our concerns with the registered manager/provider and the deputy manager. The registered manager/provider told us, they didn't take on 15 minute calls but with agreement they assess the person as a 30 minute call. They said, "So the girls do the care they need to do and then leave". They told us they had an agreement with the local authority that where calls are shortened they could still charge the full amount. They said, "It was swings and roundabouts as sometimes the girls stay longer". They were unable to show us a copy of this agreement.

The failure to ensure there was sufficient numbers of staff deployed to meet people's needs is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager/provider did not have a safe and effective recruitment process in place to help ensure that the staff they recruited were suitable to work with the people they supported. Disclosure and Barring Service (DBS) checks were completed on all staff before they commenced work. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. However, the records identified that the registered manager/provider had not met the recruitment requirements with regard to obtaining satisfactory evidence in respect of new staff's conduct at previous employments. All of the staff recruitment files we looked at contained gaps in staff employment history, which had not been explored by the registered manager/provider or the deputy manager. One member of staff had been employed when only one reference had been received. The deputy manager told us they were sure there was a second reference but could not find it.

The failure to ensure there was a robust recruitment process in place meant that the registered manager/provider could not assure themselves that the staff they recruited were suitable to work with the people they supported. This is a breach of regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from abuse because systems and processes designed to protect them did not operate effectively. All of the staff and the registered manager/provider had received training in safeguarding and told us they knew how to raise observed concerns. However, we found a number of

occasions where people were experiencing potential abuse, which had not been identified, acted upon or reported to the appropriate authority. One person who was at risk of pressure related injuries had started to develop a sore patch on their skin. This was identified by care staff however the person declined assistance from the district nursing team. Care staff treated this sore with topical creams under the advice of the registered manager/provider. The wound deteriorated over a period of six days and was described as 'cracked' and 'weeping'. The person continued to decline assistance from the district nursing team. The registered manager/provider did not identify this concern as potential self-neglect and report it to the appropriate authority.

Staff missed the lunchtime call for another person, which meant they missed their medication and their lunchtime meal. A family member told us, "We never even got a phone call". The deputy manager told us this was a scheduling error, however, they did not record this missed call as a safeguarding concern or raise it with the appropriate authority.

The failure to protect people from abuse and have effective systems in place to identify, investigate and report instances of abuse to the appropriate authority is a breach of regulation 13(1) & (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection all of the concerns highlighted above have been reported to the local authority adult safeguarding team.

Inadequate

Is the service effective?

Our findings

People and their families told us they felt care staff understood their needs and had the skills to support them. One person said, they received care from the registered manager/provider, who "knows what she is doing; [Registered manager/provider] is very good". A family member told us, staff "understands [my relative's] needs; what [my relative] is going through". Another family member said, the "[Registered manager/provider] came out and did an assessment of [my relative's] needs".

However, we found that people were not always supported to maintain good health because health professionals were not always called when concerns were raised. One person's daily record of care stated that, '[the person] says she feels a little breathless today'. The record did not contain any information in respect of any action taken by staff. We asked the registered manager/provider what action they had taken regarding this incident and they told us, if "staff ring in to say she is breathless; I say 'is she breathless'; if they say no [she does not visibly appear breathless], I say 'note it down and do nothing". A further entry in the record of care, four days later stated '[The person] quite breathless again this morning'. This record did not contain information regarding any action taken. We raised this incident with the registered manager/provider who told us that, "the girls would have told [a family member]". They agreed they could not confirm that any action had been taken. A further entry in the person's record of care stated there was 'blood present in commode from piles'. The registered manager/provider told us that staff would have called the GP. They were unable to show us any evidence to demonstrate that a health professional had been informed. The registered manager/provider subsequently told us that, "[a family member] has told us we can't call a doctor and have to go through her". The registered manager/provider was not able to provide any evidence to confirm that a member of the person's family had been informed of the concerns.

