Divinus Support Limited

Divinus Support Ltd

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Divinus is a domiciliary care service providing personal care to people in their own homes. Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided. At the time of this inspection there were 18 people using the service, 13 of which were in receipt of personal care.

People's experience of using this service and what we found
At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

Right Support:
People were exposed to risk of harm as systems to ensure the safe and proper management of medicines were inadequate. Since our last inspection care plans and risk assessments continued to lack robust and clear guidance, with incorrect or conflicting information. Risk assessments continued to fail to direct staff on recognising symptoms of known health conditions.
Staff had not always been safely recruited. References had not always been appropriately obtained and we were not assured staff had access to training.

Right Care:
Staff call monitoring systems were not always effective to ensure safe care delivery. The provider could not be assured people received their care calls as expected as there was a lack of monitoring. The provider was not monitoring care records to ensure people received kind and caring support.

Right Culture:
Governance systems remained inadequate, and the service was not well-led. The provider failed to carry out their regulatory responsibilities and did not have adequate oversight of the service. They lacked recognition and understanding of risk and subsequently lacked robust assessments and controls to protect people and keep them safe. There was a high number of incidents requiring police intervention and a failure to identify and act on where things were going wrong.

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

Rating at last inspection and update: The last rating for this service was inadequate (published 28 December 2022)

Why we inspected

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well led which contain those requirements.

We have found evidence that the provider still needed to make improvements. Please see the safe and well led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Divinus Support ltd on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified continued breaches in relation to staff training, safeguarding, recruitment and oversight and management of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service therefore remains 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Divinus Support Ltd

Detailed findings

Background to this 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 Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 2 inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager.
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. This person was also the provider of the service. We have referred to them as 'the provider' throughout this report.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 5 October 2023 and ended on 10 October 2023. We visited the location's office on 5 October 2023 and attempted to carry out phone calls to people, their relatives and staff on the 7 and 8 October 2023.

What we did before the inspection
We reviewed our systems and information we held about the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report.

During the inspection
We were not able to speak with people who use the service. Despite repeatedly asking the service for their contact details, we were not provided with them. We did manage to speak with 2 people's relatives about their experience of the care provided to their family member. We had contact with 6 members of staff including care staff, the administrator and 2 directors of the provider company. We reviewed a range of records available. This included care plans and staff recruitment records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection, the rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At our last two inspections the provider had failed to provide staff with the training needed to equip them for the roles they were employed to perform. This was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at the last inspection.

At this inspection not enough improvement and the provider remained in breach of regulation 18. This means the provider has been in breach of Regulation 18 for 3 consecutive inspections.

- The provider failed to have a system in place to monitor people's call times to ensure they were not put at risk by variance in punctuality or call duration. This placed people who were unable to use or access a telephone at increased risk. A member of staff told us care call compliance was not being monitored at this time.
- Staff were still not receiving the training needed for the care roles they were employed to perform including having their competency assessed.
- We reviewed the service's mandatory training matrix and identified gaps in relation to the completion of training, and competency checks. For example, 3 staff had not undertaken moving and handling training and a further 3 staff had out of date training. 9 staff had not completed oral health training, 6 staff had not completed nutrition and hydration training and 7 staff had out of date safeguarding training.
- A further review of the staff training matrix showed 2 staff employed still had not received training in health and safety awareness. This placed people at increased risk of not being supported in a safe way and in line with their needs.
- Staff training continued not to be delivered in a safe and effective way to ensure staff had the necessary skills to keep themselves safe whilst delivering people's care. For example, despite using equipment to assist people to move, staff still did not receive practical 'hands on' moving and handling training to enable them to use equipment safely.

This demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were still not protected by safe recruitment practices. Robust checks had not been completed on staff's character, skills and experience before they began to care for people. Gaps in staff employment history had not been consistently explored. Checks had not been completed on a staff members conduct in previous social care roles. This mean the provider could not be assured that people were suitable to support vulnerable people.

● One staff record did not contain a reference from their last employer or sufficient attempts to gain one. They had a personal reference written by a friend 4 years prior to them starting work for Divinus Support Ltd. There was no evidence of completion of The Care Certificate or any induction. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Other staff files contained no evidence of an induction, limited supervisions and lack of effective spot checks of performance being completed. The appropriateness of this arrangement had not been considered or assessed.
● Two other staff had worked for the provider for over 13 years. During this time, their Disclosure and Barring Service (DBS) check had not been renewed. Whilst there is no requirement to repeat a DBS check, services should undertake a risk assessment taking into the account the nature of the work staff undertake and the potential scope for abuse. No such risk assessment had been completed by the provider. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe recruitment, training and support. This was a breach of Regulation 19 (Fit and proper persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection we found systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider remained in breach of Regulation 12.

