Review of compliance

Dimak Healthcare Limited Dimak Healthcare	
Region:	East
Location address:	3 and 3a, Market Street North Walsham Norfolk Norfolk NR28 9BZ
Type of service:	Domiciliary care service
Date of Publication:	December 2011
Overview of the service:	Dimak Healthcare is a domiciliary care agency, which provides personal care to adults who live in their own homes. The level of support provided is decided following an assessment of need. The agency has a manager who is registered with the Care Quality Commission.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Dimak Healthcare was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Dimak Healthcare had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 09 - Management of medicines
Outcome 12 - Requirements relating to workers
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 18 October 2011, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People we spoke with were happy with the care they received and told us that they were offered choice in the way that their care was delivered. Two people told us that staff knew exactly what help they needed, however, another person told us that not all staff were aware of their likes and dislikes.

One person told us that carers did not always visit at the agreed time because they were too busy. They also told us that very occasionally calls were missed but that they could telephone the manager, who would ensure that someone visited.

People who needed help to take their medicines told us that they had not experienced problems with receiving medicines correctly.

Everyone we spoke with were complimentary about the staff and told us that they thought the staff were competent and knowledgeable about the care they provided. People told us that when new carers began to work for Dimak Healthcare they always visited with more familiar and experienced staff at first. This helped them to learn the job.

People told us that they saw the manager quite regularly and he occasionally telephoned to ask whether they were happy with the service.

What we found about the standards we reviewed and how well Dimak Healthcare was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People using the service receive care that meets their assessed needs but we have concerns that the current system of care planning does not take into account their preferences or wishes.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People using the service are at risk because of unsafe medicines management.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

People using the service are protected by safe recruitment practices.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The staff team have adequate training and support to enable them to understand and meet the basic needs of people using the service. However, the lack of NVQ training could prevent staff from further developing their skills to benefit people using the service.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The quality monitoring process is not robust enough to identify and manage risks relating to the health, safety and welfare of people using the service.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

We have taken enforcement action against Dimak Healthcare Limited.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People we spoke with were happy with the care they received and stated that they were offered choice in the way that their care was delivered. One person said "The care is quite good." Two people told us that staff knew exactly what help they needed, however, another person told us that not all staff were aware of their likes and dislikes. One person told us that carers did not always visit at the agreed time because they were too busy. They also told us that very occasionally calls were missed but that they could telephone the manager, who would ensure that someone visited.

Other evidence
Following our last inspection we had concerns about the lack of information in people's care records and lack of communication about people's care needs.

During this inspection we found there had been little improvement in care records. Initial assessments of people's needs carried out by the manager were brief. Care plans we saw in people's homes were also very brief and consisted of listed tasks. There was no explanation about how to carry out these tasks and no indication of people's individual preferences and how they should be met.

Potential risks associated with delivering care in people's own home environment were assessed to ensure that care could be carried out safely. People had moving and handling assessments where this was a relevant part of their care. Some of the assessments were not dated and some people had more than one assessment in their file, which made it difficult to establish which were accurate and up to date.

The manager showed us examples of a new care planning system that was yet to be implemented. The new care plans contained more information about the person's needs and the instructions for staff were more detailed. When fully in use, these care plans should improve the way care is delivered and reviewed.

There had been improvements in the way information about people's health and care was communicated between staff at Dimak and with other professionals or family members. For example, we saw records to show that the manager had acted upon information about a person who was at risk of developing pressure sores. We could also see that information from people using the service or their family was passed on and acted upon by staff.

Our judgement
People using the service receive care that meets their assessed needs but we have concerns that the current system of care planning does not take into account their preferences or wishes.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
People who required help to take their medicines told us that staff were helpful and efficient and that they had experienced no problems with receiving medicines correctly.

Other evidence
Following our last inspection we had concerns about the way people were supported to take their medicines and the poor standard of medicine records.

During this inspection we could find no improvements in the ways medicines were managed. There were no care plans or risk assessments relating to medicines. One of the people we visited had their eye drops administered by staff. Their care plan just stated that staff should give the eye drops, there was none of the information we would have expected about how this should be done.

In August 2011 the manager had found gaps on this person's medicine administration record. This meant that it was not possible to be sure that the person had received their eye drops as they were prescribed. The manager had instructed staff to sign the sheet retrospectively, which was not safe practice. We found there were also a number of gaps on the record for September and October.

Another person's medicine administration record had become detached from the instructions set out by the pharmacist, which meant that there was no record to show exactly what medicines staff were signing for. This could increase the potential for

errors and put people using the service at risk. We asked the manager to address this issue as a matter of urgency. We later received confirmation from the manager that a new medication administration record was in use the day after our inspection.