The failure to ensure that concerns regarding people's health and wellbeing were identified and an appropriate health professional informed is a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records of care did not always contain sufficient information about people's nutritional and hydration needs to allow staff to support them safely. The nutritional assessment for one person who was diabetic did not contain any information to help staff understand how to support the person with their dietary needs effectively. Another person's risk assessment checklist was ticked to indicate that they did not drink enough. Under 'action to be taken' it stated 'encourage fluids'. There was no information in the rest of the care records, including the person's plan of care to remind staff of this risk or the need to ensure they remained hydrated. Staff told us about another person who was cared for in bed and was at risk of at risk of poor hydration. One member of staff said you have, "Got to monitor her food to make sure it is not out of date. All we do is refresh her drinks; make sure you push fluids cause of UTI [urinary tract infections]". Another member of staff told us the person was at risk of malnutrition and dehydration. They said "Got to encourage her to eat and drink". We looked at this person's care records and found they did not contain any information regarding their nutritional and hydration risks or information to assist staff in understanding how they should support them with their nutritional and hydration needs.

The failure to have effective systems and processes in place to ensure that people's records in respect of their dietary needs were contemporaneous and complete is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people who required support with their food and drink told us they were happy with the support they received. One person said, "They [staff] cook me egg and bacon [for breakfast]. They say that's what they usually do. I am happy with that". They added they were having "Jacket potato for my lunch". Staff offered people a choice of what they wanted to eat and drink.

Staff told us they did not always feel supported by the management team. They told us they were required to support one person who continually displayed inappropriate sexual behaviour towards female staff. Staff described the behaviour they were subjected to and how it made them feel, this behaviour included inappropriate sexual comments and inappropriate physical touching. Staff had reported their concerns to the registered manager/provider and the deputy manager. However, they are still being scheduled to support this person without any safeguards being put in place to protect them.

The failure to ensure that risks relating to the safety of staff were monitored and action was taken to mitigate those risks is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had received an induction into their role. Each member of staff had undertaken an induction programme which included classroom training and a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff who were new to care completed an induction which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The care certificate was also available to staff with care experience if they chose to undertake it. One member of staff told us, "I have a care background but did the care certificate as a refresher".

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This only included essential training, such as moving and handling, safeguarding, medication awareness, first aid awareness and infection control. Staff were also supported to undertake a vocational qualification in care. However, staff did not always have access to other training focussed on the needs of the people using the service. One member of staff told us they were, "Not happy with the training. I have been asking and asking for diabetes training as a number of our clients have it but they just say we will arrange it in the future but never do". Another staff member's record showed they had previously completed end of life training and dementia awareness training. Another member of staff told us, "Training has made me more aware of things; helps me understand people are different and how to help them. The more confident you are, the more they are confident in you and feel trusted".

Staff had received at least one supervision during 2016. We saw that the previous supervisions had been completed in 2013. The registered manager/provider told us they had "slipped" due to their absence from the service but had now been "re-started along with annual appraisals". Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. The deputy manager had conducted spot check competency assessments in people's homes to ensure staff were appropriately skilled to meet people's needs. One member of staff told us they felt their supervisions were valuable to them and said, "You can put views across and the feedback is nice as well". Another member of staff told us, they had just had a spot check with a new client. They said, "You'll be there and [the deputy manager] would just turn up to see what you are doing. Speak to the person, look at the book and give you feedback straight

away, 'like that was good'; sometimes [the deputy manager] will tweak little things. She suggests ways to be more efficient". They added that "Supervisions are getting back on check". Records showed that when concerns were identified during a staff spot check such as, inappropriate finger nails or no name badge, this was recorded and the deputy manager took action to resolve the concern.

The registered manager and staff had received training regarding the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. The registered manager told us that none of the people they were supporting lacked capacity to make decisions. The registered manager/provider and deputy manager were scheduled to refresh their MCA training in April 2017.

