Dolphin Care (IOW) Limited

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Inspection report

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10 August 2017
21 August 2017
25 August 2017

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19 October 2017

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

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 24 people with personal care.

We had previously carried out an announced comprehensive inspection of this service on 10, 20 and 21 March 2017. Following this inspection, the service was rated inadequate and placed into special measures. Services that are in special measures are kept under review and comprehensively inspected again within six months of the published inspection report. We expect services to make significant improvements within this timeframe. 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 at its next planned comprehensive inspection and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During the March 2017 inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These included regulations in respect of safe care and treatment; and good governance. We issued two warning notices and told the provider that we required them to take action to ensure they met those regulations by 5 May 2017 and 26 May 2017 respectively. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

This inspection was not a comprehensive inspection to review special measures. We undertook this focused inspection to check that the provider had taken action in relation to the warning notices issued at the last inspection and to confirm that they now met their legal requirements in respect of these breaches. This report only covers our findings in relation to those two regulations. Therefore, we are unable to review special measures or amend the rating given at the previous inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk.

This inspection was announced and was carried out by one inspector on 10, 21 and 25 August 2017. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The registered manager had assessed the risks to people and had taken action to minimise the likelihood of harm.

People received their medicines safely and in a way that met their needs. People had access to health professionals and other specialists if they needed them.

The provider had taken action to ensure staff were supported and safe when supporting people in the

community.

People's records and those related to the running of the service were accurate and up to date.

The provider had recently established a system to monitor the quality and safety of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The registered manager had assessed individual risks to people and taken action to minimise the likelihood of harm.

People received their medicines safely and in the right way to meet their needs.

People had access to health professionals and other specialists if they needed them.

We could not improve the rating for Safe from the existing rating because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Inspected but not rated

The provider had taken action to ensure staff were supported and safe when supporting people in the community.

People's records and those related to the running of the service were accurate and up to date.

The provider had recently established a system to monitor the quality and safety of the service provided.

We could not improve the rating for well-led from the existing rating because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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. We had previously carried out an announced comprehensive inspection of this service on 10, 20 and 21 March 2017. Following the inspection, the service was rated inadequate and placed into special measures. During the March 2017 inspection, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in respect of safe care and treatment; and good governance. We issued two warning notices and told the provider to take action to ensure they met those regulations by 5 May 2017 and 26 May 2017 respectively.

We undertook this focused inspection to check that the provider had taken action and confirm that they now met their legal requirements in respect of these breaches. This report only covers our findings in relation to those two regulations. Therefore, we are unable to review or amend the rating given at the previous inspection.

This inspection was announced and was carried out on 10, 21 and 25 August 2017. The provider was given 24 hours' 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 provided to us by the provider in respect of the actions that had taken since our last inspection, along with other 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 visited two people in their homes and spoke with a third person by phone. We also spoke with two relatives.

We spoke with two members of the staff and received feedback from a third, the deputy manager and the registered manager. We looked at care plans and associated records for five people using the service. We also looked at other records related to the running of the service, such as, policies and procedures and quality assurance records.

Inspected but not rated

Is the service safe?

Our findings

During our inspection in March 2017, we identified a breach of Regulation 12 of the Health and Social Care Act 2008. People were at risk because the provider had failed to ensure that risks to people's health and wellbeing were identified and acted upon. Following that inspection, we wrote to the provider requiring them to take action, by 5 May 2017. At this inspection, we found that the provider had taken action and they were no longer in breach of this part of the regulation.

The registered manager had assessed the risks associated with providing care and support to people. These were recorded along with the actions identified to reduce those risks. For example, one person used bed rails on their bed to assist them to mobilise. The registered manager had identified the risk to the person of using the bed rails and detailed the action staff should take to mitigate those risks. There was also a risk assessment in place for a different person who was at risk of pressure sore injuries, which detailed the action staff could take to reduce those risks. We saw this was in line with the person's care plan. One person told us, "I feel safe when they [staff] are here. They know what they are doing." Another person said, "The girls [staff] have been coming a long time; we know them all. They know how to look after me; I am definitely safe with them." A relative told us staff, "Do what [my relative] wants. They know how to help [my relative] and keep them safe." A member of staff told us, "The risk assessments are much better and there is more information in them." Another member of staff said, "All of the care plans have been updated recently with new risk assessments." Staff were able to describe the risks when providing care to people and the action they would take to mitigate those risks.

