Divine Motions Healthcare Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Divine Motions Healthcare Services Ltd is a domiciliary care agency. At the time of our inspection they were providing support with personal care to 55 people who lived at home.

People's experience of using this service and what we found
At the last inspection we found the provider's systems for the safe management of medicines, safe staffing and good governance were not effective. At this inspection we found the required improvements had not been made and the service remained in breach of the regulations.

People praised the regular care staff who supported them but felt the management of the service was not responsive with their issues / concerns not being heard or responded to. For example, in a comment typical of many, one person told us, "They are really nice carers, but it's the organisation that lets it down. The office says they will ring back and then they don't. It really upsets my routine and stresses me out. They really have to look at how the place is run".

Some people did not consistently receive their care calls at the times as agreed for their package of care. The system to allocate calls was not effective and was inadequately monitored.

Medication management was not safe. Staff were not provided with full information regarding people's medication and the risks associated with it. The systems in place could not provide assurances that people received their medication as prescribed.

The provider's governance systems failed to identify and address a number of areas of concern that were found during this inspection. A lack of management oversight meant risks to people's safety were not being responded to in an appropriate and timely manner.

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 January 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when, to improve. At this inspection we found required improvements had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook a focused inspection to review the key questions of safe, responsive and well-led. The inspection was prompted in part due to concerns received about people's calls being late or missed, people receiving unsafe care and a lack of effective management of the service. A decision was made for us to inspect and examine those risks.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on

the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Divine Motions Healthcare Ltd on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified there were continued breaches in relation to safe management of medicines, staffing and good governance. Please see the action we have told the provider to take at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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

Details are in our safe findings below.

Is the service responsive?

Inadequate

The service was not responsive

Details are in our responsive findings below

Is the service well-led?

Inadequate

The service was not well-led

Details are in our well-led findings below

Divine Motions Healthcare Services Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the CQC. This means they are legally responsible for how the service is run and for the quality and safety of the care provided. The service notified us that the registered manager was absent and the general manager of Divine Motions Healthcare Ltd was in charge of the service at the time of this inspection.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the general manager would be in the office to support the inspection.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and healthcare professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
On 15 April 2021 we spoke by telephone with 25 people who used the service and 9 relatives about their experience of the care provision. We also spoke with one member of staff who provided care to people. We visited the providers office on 13 May 2021. We spoke in-person with the general manager and an office administrator. We received feedback from a Local Authority who commissioned services from Divine Motions Healthcare Ltd.

We looked at a range of paper and electronic records. This included five staff files in relation to their recruitment, staff supervision and training records, eight care plans, complaints log and a variety of other records relating to the overall management and governance of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested the provider send us additional evidence after our inspection in relation to staff working rosters, staff recruitment, training and care planning.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At our last inspection the provider failed to have effective systems in place to ensure staff were effectively deployed to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 18.

● The majority of people using the service said that they felt safe with the care staff particularly if it was their regular carer or someone they were familiar with. Weekends or holiday periods were commonly referred to as being times when regular care staff were off work and the service became inconsistent.
One person told us, "My two main carers are brilliant but at weekends it's usually someone I don't know, or no-one turns up. The office doesn't give the new or different staff the right information. They are late for breakfast and early at dinner times at the weekend." Another person commented, "I haven't felt unsafe with the carers that come but they don't always come when they should on a Sunday."
A third person said, "I feel safe and valued with my regular carer but I'm supposed to have a bath at my 9 am visit but this week it's been 10.30 and then 10.00."
● For many people we spoke with, call times were not consistent or in keeping with their wishes or health needs. One person told us, "I complained yesterday as nobody turned up at all and they didn't ring to let me know. The man I spoke to did apologise and said he had forgotten to tell me that the carer had a family emergency." Another person commented, "I have a regular carer during the morning calls, but I have a different carer every evening which doesn't always run smoothly." A third person said, "Carers are supposed to come in 4 times a day, 7am, 12, afternoon and evening. I'm lucky if I get three of these visits a day."
● We looked at the electronic records of eight people currently using the service. Each had care plans and completed risk assessments relating to areas of risk such as moving and handling, mobility and general environmental risks around the home. Care plans and assessments were however inconsistent in their quality ranging from a basic generic list of tasks to a more detailed plan of care.
● Information about people's background, life history and likes / dislikes were not fully documented for all of the people whose records we looked at. This information could be important for staff to know if the person is living with dementia and/or unable to express their needs verbally.

This meant that the provider had continued to fail to ensure effective systems in place to ensure staff were effectively deployed to meet people's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection on 21 and 28 November 2019, we found the systems in place were not effective to ensure the safe management of medicines which placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 12.