People told us that staff sought their consent before providing care. One person said, "We have a chit chat and get on very well. If I don't want to do something they say okay". Another person told us staff do "what I want; check what I would like". Daily records of care showed that where people declined care this was respected. A member of staff told us, "I always ask first. It is common courtesy to ask. If they don't want to do something that is their choice". Another member of staff said, it's "[their] choice; what [they] do. So if [they] didn't want a wash I wouldn't force [them] but write it in the book".

Requires Improvement

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person told us, "They do a lot of little jobs; carry the washing out, do some cleaning". Another person said, "They go the extra mile and went shopping for me". A third person told us, "We have a nice chat". A family member said, "Very good, we couldn't do without them. Nothing but praise". Another family member told us, "They [staff] are very patient and give [my relative] a bit of encouragement but don't rush him. They are very kind". They added "They do the little extra, like dropping me off at [a supermarket]". A friend of one person said that staff were "Very good; couldn't be better; kind, caring, loving; go beyond the call of duty. Best thing since sliced bread". All of the people we spoke with said they would recommend the service to friends and family.

However, the registered manager/provider did not always take action to ensure that people felt supported and valued. Staff were not always rostered to stay with people for the length of time they were assessed as needing; staff were not always allocated travelling time between calls, which meant they were rushed and arrived late; and people assessed as requiring support from two people were scheduled to receive care from one member of staff. People's records of care did not always provide staff with information regarding their personal histories and preferences to enable staff to understand people's likes, dislikes and how they wanted to be supported. We raised these concerns with the registered manager/provider, who accepted the records were incomplete and that people did not always receive the support they had been assessed as needing.

People were supported by staff who understood the need to respect people's privacy and dignity. One person, who was supported by the registered manager/provider, told us they "treat me with respect and kisses me goodbye. The [registered manager/provider] is like a friend". Another person said, "I feel confident with them so I don't mind getting undressed". A family member told us, staff supporting their relative, "Treat [my relative] with respect and dignity. You would think they have known each other for years; she has only been coming [for a few months]". Another family member said, "They make sure [my relative] is warm and covered". One person's care records stated 'Please cover with brown cover to keep warm when being washed as feels the cold'. We spoke with this person who confirmed that staff always covered her with the brown cover when completing personal care.

Care staff told us how they would maintain the person's privacy and dignity when providing personal care to people. They explained that this would be done by closing curtains and doors and ensuring people were covered with a towel when having a wash. One member of staff said, "Cover with towels. Shut curtains and ask, like do you want your top done first. I avert my eyes as much as possible and talk to them". Another member of staff told us, "I ask [them] if okay to get washed or dressed; offer [them] a choice of clothes; explain what we are going to do. Keep a towel over [them] for privacy". Staff understood the importance of respecting people's choice. One person said, "The first thing they ask is whether I want a wash or a shower". They added "They automatically know the clothes I want as they are put out ready but I can change my mind if I want to".

During our visits we observed staff engaging with people in a positive way, encouraging them to remain as

independent as possible. One person told us, "They like me to do what I can and then they'll do the rest". We heard staff offering a person they were supporting a choice of how they wanted to be supported. They said, "Which way would you like to roll. This way or the other?" and then check whether the person was comfortable before they started providing care.

People, and when appropriate their relatives, were involved in developing their care plans. One family member told us, "The [deputy manager] comes out, goes through the care plan and makes sure it's okay". Another family member said, "[My relative] can't stand at the moment. My sister and I help out [with providing her care]. We wanted to do that. It was one of the reasons we went with [Dolphin Care (IOW) Limited], so we could help, as we wanted to be involved in [my relative's] care". A third family member told us staff, "Keep me informed of [my relative's] health or any concerns but in truth I am always here".

Requires Improvement

Is the service responsive?