● Risk assessments were either not in place or were not sufficiently detailed to help staff provide safe care.
● Risk assessments associated with health conditions, were not consistently in place or contained conflicting information, therefore failing to guide staff on how those risks should be managed. For example, one person had a catheter in situ. There was no care plan in place for staff to follow when providing care. A member of staff told us this person did not have a catheter and yet their daily notes made reference to a catheter.
● Monitoring of accidents and incidents that occurred was poorly managed. For example, one person had experienced 11 falls in August and September 2023. Only brief comments had been recorded by the provider and these related to the person being reminded to wear slippers and use their frame. There had been no analysis of the times of the falls, the location and any consideration of a referral to any specialised support. This meant we could not be certain whether appropriate action had been taken to ensure lessons were learned and the person continued to be at risk of further falls.

The provider failed to ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded, and managed. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection we found medicines were not managed safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and significant concerns remained about the safe management of people's medicines. The provider remained in breach of Regulation 12.

● Medicines were not consistently managed safely. Systems and processes in place were not effective or robust in identifying and acting on concerns. Monthly audits were completed of people's medication administration records (MARs) but did not consistently recognise errors or the concerns with the records we found during inspection. This put people at risk of harm.
● MAR charts were completed on a monthly basis by staff. The MAR charts were not completed in line with National Institute for Health and Care Excellence (NICE) guidance. MAR charts did not contain the strength of the medicine, clear instructions on how often or the time the medicines should be taken, how the medicine was to be taken or used and additional information such as specific administration instructions.
● Some care planning documents we reviewed stated people were independent and only required prompting to take their medicines. However, we found staff were actively involved in the administration of these people's medicines without the necessary guidance to do this safely and ensure regular reviews. This had the potential to put people at risk of not receiving their medicines safely and as prescribed.
● Handwritten entries on MAR charts were not made in line with good practice guidance. Recordings were scribbled out at time and blue ink used to make entries on MAR charts. NHS guidance states staff handwriting must be legible and written in black ink to enable legible photocopying or scanning of documents if required.
● Guidance and records were not always in place to support the safe administration of topical medicines. We found that guidance was not clear for how often creams should be applied and there were gaps in recordings of administration.
● Medicine stocks were not clearly recorded on the medicine administration record to evidence that staff were checking medicines were administered as the prescriber intended.
● 'As required' medicines protocols (PRN) were not in place. This meant staff did not have clear instructions about when 'as required' medicines should be offered and administered.
● Systems in place were not robust to ensure changes in people's medicines were managed safely. For example, one person was prescribed a medicine and for several weeks staff recorded that the medicine had not been available for over 4 weeks. No further actions had been recorded, for example, to follow up with family. The provider was unable to confirm if the person still needed these medicines and they did not have them, or if the medicines were no longer required and their care plans had not been updated. People were therefore placed at risk of harm from not receiving the medicines they needed.

Medicines management was not robust enough to demonstrate that medicines were always managed safely. This 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.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found we were not assured staff would recognise and respond to abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider remained in breach of Regulation 13.

● There continued to be a lack of robust systems in place to protect people from the risk of abuse.
● Where staff carried out shopping tasks for people there were no care plan guidance in place for staff to do this safely. Risk assessments completed were not suitable and did not explore the risks to people to protect them from the risk of financial abuse.
● Staff had access to people's personal debit cards and security banking pin numbers to pay for goods purchased on their behalf. Whilst staff told us receipts were obtained, these were not available in the providers office and had not been audited.
● The provider could not be assured staff were not using their own personal store reward cards when purchasing goods as there was a lack of systems in place to ensure oversight of this.
● There were no records of financial transactions completed. A member of staff told us the provider was currently not checking the records as they were unsure of the long-term future of the service.
● A staff member described how their moving and repositioning training took place in people's homes, with staff undertaking the training watching other staff support people during their care. This was not appropriate and there was no evidence people's consent had been sought.
● A lack of professional boundaries and robust guidance placed people at risk of harm and abuse. The provider was permitting their own family members to work together delivering people's care without an appropriate risk assessment in place.
●Training records showed out of 10 staff, 7 were not up to date with annual safeguarding training, as required by the provider. Staff we spoke with had mixed levels of knowledge around safeguarding concerns. All staff we spoke to said they would report a safeguarding concern to management, however not all staff were able to describe how they could escalate safeguarding concerns outside of the provider organisation. This had not been identified by the provider as a knowledge gap. This meant people were cared for by untrained staff which put them at risk of harm.

