Divine Motions Acacare Limited

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Inspection report

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 13 and 15 December 2017 and was announced. Divine Motions Acacare is a domiciliary care agency which provides personal care to people in their own homes. It provides a service to older adults and younger disabled adults. People received support through scheduled visits. At the time of our inspection there were 113 people using the service.

The service had a registered manager who had been in post since 2014. 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 2008 and associated Regulations about how the service is run.

We previously inspected the service in August 2017. At that inspection we gave the service an overall rating of "Good". Since that inspection the service had gone through a period of rapid expansion after being awarded a large contract by a local authority. The systems in place for assessing and monitoring the quality of care people received were not sufficiently robust to effectively manage the increase in the number of people using the service which resulted in some areas of the service no longer being well-managed.

Staff did not always follow the provider's medicine administration policy and procedures and the provider's medicine administration auditing process was not sufficiently robust to identify this. This meant there was a risk of people receiving their medicine in a way which was unsafe.

Half the people we spoke to told us they had experienced late visits. People also told us they had experienced missed visits particularly at weekends. This meant that people were at risk of unsafe care and treatment as they received support with their personal care, taking their medicines and having their meals late or not at all on occasions. People told us that the issue of missed visits and poor punctuality was particularly bad in the three months before our visit but it had improved recently.

Registered providers must notify the CQC about certain changes, events and incidents that affect their service or the people who use it. The provider did not notify CQC of notifiable events such as allegations of abuse. This meant the CQC did not have full oversight of the risks associated with the service.

The provider had a thorough recruitment process which was adhered to by the management and included conducting appropriate checks on staff before they began to work with people. People were supported by the right number of staff to meet their needs. However, staff were not adequately supported by the provider to deliver effective care because staff training and supervision were not up to date.

People felt safe from abuse. Staff had been trained in protecting adults from abuse and had good knowledge of how to recognise abuse and report any concerns. People were protected from avoidable harm because risk assessments identified the risks each person faced and gave staff guidance on how to manage those risks which staff followed.

Staff understood their responsibility in relation to infection control. They had access to an ample supply of personal protective equipment such as gloves and aprons. They consistently followed the provider's infection control policies and procedures which helped to protect people from the risk and spread of infection.

Staff treated people with kindness and respect. They supported people in a way that maintained their privacy. However some people's dignity was compromised when they had to wait to be supported with personal care because staff arrived late.

People who were supported with their meals told us the quality of food was good and they had a sufficient amount to eat and drink. Staff supported people to maintain good health and access external healthcare professionals.

People were supported by a consistent staff team. People were involved in planning their care and were asked for their consent before care was provided. Staff knew people well and understood people's routines and preferences. People were given choices and their wishes were listened to and acted on.

Staff understood the main principles of the Mental Capacity Act 2005. People felt able to raise any concerns and knew how to make a complaint. The provider responded appropriately to people's concerns and complaints but did not have a system in place to monitor them so as to identify trends and drive improvement.

There were a variety of systems in place to assess and monitor the quality of care people received. However these were not always effective in identifying areas which required improvement. The management of the service was reactive rather than proactive which meant that there was not a clear strategy for ensuring that people received consistently good care or a contingency in place for when things went wrong.

We found breaches of the regulations in relation to the provider's failure to provide safe care and treatment, notify the CQC of notifiable events and the lack of effective systems to assess and monitor the quality of care people received. You can see what action we asked the provider to take at the back of the full version of this report.

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.

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

Some aspects of the service were not safe.

People experienced late and missed calls which impacted the quality of care they received. Staff did not consistently follow the provider's policies and procedures regarding managing people's medicines.

Staff knew how to recognise abuse and report any concerns. Risks to people were assessed and staff had guidance on how to manage the risks identified.

People were protected from the risk and spread of infection.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider's support for staff through training and supervision were inconsistent.

Staff understood the main provisions of the Mental Capacity Act 2005.

People who required it were supported to have a sufficient amount to eat and drink.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect. They were involved in making decisions about their care and the support they received.

People were supported by a consistent staff team who knew people well.

Staff supported people to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff frequently arrived at people's homes late and some people experienced missed visits.

There was a complaints procedure in place but the provider did not have a system in place to monitor complaints so as to identify trends and drive improvement.

Is the service well-led?

Requires Improvement

The service was not well-led.

The systems in place to assess and monitor the quality of care people received were not as effective as they needed to be.

The standard of record keeping was inconsistent and the provider did not always have access to records relating to people, staff and management of the service. The provider failed to submit statutory notifications to the CQC.

Divine Motions Acacare Limited

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.