Our findings

People were at risk of not receiving care that was personalised and responsive to their needs. The registered manager/provider had not fully engaged with the people they supported or their families to make an assessment of their preferences and needs. People's care records did not always contain guidance, which described people's routines and provided care staff with detailed information of the exact care people required at each visit. Nor was there any information in respect of people's likes and dislikes or their personal histories to help staff to understand how to support them in a way that they would prefer. For example, what they like to eat, whether they prefer a bath, shower or wash, or how people prefer to be supported when mobilising. One person's care records stated they need assistance from the bedroom to the bathroom but did not explain what assistance and how staff should support the person to mobilise. Another person's care records stated they were allergic to penicillin. However, there was no information regarding the severity of the allergy, how it affected the person or action staff should take if the person had an allergic reaction.

A third person had been prescribed a preventative spray for angina [chest pain], which was recorded on their medication information chart. However, their care records did not contain any reference to that condition or how to support the person if an attack happened. The person told us they had not had an attack of angina but medicine had been prescribed because they were at risk of an attack. This person's care records identified that they had a catheter. A catheter is a device used to drain a person's bladder through a flexible tube linked to an external bag. However, there was no information in the care records to help staff understand how to support this person with their continence needs or the risks related to catheter care.

A further person's 'Medication Monitoring Diary' stated 'Creams may not be needed at every visit'. There was no other explanation to help staff understand when creams should or should not be applied.

We visited a different person, who was living with dementia, and observed them displaying behaviours that other people and staff may find distressing. We looked at their care records, which did not contain any information about the person's dementia or their behaviours. We raised this with the deputy manager who told us they had not put it in the care plan because of confidentiality, "As you don't know who might read the file".

The minutes of a staff meeting dated 2 November 2016 identified a non-personalised approach to care planning. They stated 'Some girls have been moaning about care plans not being done. It's a plan a general idea'.

Although, people's care plans were basic and did not contain detailed information regarding people's needs, care staff members were able to describe the care and support required by individual people. A member of staff told us that people's care plans, "don't give you a lot of information about the clients. I raised it with [the deputy manager] and she said 'it was about confidentiality'. You have to work it out for yourself. Sometimes you know from the medication what's wrong with people". Another member of staff said, "I can't remember when I last looked at a care plan. No time, you need all the time to do what you need

to do". They added "I do read the daily record books to know what's going on". A third member of staff told us the care plans only contain basic information and said, "We all know more. We all know people's little routines but it is not in the care plan". They said they obtained information about how to care for a person by asking them and their family members.

The registered manager/provider and the deputy manager told us their staff know what to do because they are always introduced to people and shadow to see how to support them. One family member said, "I've met [the deputy manager] she is a lovely woman. She brought the girls out. She was good and sat with them to make sure they did the job properly". A member of staff told us, "When we go to a new person [the registered manager/provider or the deputy manager] shows us what is needed. Never been to a person I have not been introduced to". However, a different member of staff said, "Most of the time we are introduced to a new person but on rare occasions you have to go in 'blind'. I always introduce myself and read the care plan and ask them what they want".

The failure to ensure that an assessment of people's needs and preferences were completed; and the failure to design care and treatment to meet those needs is a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager/provider sought feedback from people and their families regarding the service through a quality assurance survey. We looked at the results of the last survey which was sent out in November 2015, all were positive some comments included: 'my carers do all that I ask', 'I am delighted with the care given all my carers cope cheerfully' and 'I am very happy with my carers and I look forward to them coming'. The results of the survey had been put onto a graph and analysed. People were also able to provide feedback during client reviews. We looked at two reviews and found people had made positive comments about the service. The review of one person from October 2016 included feedback from the person, 'happy with care staff' and 'I know how to complain if I want to'. The comments from another person who was reviewed in January 2017 included the following comments, 'I like to see them all', 'Carers arrive at the agreed time' and 'I enjoy the company of all the carers they are kind and always cheerful'. The registered manager/provider told us they would speak with a person if they raised any concerns. We saw that the service had received a number of compliment cards from the people they supported and their families.