Systems were either not in place or robust enough to demonstrate people were protected from abuse. This placed people at risk of harm. This was a repeated breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider continued to have arrangements in place for preventing and controlling infection.
● Staff continued to have access to personal protective equipment (PPE) which they could collect from the providers office. However, not all staff had undertaken training in infection prevention and control. Of the 10 staff employed, 1 had not completed the training and 2 staff still had out of date training.

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 our last inspection we rated this key question inadequate. At this inspection, the rating has remained 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.

At this inspection we found improvements had not been made. It remained that systems were either not in place or robust enough to demonstrate effective oversight and governance of the service. This was a repeated breach of regulation 17.

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

- At this inspection there were repeat breaches of regulations relating to safe care and treatment, staff and fit and proper persons and good governance. The provider failed to ensure governance systems were effective in identifying where fundamental standards were not being met or driving improvements where required. They were not robust and did not identify the continued significant concerns found on inspection.
- The provider continued to fail to fully understand their roles and responsibilities and make the required improvements to ensure people received consistently good and safe care. The provider had been in breach of the regulations and failed to meet regulatory requirements over the past 3 inspections.
- Quality checks and audits were not operated effectively. Systems to analyse safe record keeping and administration of medicines, incident and accident trends, identify learning and improvements were ineffective. This meant the provider had failed to ensure a complete and accurate account of people's care and treatment, placing people at risk
- There were no systems in place for the provider to monitor and ensure they had oversight of whether people were receiving their care calls at the right time or not. This meant, we could not be assured people's needs were being met in line with their commissioned hours.
- The provider continued to fail to ensure people's care and risk management plans were person centred and detailed to guide staff in how people's specific needs were being assessed and met.
- There remained shortfalls in the monitoring of staff performance and training. There continued to be a lack of opportunities for staff to access supervision to discuss their performance, any concerns they might have and identify any training needs.

Systems were either not in place or robust enough to demonstrate effective oversight and governance of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

● We found the provider was using covert surveillance at their office. This is where there are hidden cameras or microphones that people are not aware of in use. If they are using cameras to record their staff or visitors to their office, providers must display prominent notices warning visitors of the type of surveillance that is in operation there, and who can be contacted about the scheme. It must be made prominent and clear to staff when, how and why surveillance is taking place, and who they can contact about it.
● Whilst the provider had a duty of candour policy in place, we were unable to see that the provider had always followed this. This was because accidents and incidents and the provider's responses and actions to them were not recorded.
● The provider was not acting in a transparent manner. Two of the providers immediate family worked at the service, delivering personal care to people. The provider completed the competency assessments of their own family members skills to work and deliver safe care. Arrangements were not documented to evidence that potential safeguarding risks and conflicts of interest had been considered.
● The provider told us the local authority had visited the service to review their progress against their action plan and had no complaints about progress being made. This was not in line with feedback CQC received from the local authority where concerns continued to be shared about Divinus Support Ltd and poor oversight and ineffective systems in place.
● Providers must ensure that their CQC inspection rating is displayed conspicuously and legibly at their service location and on their website if they have one. The provider failed to display their rating at their office location.

The provider was not acting in an open and transparent manner. This was a breach of regulation 20 (Duty of Candour) 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
● Since our last inspection, satisfaction questionnaires had been sent to people using the service. The majority of responses available to view were positive, however where comments had been made such as "not always on time but not by much" and "would prefer earlier call" no action had been recorded to address the feedback.

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 Systems had not been established to ensure safe and effective administration of medicines. There was a failure to establish systems to effectively monitor risk and do all that is reasonably practicable to mitigate risk.

The enforcement action we took:

Notice of Decision to Cancel the Provider

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate a robust quality assurance process to continually monitor and oversee the quality of the service and ensure any shortfalls were addressed.

The enforcement action we took:

Notice of Decision to Cancel the Provider and Registered Manager

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure appropriate staff recruitment processes were in place and carried out.

The enforcement action we took:

Notice of Decision to Cancel the Provider and Registered Manager

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider failed to comply with the Duty of Candour and did not act in a transparent manner.

The enforcement action we took:

Notice of Decision to Cancel the Provider and Registered Manager

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that fully trained staff were deployed sufficiently to meet people's assessed needs.

The enforcement action we took:

Notice of Decision to Cancel the Provider