Care Quality Commission

Dendera Ltd

Dendera Ltd

Inspection report

Ashford House, Second Floor
100 College Road
Harrow
Middlesex
HA1 1BQ

Tel: 02084274745

Date of inspection visit:
12 April 2018

Date of publication:
02 July 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 12 April 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service. At the time of the inspection Dendera Limited provided domiciliary care and support for fifteen people in their own home that were receiving personal care. The service worked mostly with older people all of whom were living in the same London borough and all receiving a short term re-ablement service. Re-ablement is a rehabilitation service designed to help people regain independence, usually after a period of time in hospital. The service worked with people for an average of four weeks on a targeted re-ablement programme in order to assist people to regain their independence. If the service thought that people were in need of more weeks they raised this with the purchasing authority and their views were listened to, as we saw in one example for a person currently using the service. Aside from this the vast majority of people needed no more than the four week programme and in one recent case a person had themselves ceased using the service as they did not feel they required it, which was assessed and acted upon. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

This was the first inspection of the service since registration in April 2017.

There was a registered manager in post. A registered manger is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of law; as does the provider. The registered manager was present during the inspection.

Procedures relating to safeguarding people from harm were in place. Staff we spoke with understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act 2005. No one using the service at present lacked capacity.

The service operated safe staff recruitment procedures and ensured that all staff were suitable for the role before beginning any care work.

Medicines were managed safely and the service checked people could do this independently. Assistance, by way of asking people if they had taken their medicines, was provided to some people if this was needed until it could be verified that people could manage their medicines independently and safely without being reminded.

Risk assessments provided staff with guidance on how to mitigate people's individual personal risks. Risks had been clearly identified and risk reduction measures were identified and acted upon.

Staff were provided with a suitable induction as well as on-going regular training and supervision to support them in their role.

People were involved in planning their care and had regular reviews to gain their opinion on how things were. People and relatives felt that they were treated with dignity and respect. Care plans were person centred and included information on how people wanted their care to be delivered as well as their likes and dislikes.

People and relatives were provided with information on how to make a complaint and their views were obtained and acted upon.

People who used the service, relatives and stakeholders had a range of opportunities to provide their views about the quality of the service. The provider regularly monitored the care of people as although the service provided to each person was short term the provider saw it as important to make regular contact to monitor the quality and effectiveness of the service. The provider was also required to report back weekly to the local authority that commissioned the service about progress of each person and the effectiveness of the service in achieving the goal for people to regain their independence.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were provided with training and guidance to enable them to recognise abuse and how to respond to any concerns of potential abuse.

Risk assessments provided staff with appropriate guidance on how to keep people safe and this included medicines management. Medicines were safely managed.

The provider followed safe staff recruitment practices and people received a continuity of care and on most occasions had the same staff visiting them.

The provider had taken steps to understand and learn from any incidents that occurred and took steps to address improvements as a result of these.

Is the service effective?

Good

The service was effective. People's needs were assessed in consultation with them, their family if appropriate, and commissioning authority.

Staff received regular training, an induction before commencing their work and supervision to support them in their work.

The service worked in line with the Mental Capacity Act 2005 (MCA) and recognised how this influenced the care that they provided.

People were supported to have enough to eat and drink so that their dietary needs were met.

Is the service caring?

Good

The service was caring. People were treated with respect and staff maintained privacy and dignity.

People were encouraged to have input into their care and their views were respected. We were informed that care staff usually responded with kindness, respected people's dignity and their rights.

Is the service responsive?

The service was responsive. People's care was person centred and planned in collaboration with them, with clear goals set to allow people to become independent once more. People using the service and relatives confirmed this.

The provider monitored the care provided to people using spot checks and regular phone calls to people to ask them about the quality of their care.

People knew how to make a complaint. There was an appropriate complaints procedure in place and the provider to responded to any complaints that were made.

Is the service well-led?

The service was well led. People were asked about their views on the support they received from the service.

The registered manager had a monitoring system in place to ensure care was assessed, audited and that people's needs were met.

People's views were obtained and were acted upon.

Care Quality Commission

Dendera Ltd

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 April 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by two inspectors, one of whom contacted care staff by telephone, and an expert by experience that carried out telephone interviews with people using the service and relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information that we had received about the service and any formal notifications that the service had sent to the CQC. We looked at four care plan records and risk assessments, three staff files personnel records and other documented information related to the management of the service.

During our inspection we made contact with fourteen of the fifteen people using the service and eleven relatives. We spoke with one care co-ordinator, the manager of the service and three of the eight care staff currently employed. Prior to this inspection we also contacted the local authority that commissioned all of the care packages that the service provided but did not receive feedback from them.

Good

Is the service safe?

Our findings

People using the service told us, "'I feel safe. My carer is absolutely amazing and I'm lost for words. There is no need for complaints as the care is out of this world" and "'We've only been using the service since early April, so it's very recent. It is safe and so far, we're happy with everything."

