Destiny 24/7 Care Services Ltd

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Inspection report

24a Redwood Drive
Steeple View, Laindon
Basildon
Essex
SS15 4AF

Tel: 01268546688

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 24/7 provides personal care to adults in their own home. It also provides a recruitment service which supplies staff to the adult social care sector. This element of the service does not require to be registered under the Health and Social Care Act 2008. We focussed our inspection on the people in receipt of personal care only. This announced inspection took place on the 23 June 2017and two people were using the service.

During this comprehensive inspection we found multiple breaches of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people's safety had not always been assessed before care and support was delivered. Staff had not been trained with specialist training. Assessments and care plans did not always provide staff with specific information about how the person's care needs were to be met, and were not always in place before care was being delivered. Audits and governance systems were not in place. You can see what action we told the provider to take at the back of the full version of the report.

The service was run by the provider who was also the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider did not have a robust approach to monitoring the quality of the service people received and did not act in an open and transparent way. The registered manager did not give complete and accurate information about the number of people they were providing personal care to, although this was not the case at the time of the inspection.

Care plans were not always in place and did not reflect the support that each person required. Assessments to consider what support the person needed were not always carried out before care was delivered to them. Information about how people's health needs affected their daily living was not always recorded. Because of this, there was potential risk because their processes were not robust or clear or being followed.

Staff had been trained to support people to take their medicines, but the registered manager had not checked that staff were competent to do this safely. At the time of the inspection no one required assistance to help take their medicines. Because of this, there was the potential of unsafe practice to occur.

People did not require assistance to eat and drink to maintain their health, but when the registered manager carried out assessments before the person received care they explored this area. The registered manager supported people to have access to health professionals when needed.

Relatives told us they felt their family member was safe when staff visited them, and the registered manager and staff understood their responsibilities in terms of safeguarding people from abuse.

Staff understood the principles of the Mental Capacity Act 2005 and had been trained. Written consent was not always obtained before the service was provided but staff told us they asked for people's consent before supporting them.

Relatives told us they felt able to raise any concerns with the registered manager and staff told us that the registered manager was approachable and accessible.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's needs were not always assessed and risks to their safety had not always been identified and explored before care was delivered.

There was a sufficient amount of staff who had been recruited appropriately.

Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had been trained in core topics, but had not been trained in additional specialist areas.

Supervision was carried out but not always recorded, a robust induction was not provided to new staff.

The registered manager understood the legal requirements of the Mental Capacity Act 2005 but signed consent was not always obtained.

Is the service caring?

Requires Improvement

The service was not always caring.

The registered manager did not always treat people in a caring way because they did not assess if they could care for them safely.

People were cared for by staff that were friendly, caring and respectful.

Staff were attentive to people's individual needs and had a good knowledge and understanding of their likes, dislikes and preferences.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were not always in place and did not always reflect the support that each person required. The registered manager did not always carry out an assessment before delivering care to people.

People knew how to make a complaint and were confident they would be listened to and any concerns would be acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager did not provide us with complete and accurate information about the number of people they were providing personal care to.

Quality monitoring systems were not in place that identified the areas of the service that needed to improve. The registered manager was willing to learn and develop.

People and staff were able to approach the registered manager and felt listened to when they did.

Destiny 24/7 Care Services 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.

The inspection took place on 22 June 2017 and was announced. The provider was given 48 hours' notice as we needed to be sure that someone would be at the location. The inspection was undertaken by one inspector.

We reviewed the information we held about the service. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

We looked at information we held about the service and reviewed information sent to us from other stakeholders, for example, the clinical commissioning group and the local authority.

We spoke with the registered manger, the director, one staff member and one relative. We reviewed two people's information, to see how their care and support was planned and delivered and looked at other records related to people's care. This included information relating to quality assurance, complaints and accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

Risks to people's safety had not always been consistently assessed before care and support was provided for them, so staff did not always have the correct information to know how to deliver support to minimise the risk of harm. For example, one person had their care needs assessed before care started, and one person did not. Information relating to one person showed that risk assessments had been carried out, which included domestic and personal care tasks, risks to their safety at home and in the community and their physical and mental health. The other person receiving care did not have any risk assessments in place.

Because of the lack of records there was potential risk, even though the registered manager, the director and staff member delivered care to this person, and may have had a working knowledge of their care needs. If staff was used to support this person from their recruitment company, the correct information would not have been available, and there was the potential that this person may not have received care in the correct way.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) and found that it needed to make improvements around signed consent. For example, one person who used the service or their representatives had signed to say that they gave their consent to the care being delivered. Another person who had recently been referred to the service had not signed to say that they had given their consent to the care being given, because the registered manager had not completed the assessment.

At the time of the inspection, the registered manager told us they supported one person with their nutritional needs. As there was no assessment of care plan available for this person, we were unable to judge if people were supported to have sufficient food that met their dietary needs and preferences.

This is breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Despite inconsistencies, relatives told us their family members felt safe when staff visited them. One relative said, "They have done everything we have asked them to do. I can't say anything bad at all."