We inspected Divine Motions Acacare because we received information from a local authority which commissions the service and feedback from people using the service, raising concerns about the safety and quality of care provided. This inspection took place on 13 and 15 December 2017 and was announced. The provider was given 48 hours' notice of the first day of the inspection because the location provides a domiciliary care service and we needed to be sure the registered manager would be available at the registered office. The inspection was conducted by a single inspector.

Before the inspection we reviewed the information we held about the service including the Provider Information Return. This is information we require providers to send to us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at reports from previous inspections and statutory notifications submitted by the provider. Statutory notifications contain information providers are required to send us about significant events that take place within services.

During the inspection we spoke with the registered manager, deputy manager and the quality assurance lead. We looked at eight people's care records, four staff files, medicines administration records (MAR) for seven people and other records relating to the management of the service. We requested further information from the provider regarding staff training. There was a significant delay in this information being provided.

After the inspection, we spoke with twelve people using the service, two relatives and five staff. We also

spoke with a representative of a local authority which commissions the service.

Requires Improvement

Is the service safe?

Our findings

Since our last inspection, the number of people requiring support to take their medicines had increased. People did not express any concerns about whether their medicines were administered safely. However, we found that the provider did not always manage people's medicines safely. The provider required staff to sign a person's medicine administration records each time they administered medicines to confirm that medicines had been given. We looked at seven people's medication administration records for November 2017 and found gaps where staff had not signed the records in all seven records. There was no indication whether the people concerned had refused medication, were in hospital and or if staff had neglected to administer medicines.

We looked at the provider's register of medicine errors. We saw that between 16 November 2017 and 12 December 2017 a further five people's MAR charts had multiple gaps without an explanation. Therefore the provider could not be sure that people were receiving their medicines. Staff did not always follow the provider's procedures or people's care plans when people refused their medicines. For example, one person's care plan stated their GP should be contacted if they refused to take their medicines. Care records stated the person had refused their medicines on numerous occasions during the three months before our visit but their GP was not contacted until this was raised with the provider by the person's social worker.

We discussed these failings with the registered and deputy managers who were unable to explain why the person's GP was not informed when the person refused medication. They told us that staff sometimes forgot to sign people's MAR charts but they were confident people received their medicines as prescribed.

People using the service were not always safe because staff often arrived late and sometimes did not turn up at all to provide care. Furthermore, the provider did not have an established process in place to identify when staff were late or had not attended at all and did not have an effective system which enabled it to organise replacement staff promptly. Half the people we spoke with told us they had experienced late visits. A quarter of the people we spoke with told us that on occasion staff had not arrived at all for a scheduled visit.

People told us the lack of punctuality and non-attendance was particularly bad in the three months before our visit and had impacted their care but that it had improved recently. They commented, "During the week they are fine but at weekends they sometimes turn up late morning to help me get washed and dressed and make my breakfast. I don't want to be getting washed and eating breakfast at lunchtime. It's very inconvenient", "It was really bad a few months ago. There was no knowing what time they would turn up so I had to help myself the best I could. They've been a lot better recently", "My only complaint about them really is that they don't come when they are supposed to", "Sometimes they don't turn up at all. I don't even get a call and if I call the office they don't seem to know anything about it" and "The carers have not turned a few times and I've had to get help from [a relative]. There's never any apology or explanation."

A representative from a local authority which commissions the service told us they were concerned that late and missed calls had resulted in some people missing meals, not receiving personal care and not having

their medicines. We raised these issues with the registered and deputy managers who told us that in early 2018 they planned to put an electronic system in place which would enable them to monitor people's call times and the activity of care staff more effectively. However they had not considered the other processes they would have to establish to complement the electronic system. For example, how the rota would be organised to ensure that replacement staff would be available if the electronic system identified that staff had not attended a scheduled visit.

These issues amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements were in place to protect people from avoidable harm. Records showed that risks to people had been assessed when they first started to use the service and reviewed regularly thereafter. The risk assessments were personalised and covered areas such as the person's home environment. Care plans gave staff information on how to manage identified risks and keep people safe such as, how to minimise the risk of falls.

Incidents and accidents were documented however they were not formally audited. Staff told us if they noted, for example, a person was having an increased number of falls, they would report it to the office. Due to the lack of a robust monitoring system we could not be assured that the managers and the provider had a good overview of accidents and incidents so as to identify any trends which would enable them to put measures in place to prevent reoccurrence. We discussed our concerns with the registered and deputy managers. They told us they would immediately develop procedures to ensure systems were in place to monitor accidents and incidents and take appropriate action when a trend was identified. However we remain concerned as this formed part of a pattern of ineffective systems to assess and monitor the quality of care people received. Our concerns in relation to this are further highlighted in the "Well-led" section of this report.