During our inspection in March 2017, we identified that people were at risk because the provider had failed to ensure that people's medicines were managed safely. Following that inspection, we wrote to the provider requiring them to take action, by 5 May 2017. At this inspection, we found that the provider had taken action and they were no longer in breach of this part of the regulation.

People were supported by staff who had received medicines training and had their competency to administer medicines assessed to ensure their practice was safe. The service had a clear medicines policy, including the use of homely remedies, such as over the counter creams. We saw that where staff were supporting people using homely remedies, the registered manager had contacted a health professional or pharmacist to confirm it was safe to do so. One member of staff said, "We don't administer medicines, we help people get them out of their packs; we do put creams on for them but only if they are prescribed unless we have a letter [from their GP or pharmacist]." The deputy manager was reviewing the medicine requirements for all of the people using the service. This included the medicines people required and the level of support they needed from staff, including their personal preferences. For example, one person was able to administer their own medicines but preferred staff to support them by removing the tablets from the 'blister pack' and placing them in a pot. One person told us, "They [staff] help me with my medicines. They get them out ready for me to take." The registered manager acknowledged that this was still a work in progress and not fully embedded into the service.

During our inspection in March 2017, we identified that people were at risk because the provider had failed

to ensure that people were supported to maintain good health. This was because health professionals were not always contacted when concerns were raised. Following that inspection, we wrote to the provider requiring them to take action, by 5 May 2017. At this inspection, we found that the provider had taken action and they were no longer in breach of this part of the regulation. People were supported to access healthcare services when needed such as GPs, district nurses and chiropodists to ensure they received a consistent approach to their healthcare.

Inspected but not rated

Is the service well-led?

Our findings

During our inspection in March 2017, we found that staff were at risk because the management team had not responded effectively regarding concerns raised by staff about the behaviour of one of the people using the service. Following that inspection, we wrote to the provider requiring them to take action by 26 May 2017. At this inspection, we found the registered manager had taken action to ensure staff were supported and safe when supporting this person. Staff told us that following management intervention they felt more confident in supporting this person and had not needed to raise any concerns.

During our inspection in March 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was failing to ensure that records relating to people's health, welfare and safety were accurate and up to date. We also found that documentation used to inform the provider's knowledge and decision making was not up to date and did not reflect the latest legislation and best practice guidance. Following that inspection, we wrote to the provider requiring them to take action by 26 May 2017. At this inspection, we found that the provider had taken action and they were no longer in breach of this part of the regulation.

The provider had undertaken a full review of people's care plans, which had been updated to reflect their current needs and support requirements. A person told us the registered manager and the deputy manager "Come out and see me about once a month to check everything is alright and that nothing has changed". Another person's relative said, "I see them [the deputy manager] when they come out to do a review and check everything is okay. Lots of things have changed recently." A member of staff told us, "Care plans have improved and there is more information in them. I always read them when I have been away to see what has changed." Another member of staff told us, "I think the care plans are good, you can follow them. If things change I get a text and [the deputy manager] comes out and changes them." A third member of staff who provided feedback said, "Things had improved greatly since the last inspection."

The provider showed us copies of their policies and procedures, which had been updated and personalised to reflect the care provided by the service.

During our inspection in March 2017, we identified that the provider failed to ensure they had a system in place to monitor, evaluate and improve the quality of service provided. Following our inspection, we wrote to the provider requiring them to take action by 26 May 2017. At this inspection, we found that the provider had taken action and they were no longer in breach of this part of the regulation.

The provider had recently established a system to monitor the quality and safety of the service provided. This included an audit of the medicine administration records and daily records of care when they were returned to the office; and care plan reviews. The deputy manager also carried out a series of competency checks of staff while they supported people; this included a review of the documentation in the person's home. On the date of the inspection, the quality assurance system had only recently been implemented and therefore the provider was not able to provide analysis of the audits and any action taken. They were able to explain their auditing process and the action they would take if a concern was identified.