The registered manager, the director and one staff member had received training in how to safeguard adults from abuse, they knew the signs to look for which might tell them that someone was being abused. Staff told us that if they had any concerns they would report this to the registered manager, the local authority or the Care Quality Commission (CQC). The registered manager knew how to raise and deal with safeguarding alerts and concerns but did not consider the wider implications of keeping people safe. After the inspection, we were informed by commissioners that the registered manager decided that they could not continue to provide care to one person.

Relatives told us that there were regular staff and this gave people continuity and familiarity. One relative said, "We mostly have a regular carer. They told me who the carer was going to be and when there was a change they rung me and told me. Even though it's early days, I would give them top marks for everything."

There were enough staff employed to meet people's needs and keep them safe. The registered manager and the director provided direct care to people, and they employed one other member of staff.

At the time of the inspection, we were unable to judge if people's medicines were managed safely or that staff had the correct skills to administer medicines. This was because the people receiving care provider did not require assistance to take their medicines. The registered manager confirmed that supporting people to take their medicines would be something they would support if this was needed. The registered manager did not have a framework in place to make sure that they could monitor that if people did need support to take their medicines that they were receiving them correctly. There was no framework in place to assess staff competency in this area. The member of staff employed at the time of the inspection did not administer medicines to people.

Systems needed to be improved to ensure safe recruitment of suitable staff. The registered manager had undertaken a Disclosure and Baring Service Check (DBS) on staff before they had started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal records and to check if they are barred from working with people who use health and social care services. However when criminal disclosures had been made the registered manager did not carry out a risk assessment to ensure that this person was suitable to continue to work with people. Checks on the recruitment files of one member of staff showed they had completed an application form, provided a full employment history and that the registered manager had checked that they were eligible to work in the United Kingdom.

Requires Improvement

Is the service effective?

Our findings

The registered manager, director and staff member had been given training which included health and fire safety, manual handling, food hygiene, first aid, infection control, medicines, mental capacity, safeguarding and equality and diversity. One staff member said, "I have done all of the mandatory training, I did this when I first started."

At the time of the inspection the registered manager, director and one staff member was delivering care to two people. Not all of them could demonstrate competency linked to the needs to two people who was receiving care. Whilst staff had been trained in core topics, they had not been provided with specialist training. For example, staff had not been trained in pressure care, learning disability or behaviour that challenges. Because staff had not been trained in specialist topics that related to the care they were giving, there was the potential that people may not have received the correct care. At the time of the inspection we found there had been no impact to people's safety.

We were unable to obtain a range of people's views because of the limited amount of people providing a service. Despite the shortfalls in demonstrating effective and appropriate training, concerns about this were not commented on by people using the service. One person told us they received care and support from the registered manager, director and a staff member and they knew them well. One relative said, "They are courteous and they have done everything we have asked of them."

The service provided new staff members with an induction and information about the service. One staff member told us, "I had a good induction; it covered what I needed to know. I read all the procedures which were clear and I have them to refer to if I need them."

The registered manager had not considered how new members of staff could be supported to complete the Care Certificate. The Care Certificate is a set of minimum standards that health and social care workers should adhere to in their daily working life.

Staff said they felt supported by the registered manager and that they received regular supervision.

This is breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had received training in the MCA and were able to demonstrate that they understood their responsibilities with regard to seeking consent and supporting people to make their own decisions.
We checked whether the service was working within the principles of the MCA and found that it needed to make improvements and make sure that people or their representative provided signed consent before care

had started.

Despite the lack of assessments, information was available which showed that the registered manager has liaised with the district nurses to make sure that one person had been supported to access health care services.

Requires Improvement

Is the service caring?

Our findings

There were inconsistencies in how the provider demonstrated that their approach and management of the service was always caring.

Whilst we received positive feedback about staff, commissioners told us that on the day of the inspection the registered manager handed back a care package, with very little warning or notice. The registered manager did not treat this person in a caring way because they did not correctly assess if they could safely deliver care for this person at the point of referral. They did not consider that this could put the person's health and welfare at risk.

Despite this feedback from another person's relative told us they were well supported and that staff were caring towards them, "You know by the way that they are. You can tell if they like the person or if they don't. They are quite okay with [Staff member] and [Staff member] is quite chatty with them."

The registered manager, director and staff member, knew about the people they were supporting and could describe in detail things that were important to them. One staff member said, "I introduce myself and let them know who I am and build the relationship with people through conversation with them and understanding their interests."

People's relatives told us they felt that they mattered and staff were there for them. One staff member told us, "It's so important that people retain their independence. We do that by allowing them to have a say in everything that happens in their life."

The registered manager, director and staff member could explain how they treated people respectfully. One staff member described how they maintained people's privacy and dignity when providing personal care. They said, "I ensure the blinds and windows are closed." Staff members explained how they maintained people's dignity by keeping them covered with towels whilst providing personal care."

Relatives told us that their family member had been treated with dignity and respect by the registered manager, director and staff member. They said, "All the staff are great with [Name] and they know them well."

