Destiny Intergrated Care Limited

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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 effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Destiny Intergrated Care is a domiciliary care service providing personal care to people living in their own houses and flats in the community. The service was supporting 40 people at the time of the inspection.

People and their relatives told us that care visits were often late, and some were missed entirely. People said that they found it difficult to get a response from the office when they phoned to find out where the carer was. Some people said they had to rely on their relative to help them instead of the carer from the service.

The management team did not have adequate systems in place to ensure that people received care visits at times that they were happy with. Some people lived alone and could not get help if they needed it. The management team did not know there was an issue with this until we told them what we had found during this inspection.

As a result of what we found, the management team then acted to review staff rotas, and they advised staff to call people if they were running late. They also purchased an electronic system to help them monitor if people were getting their care visits at the correct times and for the right duration. Although this response was positive, systems should have been in place to identify these failures.

People did not have completed risk assessments in place, with plans to show staff what they needed to do to keep people safe. We had been told about two potential safeguarding events where people may have come to harm. The management team had not followed safe practices in one of these cases. In the other the member of staff had not responded appropriately. Staff were not clear about how to protect people from potential harm.

Staff competency was being checked but these were not effective. The management team were not checking if staff were supporting people safely. Staff received training, but the management team were not checking if this training was effective. We found some shortfalls in staff skills and knowledge which the management team were not aware of. Staff did not have completed recruitment checks.

The management team were not assessing people's abilities to make their own decisions People's permission to share sensitive information with other agencies such as social services was not obtained

Some people and their relatives spoke well of the staff who supported them. However, most people spoke passively, finding staff to provide adequate care, but not finding staff overly kind or thoughtful. Some people did not find staff friendly.

People told us that staff promoted their dignity and offered them choices with their daily needs.

People did not have holistic care assessments and reviews in place to check that they were having a positive

experience from the service. The management team were therefore not identifying any shortfalls to the service.

Lessons were not being leant when things went wrong to try and prevent them from happening again. Audits and systems to check the quality of the service were not effective.

There were multiple breaches of the Health and Social Care Act 2008.

Why we inspected: This was a scheduled inspection based on the services previous rating.

Rating at last inspection: At the last inspection the service was rated Good (07 October 2016). At this inspection we found the service is now rated as Inadequate.

Follow up: 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 in 6 months to check for significant improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not Safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Destiny Intergrated Care Limited

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

Inspection team:
The inspection was completed by one Inspector and an assistant inspector.

Service and service type:
Destiny Intergrated Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides personal care to adults some of whom have long term health conditions.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We announced the inspection visit because we needed permission to speak with people. The service is also small, so we needed to make sure the registered manager would be available. We gave 24 hours notice to the start of the inspection. We telephone some people who used the service and some people's relatives on 8 May 2019 and visited the office on 15 May 2019.

What we did:
Before the inspection we asked the local authorities who used this service for their views. We checked statutory notifications which the provider must send us by law. We also reviewed the most recent provider information report. This is a report the service does telling us about what the service does well and

improvements it plans to make. During the inspection we spoke with six people who used the service, and six people's relatives. We also spoke with six members of staff; the registered manager and provider. We looked at nine people's care records, and three staff recruitment files. We also looked at audits of medicines records and daily notes, complaints and compliments.

Inadequate

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations had not been met .

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People and their relatives told us that they experienced late care visits. Two people had had missed calls. One person who had diabetes, told us that their lunch call was late. They said that they struggled to get something to eat so they could take their medication.
- The service supported some people who lived alone without involvement from friends or family. Some people were unable to leave their beds or were living with dementia. These people were unable to get help or call the office if their care visit was missed or late.
- We spoke with the registered manager about our concerns. They did not have an effective system in place to monitor if care visits were late or missed. We were concerned that people may not be receiving their care visits.
- Following our findings the registered manager and provider sent us evidence that they had purchased an electronic care visit monitoring tool. Staff had to log in when they arrived and left a person's house. This was soon to go live.
- Although, action was taken, the registered manager and provider had not identified that people had been missing care visits or had last care visits. As this system had not started when we inspected we were unable to see if this new system would be effective.
- People did not have thorough risk assessments in place. Few risk assessments had been completed. The registered manager told us about some of the risks which people faced. Assessments of these with plans to guide staff about how to manage these risks had not been completed.
- We identified risks such as non-response to care visits, people who had a history of self-neglect, people who smoked, people who had a history of falling, and a person who lived with a long-term mental health condition. Another person used and stored additional oxygen cylinders in their home. These risks had either not been identified or were not fully explored to promote people's safety.
- When one person's need changed identifying a new significant risk, a review of their risk assessment did not take place, to see how this new risk could be managed.
- We were not confident that the registered manager and provider were managing people's risks in a safe way.
- The service had a system of monitoring incidents. There was an event this year where a person's safety was at risk. We identified shortfalls in how staff responded to this event. These had not been identified. No post analysis had taken place to see what lessons could be learnt.
- The service did not have an emergency plan in place for emergencies such as severe weather or staff shortage. Practical information was missing from this plan and there was no evidence that this had been shared with staff who needed to know about this plan.