● Feedback from people using the service included, "My week day carer is brilliant and [they administer my medication well] but the weekend staff aren't good at doing that", "The carers leave my medication in a pot for me to take but at weekends if they don't turn up or are late I have to do it myself" and, "I'm supposed to take medication 4 times a day but when carers don't turn up I have to do it myself."
Other people commented, "The carers help me with the blister packs to get my medication", "The Chemist delivers the locked dossett box and they administer from that and record on her medication administration sheet" and, "Sometimes I don't get the visits I should or they are late. They help me with my medication and if they don't come, I have to get the tablets out of a blister pack which can be hard if my hands are shaky."
● We reviewed eight people's paper and electronic medicine administration records (MAR) and found that these important documents were not being completed consistently and/or accurately. Issues seen included numerous gaps in records and non-use of codes to indicate why a medicine was not administered.
● Assessments were not in place for five of the eight people addressing the support they required with medicines and any potential risks around the storage, administration or monitoring of medicines to help ensure their safety. The individual level of support required by each person had not been assessed or detailed in these records.
● Staff had not received medicines training since 2019 and we saw no evidence that their competency to administer medicines safely was being routinely assessed by senior staff.

This meant that the provider had continued to fail to ensure safe management of people's medicines which placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Pre-employment checks were carried out for five staff whose records were looked at during the inspection. For example, we found proof of their identity and right to work in the UK, an employment history and health care check, and a Disclosure and Barring Services [DBS] check. A DBS is a criminal record check employers undertake to make safer recruitment decisions.
● However, the staff record for one member of staff was not available for inspection. We requested this staff record from the general manager, but it was not provided to us.

Systems and processes to safeguard people from the risk of abuse
● People told us their regular staff were caring and that they looked after them well. One person said, "The girls are kind enough when they are here, which I am grateful for. All this hasn't been easy." Another person told us, "The [care staff] are very nice and do their best."
● Staff had previously undertaken safeguarding training to make them aware of safeguarding procedures and the types of abuse they should be looking out for. We were however unable to find evidence of any refresher training since 2019.
● Local Authority commissioners raised concerns about the lack of information being provided by the agency when safeguarding investigations were taking place. Two examples were provided where the agency had been asked to provide further information and had failed to do so.

Preventing and controlling infection
● Most people using the service and their relatives told us that care staff wore their PPE correctly. One

person said, "They change their gloves after they help me with personal care, so I don't worry about catching Covid." Another person told us, "PPE is worn all the time and they pop it in the bin outside when they leave."

● We saw the service had adequate supplies of PPE which they stored in their office that met current demand and foreseen outbreaks.

● There was however no evidence that staff had received up to date Infection Prevention and Control (IPC) training, which included guidance about how to safely use PPE. The general manager told us that staff had received Infection Prevention and Control (IPC) training in 2020 but there was no evidence of this on the staff files we looked at. We requested further training records from the general manager, but these were not provided to us.

● The service was participating in the COVID-19 testing programme for staff. This meant staff were routinely tested for COVID-19.

Learning lessons when things go wrong

● Staff could access care documentation via their mobile device whilst out delivering support. The care provided could then be documented and logged on people's electronic records in 'real time' although the general manager told us there were still issues with the system that needed to be rectified.

● Records were kept of incidents and accidents, complaints and safeguarding incidents. Whilst these were recorded and action taken to resolve individual concerns, there was no evidence of learning from events and improving practice. Therefore, for example, there were continued complaints about missed or late calls and further errors or omissions in recording medication administration.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- The care plans we looked at were inconsistent in quality. Three of the eight care plans were not personalised and lacked detailed guidance on to support the person in the way they wanted. Three other care plans seen were much more person centred and included some good information about the individual and their preferences for care.
- Some people using the service told us they had regular carers who they were happy with and had known for a long time. This meant that they received care from people who knew them well and had a good knowledge of their needs and preferences. One person commented, "I have 4 or 5 regular Carers that come and have no problems at all."

People using the service and / or their relatives commonly said that care and support became inconsistent at times when their regular care staff were not working. One person said, "As different carers come at different times my [partner] isn't always about. I have to explain where things are as they don't seem to have a list that they pass onto other carers. Most of them are always in a rush." Another person commented, "The regular Carer is good with [person] but the others don't really take the trouble to get to know them." A third person told us, "I asked one carer if they had a care plan on me and she admitted she hadn't looked at it!!"

- Care staff could access electronic care plans via their mobile devices however the general manager reported that the system still had some issues that needed to be rectified.

Care or treatment was not planned with a view to achieving service users' preferences and ensuring their needs are met. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

- People's communication needs were not robustly considered.
- Information in people's care plans was not consistent or detailed enough to ensure staff understood or met people's communication needs.
- Some people and relatives said they had not seen any records of care or been asked about their preferences for communication. Information for people was not available in a variety of ways to support their understanding.