A relative told us they had not thought a member of care staff had recognised a change in a person's care needs. We raised this with the registered manager who stated this would be followed up immediately and did so. Other relatives told us "We're happy with the care. The ladies do a good job and are very pleasant and smiley. We have visits four times a day with different people" and "[relative] came out of hospital last Thursday and [care staff] arrived at 9 am the following morning. She seems very pleasant and good at her job and [relative] is safe in [care staff] care."

The service had a safeguarding policy that described the definition of safeguarding and the ways in which the service would respond to any concerns. The policy and procedure commented upon people's right to be protected from abuse regardless of their heritage or other diverse needs and that people had the right to be treated with dignity and respect. Types of abuse and the action that must be taken if abuse was suspected was also outlined. Staff were trained in safeguarding during their induction and had received this training prior to being able to begin to deliver care.

We viewed four people's risk assessment and care assessment records. We found in each case that people had risk assessment and risk reduction measures included in their care plan files. These were tailored to environmental common risks and any personally identified risk that the service needed to consider when providing care. Most people had only begun using the service in the last month. The provider's risk assessment policy stated that risk assessments should be reviewed regularly, however, due to the very short-term nature of the service this was only required if people's circumstances changed during the few weeks they received a service.

The service followed safe recruitment practices. We looked at the recruitment files of three of the eight care staff that were employed. These showed pre-employment checks, such as two satisfactory references from their previous employer, or character references if this was an applicant's first job. There was photographic identification, the staff member's application form, a disclosure and barring service check and verification of staff eligibility to work in the UK. We noted that written references were followed up by the provider telephoning the referees to speak with them about the reference and to verify the validity of the references provided. This minimised the risk of people being cared for by staff who were inappropriate or unsuitable for their role.

We looked at the arrangements in place to cover the care needs and call times that had been agreed with people. Although some people said there could be delays, most said they were informed about staff running late and that few calls were being missed. The service required staff to make a call to let the agency know if they had a problem being late or could not make a visit to a client. This system worked well although a small number of people using the service had commented about care staff sometimes being late. We saw

that this had been identified where late calls had been made and the reasons had been explored and responded to. This demonstrated the provider recognised how important it was for staff to arrive on time as people expected. The registered manager told us that the commissioning authority did not require the use of an electronic visit monitoring system, however, the provider was currently looking into an electronic system for monitoring visits.

Training records showed that all staff had undertaken medicines training since starting to work for the service. We were told by the registered manager that four people were asked each day if they had taken their medicines, known as prompting, but no physical assistance to take medicines was provided. We looked at copies of medicines records for one person who was using the service, and five others who had recently completed their short term re-ablement and no longer used the service. These records were collected after completion of the four week re-ablement programme although the one person still using the service had their re-ablement period extended so was still receiving prompts from care staff. The letter "P" [for prompting] was written instead of the initials of the member of care staff. We asked the registered manager to ensure that both of the member of staff's initials be put into the chart not just the initial of their first name, which they agreed to do.

All staff were provided with personal protective equipment such as gloves and aprons that were supplied by the provider. We were informed that no-one using the service had any communicable illnesses or other conditions and that staff were in any case required to use the equipment provided when carrying out intimate personal care.

The service recorded any incidents that had occurred and it was reported by people and relatives, as well as staff, that very few, if any, had taken place. The service responded appropriately to incidents or other events that had been reported and kept a running log sheet of feedback each month from everyone using the service. Any issues identified were discussed at the monthly management meeting. The provider undertook a learning process from issues that had been raised and action was recorded and taken, for example, matching care workers to clients and the standard of care notes recording.

Good

Is the service effective?

Our findings

People using the service told us "My carer, comes in daily and always ask for my consent before providing care. She will do anything that is needed" and "My carer is respectful. There had been one or two mistakes when she didn't understand what I was saying, but she is patient, gentle and kind. I think she has sufficient skills for the task in hand."

Relatives we contacted told us "The timing of the care provided fits in well. We know we can always review the situation, if needed" and "I'm not sure what has been arranged, but I can't fault the carer, she is very good."

The service was clear about obtaining consent to care and had done so in each of the care plans that we viewed. These people had all consented themselves to their care and had not required anyone else to do so for them. People were consulted about care assessments and care plans, although some people we spoke with could not recall receiving their care plan. We raised this with the registered manager who issued an instruction to care staff to clarify this with the people they visited and remind them of where their care plan and recording file was kept in their own home.

All people's care plans that we looked at had been compiled in recent weeks as they begun to use the service, all starting with a comprehensive assessment of need provided by the commissioning local authority, which was followed by the service's own assessment about the particular areas of support being requested. Care plan progress with achieving the re-ablement goals was updated weekly as the provider was required to report to the commissioning authority about people's progress in achieving re-ablement in the four week target. The registered manager informed us that reviews of care were carried out should anyone's care and support needs require an extended period of re-ablement support, which in one case had needed to happen and support had been extended. The involvement of people, and their relatives if also involved, was included in care plans.