The registered manager/provider had arrangements in place to deal with complaints. A copy of their complaints procedure was kept in the care file in people's homes and was available to them and their families. The procedure provided detailed information on the action people could take if they were not satisfied with the service being provided. The registered manager/provider told us they had not had a formal complaint since 2014. They added "Minor issues are dealt with informally. We go and see them and sort it out straight away". People told us they knew how to complain. One person said, "If I was unhappy I would tell my family". A family member told us, "If unhappy I would go to the [deputy manager]". They gave an example where they had raised a concern about a member of staff which had been "sorted out".

Inadequate

Is the service well-led?

Our findings

People and their relatives told us they felt the service was well-led. One person said, "Very good; [The registered manager/provider] is passionate about the job". A family member told us, "Very good. First time we have had any service. It's punctual, if running late [the registered manager/provider] rings us up". Another family member said, "Yes, well organised, well organised as it can be as they can't get carers". They added "I know it is [my relative] they are here for but they make sure we are both okay". "[The deputy manager] will phone up and ask [if things are okay]".

However, the system and processes in place to ensure the service ran effectively were not robust. The records relating to people's health, welfare and safety were not always accurate and up to date. The care records for one person still referred to their husband, who the registered manager/provider had told us had passed away approximately nine to 18 months previously. The care record still referred to him as their 'next of kin'. The section marked 'relevant health details' stated 'needs support with anxiety regarding husband's health. The section marked 'recent life events' stated '[person's name] has become very tired and needs help with [their husband's] daily care'. There was no reference in the care records relating to the fact that the person's husband had passed away and how this may have impacted on their care needs.

Another person's care records stated '[Person] may need blood pressure taken. [Person's relative] will inform carer if needs to be done, please massage left arm to help decrease spasticity'. We checked this entry with the registered manager/provider who told us "We do not do blood pressure". They were unable to explain why it had been included in the care record. They also accepted that there was no explanation as to what massage means in respect of this person.

A different person's care records stated they were receiving medicine through a syringe driver. However, the registered manager/provider told us this was out of date because the person had been treated with 'pain patches' since the 19 January 2017. We looked at the person's 'Medication Monitoring Diary', which confirmed they were receiving pain relief through 'pain patches'.

Other people's records did not contain up to date information regarding their medicines, nutritional and hydration needs, risks relating to people's health and wellbeing or health care needs. The 'client history form' for one person had not been updated since October 2015. This form was used to formally record information about the person's health and wellbeing that had been phoned in by staff or recorded in the person's daily record of care. We looked at this person's daily record of care book and found they were cared for in bed and had complex changing care needs.

The failure to ensure that there were systems and processes in place to ensure that people's records were accurate, complete and contemporaneous is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager/provider did not have systems and processes in place to effectively assess, monitor and improve the quality and safety of the service provided. The registered manager/provider did not carry

out any audits, apart from spot checks of staff, to ensure that the service they provided met the fundamental standards of care and that people they supported were safe. As a result of the failure to have an effective quality assurance audit process they had not identified the serious concerns we found during this inspection. The registered manager/provider told us, "I think the care is paramount and we have to fit the paperwork around them [people using the service]".

The failure to ensure that there were systems and processes in place to effectively assess, monitor and improve the quality and safety of the service provided is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager/provider did not have a structured process in place to ensure they kept themselves up to date with regard to the latest legislation and best practice guidance. The registered manager/provider told us, "I usually go on Google to keep myself up to date and go on [the website of the company that provided their policies]; we listen to the news and [the deputy manager] also finds things on social media". They added that they also get the Skills for Care magazine and a human resources circulation.

We asked to see a copy of the registered manager/provider's policy on duty of candour which details the action staff should take when an accident occurs. They told us they were unaware of what that was. We explained requirement of the regulations to them and they said, "No I don't have that. I did ask safeguarding what it is but they didn't get back to me".

We looked at the policy file for the service and found these were generic and had not been updated since December 2011, which was before the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We raised this with the registered manager/provider who told us that they had purchased the policies from an on-line company, who sent through regular updates. However, they were unable to provide us with any copies of the updated policies and procedures and were unable to remember their log on details to access the up to date information on line. By the third day of the inspection they were still unable to access any up to date policies from the internet.