The lack of measures and systems in place to promote people's safety meant that this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People said that they felt safe with staff. One person said, "Oh yes, I feel safe." Another person said, "Yes I think so."

Systems and processes to safeguard people from the risk of abuse
● The registered manager and provider did not have good processes to protect people from potential abuse. A member of staff had noted that a person had bruising on parts of their body. They reported it to the registered manager, but appropriate action was not taken. The registered manager told us that this person was prone to bruising in certain areas of their body. But bruises were found in other areas of their body where they had not had bruises before. A safeguarding referral was not made. There was not a clear plan in place about what to do if this happened again.
● A relative told us about bruising which their relative had experienced. They believed it was by a member of staff being rough. They spoke with the member of staff about this and received a letter of apology. The registered manager did not know about this. This member of staff had not followed safe processes to report potential harm.
● When we spoke with staff we found that some staff struggled to tell us what potential abuse could look like. Staff did not know they could report their concerns to the local authority safeguarding team.

The lack of action and poor systems to respond to potential safeguarding concerns meant that this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● We looked at the recruitment processes for new staff. We found that the registered manager and provider were not verifying staff's references. Staff did not always have full employment histories. Staff application forms only asked for the last ten years of their employment history.
● We spoke with the registered manager and provider about this. They told us that they were aware of this issue, but they had not corrected it.

The lack of recruitment checks meant that this was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other recruitment checks were being completed. Staff identities were being checked and staff had Disclosure Barring Service (DBS) checks.

Using medicines safely
● The staff we spoke with told us how to safely administer people their medicines. Staff received training in this area and competency checks were completed.
● We looked at people's Medication Administration Records (MARs) and found these were completed and were accurate.

Preventing and controlling infection
● Staff told us how they promoted good hygiene practices when they supported people.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

●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 and found that the service was not fully compliant with the MCA.

● People had mental capacity assessments in place, however the purpose of the assessment and the outcome was not clear.

● How the assessor had assessed a person's ability to make a certain decision was not clearly evidenced.

● People had consented to receive care, but the registered manager had not gained people's consent to share personal information with other agencies such as GP's and social services.

Staff support: induction, training, skills and experience

● Staff spoke positively about their inductions. Staff were given a few weeks to spend time shadowing more experienced staff. New staff said they found this beneficial.

● Staff were receiving face to face training and this was mostly up to date. However, we found some shortfalls in staff knowledge and skills. For example, in safeguarding practices and how to communicate with people.

● The registered manager did not have systems to check if training was effective.

● Staff did not always receive training relevant to the people's needs they were supporting. For example, Parkinson's disease training.

● Staff competency checks were taking place, but these did not show how the assessor had reached a conclusion that a member of staff was competent. More challenging tasks such as supporting people with safe catheter care or supporting people to move with the use of equipment, were not being routinely checked.

●The registered manager and provider had identified that staff training needed more development. They had recently appointed a new member of the management team who was going to focus on revising how the service trained and supported staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People did not all have risk assessments. For people who did these risk assessments and care plans did

not follow good standards and guidance. For example, one person was living with a health condition and elements of their needs were not captured in their assessment. Good practice with their medicines was not being considered.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us that staff supported them with their food and drinks. One person said, "They [staff] tell me what's in the fridge and I choose."

● Staff gave us examples of how they provided people with food and drinks of their choice and how they encouraged people to eat and drink. Staff were clear with us how they would respond if a person was not eating or drinking enough.

● There was information about what people wanted to eat and drink at breakfast times, but there was limited information about other meals in people's care assessments and plans.

● The registered manager and provider did not have systems to check that staff were supporting people to have choice with food and drinks and that they were having enough to eat and drink.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● The people we spoke with told us that they felt confident that staff would respond if they were unwell. One person said, "I think they [staff] would know what to do."

● Staff told us what they had done to promote people's health. Staff told us that they would call 999 or a GP and stay with a person if they were unwell. However, we identified an event where staff did not stay with the person once they had called 999. This person was alone and vulnerable. Their health needs could have deteriorated in this time, or the ambulance crew delayed, requiring staff to find out where they were.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Most people spoke passively about the staff who supported them. People were not very positive in terms of how staff treated and interacted with them. One person said, "Well I haven't disliked any of them [staff], but it does vary, some are better than others." Another person said, "Some [staff] are very nice, some are just okay." A further person said, "On the whole [staff] are okay."
- We spoke with the registered manager about people's views of staff. They told us that they would create training sessions to support staff with their communication and presentation when supporting people. They also said they would look at this as part of their competency checks on staff.
- The registered manager and provider did not have effective systems in place to ensure people received their care visits and at times people were happy with. Some people and their relatives had late and missed care visits.
- People also told us that they found it difficult to speak to someone in the office to see where their carer was. Some people either struggled to complete the care task or they relied on their relatives to help them. One person said, "I'm lucky, I can ask my husband to help, but he is over [number of age]."