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. We checked whether the service was working within the principles of the MCA.

The provider was aware of, and understood, their responsibilities in relation to meeting the requirements of the MCA and the service assessed people's capacity. People's capacity had been documented and was included in their care plan records. The service had raised a concern about one person's capacity and had taken steps to liaise with the local authority and addressed the query about capacity that had been raised. This had been resolved and the person was able to provide consent.

Care staff received regular supervision. All the care staff were relatively new, being in post for five months or less. Records of staff supervision showed that these meetings were held every month to six weeks which care

staff we spoke with all confirmed was taking place.

The eight care staff that were currently working with the agency to provide care were appointed within the last five months. An annual appraisal would not have yet been required for any of the care staff. The registered manager said that staff's full contract of employment was not confirmed until after their three month probationary period, which was currently ongoing for most of the care staff due to how recently they had been recruited.

Induction included training in line with the Care Certificate, which is training for care workers which provides the fundamental knowledge and skills for people working in care services. Staff induction covered necessary core skills, for example, medicines, moving and handling and keeping people safe from harm. Induction commenced with a three day classroom based introduction followed by shadowing a mentor [an experienced care worker]. The length of shadowing depending on the experience of the person and the mentor reported how ready the staff were to begin working with people.

Care staff told us ""We had training before we started. This included safeguarding, manual handling medicines and infection control. They [the agency senior staff] come out and check staff to make sure that they are doing things properly" and "We had training before we started. I had worked for other companies and this one is very good. I had training from another company before I started but the manager said we need to do our own training with you."

Care staff usually only provided light meal preparation for people where this was required but mostly supervised people in being able to prepare their meals independently. All staff had been trained in food hygiene and nutrition. Where people required support with light meal preparation care plans documented the type of support required. Everyone using the service was able to independently decide for themselves what meals they wanted support to prepare and if care staff identified any issues around this it was reported to the agency. This was a part of the aim of the service to ensure that people could regain their independence and all could make independent choices about their own dietary preferences and needs.

The registered manager informed us that care staff did not routinely attend healthcare appointments with people as this was usually managed by people themselves with assistance from their family or friends if needed. The registered manager stated that this would be considered carefully if there was a need to provide assistance. This was a part of the overall consideration given to how people could manage independently. If there was a concern about someone's ability to do so this was raised as a part of the regular progress updates and consideration about what ongoing areas of support people required assistance with.

Good

Is the service caring?

Our findings

People told us, "My carer is the most kind and considerate that you could ever meet in this field of work", "[Care worker] and I try to have good conversation. She has a good heart and I look forward to seeing her. I believe that we have a genuine friendship" and "[Care worker] is very kind and she gives me useful tips, such as sitting down when pulling on my trousers. I am most impressed with the service. My carer is regular and reliable."

A person using the service said they felt their independence could be better supported, although in their conversation with us it was evident that they were very independent. A relative told us they thought it was poor that the care worker, when they first arrived, had not been made aware of the reason that their relative was being supported. We clarified this with the registered manager who told us they had not initially been given the full reason the person had been in hospital as the support was arranged urgently. The issues this relative raised were also about communication with the local social services department but they did say they had been listened to when they asked about changing times that staff visited in the morning.

A relative told us "I think they have all been quite good. Having this service has helped my [relative] to gain confidence, which supports improvement in health and wellbeing." Another relative said "The member of staff is kind and treats my [relative] with respect. She understands her needs and does respect privacy and dignity. For example, she is always careful to close the bathroom door when washing my [relative]." Other comments were also along positive lines about the way in which care workers engage and support people in their care.

A care worker told us "I usually work with the same people but they are short term and don't stay long. When we have new people the manager gives us information about them before we visit." Another said "Most of our clients are only with us for four to six weeks. The manager gives us information about their needs before we go there. We usually work with the same people. We try to help them be more independent." One care worker told us that some people live alone and the care workers were sometimes the only ones that people may see each day. This demonstrated empathy for the people in this situation.

From the views that people did share with us it was evident that care staff respected people's privacy when providing personal care. In addition to this it was also evident from people's comments that positive relationships were also established, even though people were usually only using the service for a short period of time.

The provider had clear policies in relation to the right of people to have their diverse characteristics respected. All but one of the people using the service were white British, the one person that was not had their specific characteristics relating to their heritage considered. No specific measures were required for anyone using the service. A small number of comments were made by people regarding language abilities of some staff. The registered manager showed us that they were supporting those staff through language courses at a local college to improve English comprehension when this was required. No one made any specific comments about whether the agency or care staff showed consideration for their personal, cultural

or religious beliefs or heritage. However, from other comments made it was evident that people felt that they were treated with respect.