Staff were recruited using a safe recruitment practice which was consistently applied. This included appropriate checks before staff began to work with people. Records we reviewed demonstrated that professional references, confirmation of an applicant's right to work in the United Kingdom and that they were physically and mentally fit to do the job were obtained. Criminal record checks were also carried out. This helped to ensure that staff were suitable for the role for which they were employed. The number of staff required to support people safely was assessed when a person first began to use the service and reviewed when there was a change in the person's needs. Records indicated that people assessed as requiring the support of two staff were supported by two staff. People confirmed that they were supported by the right number of staff.

People were protected from the risk and spread of infection because staff followed the provider's infection control procedures. People told us staff supported them to maintain appropriate standards of cleanliness and hygiene in their homes. They told us that staff wore gloves and aprons when supporting them with personal care. Staff understood their role and responsibilities in relation to infection control and told us they had an ample supply of personal protective equipment.

Requires Improvement

Is the service effective?

Our findings

Since the provider had recruited more staff to meet the needs of the increased number of people using the service, there had been a decline in the level of support staff received through training and supervision. Staff told us and records confirmed they received an induction before they were allowed to work with people alone. This included training in areas such as infection control, first aid and food hygiene as well as familiarisation with the provider's policies and procedures. Staff employed by the provider for more than one year received an annual performance review.

Staff felt they had all the training they needed to meet the individual needs of people using the service. People were confident staff had the knowledge and skills to carry out their role and told us, "They are good" and "I think they've been trained and know what they are doing". However records indicated that some staff had not received their annual refresher training in topics such as manual handling, infection control and medicine administration when it was due.

We wanted to check whether the provider was supporting staff through regular supervision meetings and if these were up to date. Supervision meetings are important as they give staff the opportunity to raise issues affecting their role, reflect on their own practice and learn from good practice. The registered manager told us that supervision took place monthly in the form of spot checks to observe staff practice or structured one-to-one meetings. During our visit, the provider was unable to provide records relating to staff supervision or spot checks that had taken place in the month before our visit. After our visit the provider sent us a list of dates that staff had attended supervision meeting. These records indicated that staff supervision was not happening monthly. Staff told us they received supervision but it was not monthly which indicated that staff supervision was inconsistent. Staff commented, "I had a supervision meeting about two weeks ago but I hadn't had one before that for a few months. I think it was because the supervisor left because they used to be quite regular", "I haven't had supervision for a while" and "I have supervision about every three or four months." The inconsistency with staff supervision and training had not impacted the quality of care people received but we will check this again at our next inspection.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The MCA requires providers to submit applications to the Court Of Protection if they consider a person should be deprived of their liberty in their best interests. We checked whether the service was working within the principles of the MCA. We saw the capacity assessments formed part of the initial assessment of people's needs. The registered manager told us that when they had concerns regarding a person's ability to make a decision, their family members and health and social care professionals would be involved in making decisions on their behalf and in their 'best interests' in line with

the MCA.

Staff understood the main principles of the MCA. Staff told us of the importance of allowing people to make their own decisions and the action they would take if they felt a person lacked capacity to make a particular decision.

People had access to the equipment they required to enable them to be as independent as possible. For example, the provider liaised with social workers and occupational therapists to ensure people with mobility difficulties had appropriate wheelchairs.

Care co-ordinators carried out assessments of people's physical, mental and social needs; they did so in line with national guidance such as the Department of Health guidance on care and support planning. This helped to ensure that people were involved in their care planning and that people's care was planned to promote their well-being.

People were encouraged to eat and drink sufficient amounts to meet their needs, where the service was responsible for this. Staff obtained information from people and their relatives about their dietary needs and how they wished to be supported with this. This information was documented in people's care plans, as well as how people preferred their meals to be prepared. Where appropriate, staff recorded how they supported people with their meals. These records indicated the meals prepared by staff were based on people's specific preferences and choices. For example, one person's care plan stated that they liked to have porridge for breakfast and the records of care indicated that this is what they received.

People's care files contained details of their GP and other healthcare professionals involved in their care. People's care files contained relevant information for staff about the support they needed to manage their health conditions. Where appropriate staff liaised with external healthcare professionals to help maintain people's health. For example, we saw that staff contacted a person's care manager and GP when they had concerns about the person's reduced mobility.

Good

Is the service caring?

Our findings

All the people we spoke to made positive comments about the staff who supported them. People commented, "My carer is fabulous. She is genuinely caring and goes above and beyond", "I'm very happy with the carers", "Apart from their time-keeping being a bit erratic I'm happy with the carers", "I'm happy with them. They sit and have a chat which is important", "My carer on Monday to Friday is lovely" and "I would say I'm happy with them."