Respecting and promoting people's privacy, dignity and independence

- People told us that staff did this. One person said, "Oh yes, they draw the curtains." Another person said, "In general yes."
- Some staff struggled to answer our questions about how they promoted people's privacy and dignity. These members of staff did not have a clear understanding of what this looked like and the importance of promoting this. One member of staff talked us through how they did this when they supported people with their personal care.
- The daily log books completed by staff described the care provided in a respectful way.

Supporting people to express their views and be involved in making decisions about their care

- People's care plans did have personal details in relation to what people's routines looked like. Although, people's assessments and reviews lacked this detail. We concluded that people were being asked how they wanted to receive their care.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People told us that they had late care visits because of how the rotas were planned. One person said, "They [management] are pushing them [staff] too hard, they are rushed." People also told us that staff did not call them to say they are running late. A person's relative said, "Sometimes you have to ring up staff to find out where they are."
- People had care visits at times they were not happy with. One person said, "I hang about waiting, I start to feel hungry and sick." Another person said, "They [staff] come at funny times, they were an hour early for my breakfast yesterday."
- We spoke with the registered manager about this. They later told us that they had revised staff rotas to give staff more time to get to people. Staff told us that they now telephoned people to say if they are late. One member of staff said, "We were told yesterday, we can now do that."
- Some people told us that staff were not very personable to them. One person said, "Some try and make a conversation, some don't." Another person told us that staff are not happy when they visit them. They said, "I don't want people being miserable around me." A person's relative said, "Some staff act like they are not bothered, others treat [relative] like their family." A further person's relative spoke highly of two members of staff, they added, "We dread it when they are off."
- Most people did not have assessments of their needs completed. Even though certain risks were known, there was often no plan in place to respond and help manage these needs. One person had an increased risk of falling due to their environment. How staff were to promote this person's safety was not explored. Another person had communication difficulties. How to communicate with this person was not outlined in their assessment or care plan.
- People's assessments and reviews did not capture people's interests, preferences and backgrounds. Some likes, and dislikes were identified but these were limited.
- The registered manager was completing telephone reviews and people were being asked how they found staff during staff competency checks. The assessor was not asking key questions to test the quality of people's experiences with the service. Key information was not being recorded, for example who the assessor was talking to.

This lack of person centred care meant this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- There was a complaints process in place. A person had raised an issue with the service. The registered manager had investigated and addressed the issue. They had asked the person to return to them if it happened again.
- There was no information directing people to outside agencies such as the local government ombudsman

if they were not happy with the outcome of a complaint.

End of life care and support

● This aspect of people's care planning was not being routinely considered during their assessment and review of their care needs.

● The registered manager told us about one person who they were supporting who had reached the end of their life. They told us what their plans were to ensure staff had the knowledge and information to support this person well, during this time.

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

Services were not planned or delivered in ways that met people's needs. Regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- We had mixed views about the management of the service. No one knew exactly who the registered manager was apart from some people's relatives. One person said, "It's a new one isn't it? I can just pick up the phone, if I need to talk to them." Another person said, "91% of the time I don't blame the carers, it's the management."
- The registered manager and provider were not checking the effectiveness of the quality of care it was providing. Effective systems had not been created to ensure people received their care visits on time and at times they were happy with. The registered manager was not reviewing people's experiences of their care to see if this could be improved upon. People were not being asked about their views of the care they received in a meaningful way. Opportunities to learn from mistakes were missed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager did not have a clear understanding safeguarding practices. Their knowledge of what abuse could look like and how to promote people's rights was limited. There was no system in place to check the registered manager or staff members understanding and practice in this area.
- Risk management systems were not in place to support people safely.
- Audits were not effective in identifying the shortfalls of the service. Where shortfalls were identified there was not a robust plan in place to start working on them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The registered manager had not engaged with people who used the service in a meaningful way. Staff practice and knowledge had not been reviewed to see if improvements could be made to the service.
- There was not a culture of continuous learning. Effective systems were not in place to enable the service to improve.

The lack of effective quality monitoring systems meant people were at risk of receiving poor care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The registered manager told us how they had worked with the local authority and some health professionals. The registered manager also told us that had contact with other providers locally to share ideas and give support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (RA) Regulations 2014: Person-centred care. The provider had not ensured that people received person centred care. Regulation 9 (1) (a) (b) and (c)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that safe care and treatment was always provided to people. Regulation 12 (1) and (2) (a) (b) (c).

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment. The provider had not ensured that safe systems were in place to promote people's safety. Regulation 13 (1) (2) and (3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Well Led. There was a lack of effective systems to ensure quality care was always provided. Regulation 17 (1) and (2) (a) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA 2008 (RA) Regulations 2014: Fit and proper persons employed. There was a lack of checks regarding persons employed at the service. Regulation 19 (1) and (2) (a) (3) (a)