Good

Is the service responsive?

Our findings

Care plans were person centred and included people's likes and dislikes and the way they wished to be cared for. Information contained within care plans was specific to the type of support they required. For example, if people needed help to wash and dress this was included with details of how staff should do this in the way that people preferred whilst encouraging people to do so for themselves. Some people needed help to have a meal or carry out domestic chores. Staff were given guidance about how this should be done, again with consideration of people's ability to regain their independence.

Care plans were specific to the agreed care that the commissioning local authority had requested from the agency. The service had a daily log recording the care provided to people at each visit. The registered manager told us that log sheets were always held in the person's home and these were collected at the end of the short-term service that was provided. We looked at examples of these for three people and these were usually well written. We did note that where the quality and content had been reviewed and found to require improvement that this was addressed with care staff and goals were set for this improvement. This demonstrated that the provider considered this area as an important part of ensuring accuracy, completeness and quality of recording the care and support provided.

A person told us "This company started here on the day after my discharge from hospital. It is pleasant to have someone calling in as it helps to brighten the day. My carer usually comes at 11 am, she is trying to do her best for me." Another person told us "'I have a green file from the domiciliary care agency, but I've not seen any individual care plan."

Some people were unclear about whether they had care records in their own home. The registered manager informed us when we raised this that they had issued an instruction to all care staff to remind people about their file and where this was kept at their home.

Due to the short-term nature of the service, monitoring of the re-ablement progress took place frequently. The provider was required to report this progress and any identified potential barriers to achieving re-ablement at least once a week to the purchasing authority. We looked at the minutes for the last two months meetings as well as the weekly monitoring reports. The agency were providing full details of people's [progress towards re-ablement and action n they were taking to successfully help people to achieve this.

People and relatives were provided with information on how to make a complaint when they began using the service. From the feedback that we received above it was evident that people had felt able to raise issues when they felt the need to and that they had been responded to in a way they were satisfied with, which was recorded by the service.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager. The registered manager had appropriate training and experience to manage the regulated activity.

The service provided care and support that was of a good standard and people were usually happy with it, but evidently felt able to raise anything they were not happy with.

A person using the service told us "'This domiciliary care agency was suggested by the Royal National Orthopaedic Hospital. This service is helpful and helps me to freshen up every day, which I appreciate. I think is really good that there's only been one care worker attending to me, as opposed to many faces, which I know can be the experience elsewhere." Another person said "'Everything about this care agency is good."

A relative told us "'It is only been a short experience, only over the past two weeks, but this domiciliary care agency is quick to respond. It was Social Services who initially contacted this company. It is a fantastic service and they have given full explanations. The care worker has given good advice so far. This help and support is made a big difference to the whole family's life." Other relatives said "'I can talk to the manager, who is very obliging and approachable. The service has been very important both to my own and my [relative's] welfare" and "'It's early days, but so far, so good. I think we've been lucky with the carer as she seems helpful and capable."

Care staff told us "We get good support from the manager. Will always call if I need support and they will phone the family or give good advice" and "I like the manager, I meet with them every four weeks, If I need to speak with him at any other time he is always available."

Regular staff meetings had not been established as yet due to the service having recently commenced. The manager stated that as the service was now growing and more staff were employed they would establish staff meetings in the coming months.

There were systems in place to monitor the service. For example, the manager and other members of the management team carried out audits across a range of areas. These included medicines, care plans, spot checks and monitoring staff training and staff performance. This demonstrated that the provider had good governance procedures in place and acted upon the findings of their monitoring procedures, for example, responding to changes in needs for people and any alterations to the care provided as a result, not least in terms of each person's ability to become independent once more.

The service had systems in place to ensure that care staff abilities in spoken and written English were assessed and support was provided to improve this if required. This demonstrated that the provider acknowledged the importance of both verbal and written communication. Records showed the care staff communicated regularly with the agency as required.

People using the service were asked about their views during the time they used the service and immediately after their short-term service had ended. The provider viewed the experience of people in the short time that they used the service as an important means of monitoring the quality of the service.

The care co-ordinator and part time care co-ordinator, were responsible for carrying out regular monitoring of care for people at home. It was evident by our review of care and other records that people were in regular contact with the agency and that views about their day to day care were obtained. This demonstrated that the service was open and encouraged people to freely share their views and responded to comments that people made.

The service had appropriate, up to date policies and procedures in place which were available to staff to guide on various areas of their work. The policies we viewed included, safeguarding people from abuse, equal opportunity, maintaining people's dignity, medicines management and complaints. These policies had been introduced when the agency was first registered and were not due further review at present. The policies were appropriately detailed for a service of this type and were well written and clear so that staff knew what was expected of them and what they needed to do.