One person had three partially used boxes of tablets that had been dispensed by the chemist in October last year and July and September of this year. There were no records to enable medicines to be audited; therefore we were not able to tell why these tablets had not been given. Medicines no longer in use should be returned to the chemist to reduce the risk of errors.

Our judgement
People using the service are at risk because of unsafe medicines management.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
During our inspection on 18 October 2011 we did not speak with any of the people using the service about how the provider recruited staff.

Other evidence
Following our last inspection we had concerns that the lack of background checks for new staff could create risks for people using the service

During this inspection we saw the recruitment files for three staff who had been appointed since our last visit. The required pre-employment checks had been carried out. Staff had only begun to visit people in their own homes after all relevant checks had been received and the manager was satisfied that the staff were fit to work with vulnerable people. New staff received a staff handbook, which outlined key policies relating to their job role.

Our judgement
People using the service are protected by safe recruitment practices.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People we spoke with were complimentary about the staff and told us that they thought the staff were competent and knowledgeable about the care they provided. One person said "The carers do their job well. They know what they are doing." People told us that when new carers began to work for Dimak Healthcare they always visited with more experienced staff at first to help them to learn the job.

Other evidence
Following our last inspection we had concerns that staff did not receive enough training and support to ensure they had the appropriate skills to meet people's needs.

During this inspection we looked at the training records for three recently appointed staff. We found that the range of training that staff received before commencing visits to people in their own homes was variable. The manager told us that as a minimum staff would receive awareness training in health and safety before going out to visit someone in their own home. This initial training was taught via a DVD and the manager said he supplemented this by discussions and a question and answer session. This initial training briefly covered topics such as safeguarding, infection control and risk assessments. Other topics were covered within the six to twelve week induction programme. The staff we spoke with confirmed this method of training and told us that they felt their induction training was sufficient to enable them to feel confident when going out on their own.

The manager had a library of DVDs to support the ongoing training needs of the staff team. We saw records to show that staff undertook written competency assessments

following their training. The employee history records showed that staff were shown how to complete some tasks or clinical procedures when working with people in their own homes and that their practical skills were assessed. An example was that the manager demonstrated to a new care worker how to connect a urinary catheter bag, before watching the staff member carry out the procedure. The staff we spoke with also told us that the manager had been out with them on visits to observe that they were doing things properly.

At our last inspection the manager told us that they planned to ensure that some staff commenced National Vocational Qualification (NVQ) programmes as soon as possible. At the time of this visit none of the staff had commenced this training, although one staff member had been identified to undertake NVQ level 2. The manager told us that this had not started because they had been unable to make contact with a suitable trainer.

The staff records showed that some staff had received supervision and that their performance was monitored. We saw evidence that where staff had missed or been late making calls, this was addressed by the provider. We also saw that staff received appraisals where further training and supervision needs could be identified. Staff we spoke with told us that they felt well supported by the manager.

Our judgement
The staff team have adequate training and support to enable them to understand and meet the basic needs of people using the service. However, the lack of NVQ training could prevent staff from further developing their skills to benefit people using the service.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People told us that the manager occasionally telephoned and asked whether they were happy with the service and they said they felt able to raise any concerns they had with him. People told us that they saw the manager quite regularly and said they would be able to raise any concerns with him.

Other evidence
Following our last inspection we had concerns that the provider did not have any systems in place for monitoring and improving the quality of the service.

The formal system for auditing the service that was discussed with us during our last inspection had not been implemented. However, we found the manager had made improvements to minimise risks to people's health and welfare that we identified during our last inspection. For example, relating to recruitment procedures.

There was no formal method to seek the views of people using the service. However, the manager visited people on a regular basis either to deliver care or to supervise other staff. During these visits the manager sought people's opinions about the service.

Records showed that standards of care had been discussed at the most recent staff meeting. We also saw that concerns about staff practice were monitored.

We found individual risk assessments on people's care files to ensure that risks relating

to their health, welfare and safety were identified and managed.

There were records to show that concerns and complaints were investigated and where possible resolved. The manager followed up to check that any planned actions were carried out.

There were still no audits of care or medication records and the manager had failed to identify risks to people's health and safety caused by poor medicines management.

Our judgement
The quality monitoring process is not robust enough to identify and manage risks relating to the health, safety and welfare of people using the service.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: People using the service received care that met their assessed needs but we had concerns that the current system of care planning did not take into account their preferences or wishes.	
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	Why we have concerns: The staff team have adequate training and support to enable them to understand and meet the basic needs of people using the service. However, the lack of NVQ training could prevent staff from further developing their skills to benefit people using the service.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The quality monitoring process is not robust enough to identify and manage risks relating to the health, safety and welfare of people using the service.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action taken			
Warning notice This action has been taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	People using the service were at risk because of unsafe medicines management.		30 November 2011

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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