Given the small number of people the service was caring for, there was little feedback from people using the service. However A relative told us that the registered manager listened to their concerns and would act on any concerns very quickly. They felt involved in discussions around the care and support their family member received. One relative said, "There is nothing extra they could do. I will say I have regular contact with the Registered Manager and that's good enough. I just need to know when and where they are and what they are going to do about it if anything comes up. Up until now this is exactly what they have done." We saw that information about people was kept confidential and private.

The service had information about advocacy services and the registered manager said that this would be

available to people if someone needed to have independent support and advice to help them make decisions about their lives.

Requires Improvement

Is the service responsive?

Our findings

An assessment of people's needs which could then be used to develop a detailed care plan was not always carried out before the service had started. This meant that the registered manager, director and staff member may not have had the correct information available to them. For example, one person had an individual care plan which set out their care needs, and the other person did not. The registered manager explained that the person had not been receiving care from the service for that long and that they hadn't had time to complete the assessment and care plan yet.

Information did not always include details about people's preferences, wishes and aspirations, so staff may not always know how to respond to them appropriately. Gender specific care was not considered as part of the assessment process.

Care plans did not always provide the registered manager, director and staff member with specific information about how the person's care needs were to be met and what staff needed to do to deliver the care in the way the person wanted. For example, information about pressure care, and how a person's learning disability may impact on their life was not available. Care plans did not include personalised information which showed that the person was at the centre of the care and support, and information about people's history was not considered. Specific information that would provide staff with instruction about the person's end of life care wishes and preferences was not recorded.

Because this type of information was missing, there was the potential for risk because staff may not always have the correct information needed to deliver safe care to people. Whilst we acknowledge that there was a relatively small staff group working with people, the lack of information meant that if they were unexpectedly unavailable it would be difficult for others to know how to provide care.

This is a breach of Regulation 9 (1) (3) (a) (b) (c) (d) (f) (I) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that care plans would be reviewed every three months or sooner if people's needs had changed. At the time of the inspection no one had been receiving a service for longer than this.

The service had a complaints process in place, along with the statement of purpose for the service. This is a document which sets out how they will run the service for people and what they will provide. One relative said if they were not happy with the service that they were confident their complaint would be dealt with satisfactorily, and they had been actively encouraged to share their views and experiences of the service so far. At the time of the inspection no one had complained about the service they had received.

Inadequate

Is the service well-led?

Our findings

Governance systems were not in place, which meant that the registered manager could not easily monitor the quality of services that people received. The registered manager did not understand the principles of good quality assurance and told us that this was an area of the service that needed to be developed.

There was no framework in place to make sure that all information relating to the quality of the service people received was monitored and maintained. The registered manager did not have a process in place to check the safety and effectiveness of the service and to learn from any mistakes to help the service to improve. For example, the registered manager was unable to demonstrate that systems were in place to monitor the service, in relation to medicine management, governance oversight and checks on staff competency. Because there was no system to monitor the quality of the service people received, the registered manager failed to maintain or complete up to date records, which included a record of the care and treatment provided to people and of decisions taken in relation to their care.

The registered manager did not management risk effectively. For example, we obtained feedback about the service from clinical commissioning group commissioners and were told that on the day of the inspection the registered manager handed back a care package, without warning or notice. This meant that the person who should have been receiving end of life care was put at risk. This could have been avoided with thorough and more robust quality assurance process.

Enhanced DBS checks had been carried out for everyone working for the service. However, this was not linked to the governance framework and there was no system in place, such as, risk assessments and additional assurances, such as, staff not working alone so that the registered manager could assess the suitability of people when previous criminal convictions had been disclosed.

This is a breach of Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Views about the service had been collated from people and their families and these were recorded on an on-going basis and responded to accordingly.

The registered manager did not always act in an open and transparent way, and did not supply us with the correct information. Before the inspection we asked commissioners how many people had been commissioned to receive care from Destiny 24/7. When we asked the registered manager how many people they were providing care to, they supplied us with incomplete information, although this was not the case at the time of the inspection.

The service is provided and managed by the registered manager and was supported by a small staff team. The member of staff and the registered manager were aware of their responsibilities and accountability for the safety and care of people using the service. At this stage the service did not have a clear vision or a set of values.

Relatives told us they knew who the registered manager was and they were positive about their approach and the care they were providing. They said, "[Registered Manager] is really nice. They completed the assessment and with the [Director] they were very pleasant. They have been very courteous."

The staff member told us that the registered manager was always available to provide advice and support and showed respect for them and their work. Staff were motivated and enthusiastic about the support they provided and wanted to enable people to do as much as possible.

The registered manager was keen to learn and develop and they told us they wanted to work proactively in partnership with health and social care professionals to seek advice and support for the benefit of the people they supported. They told us about the ways in which they wanted to develop their business and that that they planned to contact the local authority to see if there were any ways in which they could support them.

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 The provider did not have effective processes in place to assess people's needs and plan their care in a way that put the person at the centre of what they do.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that risk was properly assessed in relation to people's health and safety and their medicines.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provision of staff support and development for staff may not be sufficient to give them the knowledge required to carry out their roles.

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 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not in place to review the quality of the service. A framework for robust governance was not in place.

The enforcement action we took:

Action plan requested