Care or treatment was not planned with a view to achieving service users' preferences and ensuring their needs are met. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Complaints and concerns were logged by the service however there was no evidence that this had led to consistent improvements in care.

● Some people and relatives expressed a lack of confidence that their concerns or complaints would be heard and acted upon. One person commented, "They are really nice Carers, but it's the organisation that lets it down. The office says they will ring back and then they don't. It really upsets my routine and stresses me out. They really have to look at how the place is run." Another person said, "I have complained time and time again to the office over the weekend visits, but they don't seem to care. I often have to phone up on the Monday to say a carer didn't turn up (weekends) but get told it will be sorted but it never is." A third person told us, "When my daughter rings to speak to the Manager, they are always "not working that day". The man she speaks to says he will call her back and then never does."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

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

At our last inspection on 21 and 28 November 2019, good governance systems were either not in place or robust enough to demonstrate safety was always effectively managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider continued to be in breach of regulation 17.

- The provider did not have effective systems in place to routinely monitor staff working practices and to respond when there were issues or concerns. Most of the people we spoke with were not happy with the way the service was being managed. This was mainly in relation to late or missed calls and a lack of communication from the office.
- Governance systems in place did not operate effectively because they had failed to pick up and/or act on a number of issues we identified during our inspection. For example, this included issues relating to medicines management, risk assessments, call management and staff training.
- Both paper and electronic MAR's seen were inconsistently completed and these were not being fully audited for compliance.
- Poor record keeping including the lack of completed care plans and risk assessments for some people meant it was difficult to track any changes made in the planned care being provided. There was no evidence of a consistent review process for these documents.
- New electronic care planning systems had been introduced but it was clear that these had not yet been fully implemented. There were both electronic and paper systems in place and these were difficult to audit effectively.
- There was no evidence that staff had received up to date Infection Prevention and Control (IPC) training during the 2020 pandemic or that there had been any refresher training around important areas such as Safeguarding and medicines since 2019.
- Complaints and concerns were logged by the service however there was no evidence that this had led to consistent improvements in care. Some people using the service and relatives expressed a lack of confidence that their concerns or complaints would be heard and acted upon.
- The management structure in place was not effective. The service had the general manager for day-to-day management of the service whilst the registered manager was absent. They were supported by a care

coordinator and office administrator. Commissioners and healthcare professionals told us that they did not have confidence in the ability of the organisation to respond promptly and effectively to any requests, issues or concerns raised. They gave multiple examples where information requested had not been provided in a timely manner. This issue was also evident during our inspection process where requests for information were not actioned in a timely manner or, alternatively, not responded to at all.

This meant that good governance systems were either not in place or robust enough to demonstrate safety was always effectively managed. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● One person told us, "I don't know of any care plans and I haven't had a review at all." Another person said, "I think I have a care plan but not sure, in the past I used to get surveys or phone calls to ask how things are going but not now. I think this was before Divine took over." A third person commented, "I have never been asked for feedback about the service, but the girls are nice, so I probably could recommend, but they need to get more organised in the office." Another person using the service commented, "They have asked me a few times to do surveys, but I don't bother with them anymore as its same old, same old and nothing changes."

● We were concerned that the people using the service and/or their relatives we spoke with had not been advised (as requested) that CQC would be contacting them by telephone. One person said, "I didn't get a call to say you were going to be talking to me today, but that doesn't really surprise me."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and how the provider understands and acts on duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● We found no evidence the service had learnt from complaints, concerns or incidents. Records of these were available but did not include any effective insight, for example, analysis for trends or patterns that would enable the provider to improve quality.

● The provider had failed to effectively monitor the service's performance and ensure that high quality care was provided. They had not identified significant on-going issues with the service's performance prior to this inspection. Action was not evident as to how the provider was addressing these quality issues.

● Information requested was not provided to CQC in a timely manner. Some information we required was requested multiple times and was still not forthcoming.

Working in partnership with others

● The provider had not worked effectively in partnership with commissioners and other healthcare professionals to help ensure people's needs were being met. Feedback provided to CQC indicated a current lack of confidence in the management at Divine Motions Healthcare Ltd. Recent issues highlighted included ongoing concerns about missed / late calls and the services failure to respond in a timely and effective manner.

● The service had not provided information in a timely manner as requested when safeguarding investigations were taking place.

This meant that good governance systems were either not in place or robust enough to demonstrate safety was always effectively managed. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 failed to ensure care was provided in a safe way, by establishing effective systems to ensure the proper and safe management of medicines.

The enforcement action we took:

We issued a warning notice. The provider is required to be compliant with the regulation by 31 August 2021.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effective governance systems.

The enforcement action we took:

We issued a warning notice. The provider is required to be compliant with the regulation by 31 August 2021.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed.

The enforcement action we took:

We issued a warning notice. The provider is required to be compliant with the regulation by 31 August 2021.