The service was inspected in July 2014; however the rating for that inspection was not being displayed at their premises or in their office. We raised this with the registered manager/provider who told us they were not aware they were required to do so. By the second day of the inspection we saw that the ratings were being displayed.

The information used by the registered manager/provider to make decisions about people's health and wellbeing was not always relevant and up to date. For example, when we raised concerns regarding the management of a medicine being administered by staff, the registered manager/provider referred to a copy of the British National Formulary 49 (BNF), published in 2005. This was a joint publication by the British Medical Association and the Royal Pharmaceutical Society and provides healthcare professionals with a quick reference guide to current information about the use of medicines. This book has been superseded on 24 occasions with the latest version being BNF 75.

The failure to ensure that records related to the effective running of the service were available and up to date is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager/provider told us their philosophy of care was about, "What can we do to make [people's] lives comfortable and keep them happy". Care staff had fully embraced the registered manager/providers philosophy of care which was reflected in the positive feedback we received from the

people and their relatives we spoke with. One member of staff told us they, "Enjoy it [working for Dolphin Care (IOW) Limited]; enjoy the clients and care, giving them independence in their own homes".

There was a management structure in place, which consisted of the registered manager, deputy manager and senior care staff. Most staff told us the management team were approachable and supportive. One member of staff said, "[The registered manager/provider or the deputy manager] good; very approachable; can raise concern". Another member of staff told us, "[The registered manager/provider or the deputy manager] are on call all of the time. You can ring them all of the time and you have the senior carers you can contact". A third member of staff said, "Enjoy working here; small firm; love the clients; go to the same ones regularly. If any problems you can ring anyone, always very helpful". A further member of staff told us it was "a good service. Management has been good to me". They added "Enjoy what I do; love my job; would recommend the service to friends and family".

However, other staff raised concerns about the management of the service and the approachability of the management team. One member of staff told us that because the registered manager/provider and deputy manager are always out providing care it "makes you feel like it is a problem contacting them [The office]. Like if you are worried about a family not doing meds right. So you think twice about saying anything as you don't want to add to their work". They added "I think they take on too much. They keep taking packages when we don't have the staff. They just say we'll get more staff". Another member of staff said, "[The deputy manager] has a difficult job and has a lot on her plate". They added they felt the deputy manager "needs to up her game and could be a bit more paper work [focused] she needs to get it sorted. For example the rotas I get them and think here we go again, back and forth back and forth, so we are always late but they could be worked out better. So frustrating". A member of staff concluded their interview with us saying, "I love the clients and on a personal level I like [the registered manager and deputy manager] but I really worry that something bad is going to happen because things aren't right and it will come back on us girls".

Regular staff meetings provided the opportunity for the registered manager/provider to engage with staff. However we received mixed views from staff as to whether any issues they raised would be listened to and acted upon.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people's individual needs and preferences were assessed; and care and treatment was designed to meet those needs.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that people were protected from abuse and to have effective systems in place to identify, investigate and report instances of abuse to the appropriate authority.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that there was a robust recruitment process in place to enable them to be assured that the staff they recruited were suitable to work with the people they supported.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that there was sufficient numbers of suitably qualified staff deployed to meet people's needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks to people's health, wellbeing and environment were identified and acted upon; that risk assessments relating to people's health, safety and welfare were completed; that concern regarding people's health and wellbeing were identified and an appropriate health professional informed; and that medicines were managed safely.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that risks relating to the safety of staff were monitored and action was taken to mitigate those risks; that there were systems and processes in place to ensure that people's records were accurate, complete and contemporaneous; that records related to the effective running of the service were available and up to date; and that there were systems and processes in place to effectively assess, monitor and improve the quality and safety of the service provided.

The enforcement action we took:

Warning notice issued