We received mixed feedback on whether people's dignity was maintained. The negative comments we received were due to staff arriving late. People told us, "It's not on having to wait for hours to have a wash. Once they're here it's fine" and "It makes me feel a bit helpless when I'm left waiting for the carers to turn up. It's very frustrating and inconvenient." However, other people told us, "I find it hard accepting help even though I know I need it but they are very considerate", "They respect my wishes." A relative told us, "They are polite and respectful. [The person] is very proud but the way they are makes it easier for [The person] to accept help." People who wished to be supported with personal care by staff of the same gender told us that they were. This helped to make people feel that their views mattered.

Staff provided care in a way which maintained people's privacy. People commented, "When they have helped me in the bathroom I like to be left alone. They know that now and get on with what they have to do" and "If I'm not feeling up to getting out of bed they respect my wishes." A relative told us, "They asked [my family member's] permission before telling me anything."

People were supported by a consistent staff team who knew them well. This facilitated the development of meaningful relationships which in turn benefitted people's general well-being. People commented, "I couldn't do without my carer. She is the silver lining in the cloud of becoming disabled", "I usually have the same carers and they know what to do" and "My carer know the ropes and is lovely." A relative commented, "[The person] has a pool of regular carers who [the person] is really comfortable with. It has made [the person's] life much easier."

People and where appropriate their relatives told us they were involved in helping the service to plan the care and support they received. Before people began to use the service they were visited by a care co-ordinator who carried out an assessment of their needs and preferences with their input. The provider ensured people were given information to help them understand the care and support choices available to them before they started using the agency. People told us they had been given a booklet about the service which helped them understand what they could expect.

People were supported to retain as much independence as possible. People's records detailed the level of support they required from staff with day to day tasks. People told us they did as much for themselves as they wanted and were able to. They commented, "They know I like my independence and let me do what I can. They know I'll ask for help when I need it" and "My carer knows me well enough to know that I don't want her taking over. I need to at least try to do what I can for myself." Staff we spoke with understood the importance of supporting people to have as much control of their life as possible, including making their

own decisions, and involving people in their daily care regardless of their needs. They explained how they allowed enough time for tasks and did not rush people.

Requires Improvement

Is the service responsive?

Our findings

People received personalised care but the support they received was not always responsive to their needs as it was not provided at the time people required it as highlighted in the "Safe" section of this report. With the exception of staff lateness and staff failing to turn up on occasions, people were satisfied with the quality of care they received.

Before people began to use the service an assessment of their care and support needs was undertaken to ensure the service could meet their individual care and support needs. The sample of care plans we looked at were person-centred. Care plans included information about people's background and preferences on how they wished to receive their care and detailed daily routines specific to each person and their visit. People were involved in the review of their care plans. Care plans were reviewed every six months or whenever there were changes in a person's needs. If a person's needs had changed, the service liaised with the local authority in order to organise an amendment to their care package so that people received appropriate support. Staff told us they had access to an up to date copy of care plans in people's homes.

The provider had arrangements in place to respond appropriately to people's concerns and complaints. People told us they knew how to make a complaint if they needed to and would feel comfortable doing so. People told us they had complained about staff being late and that this had improved recently. One person told us "I get [a relative] to ring the office when they don't turn up on time." There was a system in place for the registered manager to log and investigate any complaints received which included recording any actions taken to resolve the issue raised. However, the provider but did not have a system in place to monitor complaints so as to identify trends and drive improvement.

The provider had equality and diversity policies in place and staff had received equality and diversity training. The provider was committed to promoting diversity and inclusion. This included taking into consideration any communication and language needs of people using its services. The registered manager told us that no one currently using the service required information in accessible formats, for example in large print. We noted where people had a hearing impairment and required hearing aids, their care plans included information for staff to support people to wear these and check they were working.

Requires Improvement

Is the service well-led?

Our findings

People received care and support from a service which at the time of our visit was not well-managed or well organised. People commented, "The carers are great. It's the company that's the problem", "The communication with the office is poor", "Things were really bad a few months ago. No-one would turn up then two would turn up within five minutes of each other but it's got better recently" and "They seem a bit disorganised." However other people told us, "I'm very happy with them" and They seem pretty organised."

Staff were clear about their roles and responsibilities but the management were less clear about theirs. The registered manager did not fully understand her responsibility to submit statutory notifications; she had not complied with her legal obligation to notify the CQC without delay about certain incidents which had adversely affected the health, safety and well-being of people using the service. We compared information received from a local authority with notifications submitted by the registered manager. Our records indicated that at least five allegations of abuse had been raised about the service which the registered manager had not notified the CQC about. We raised this with the registered manager who told us that although they were aware of the incidents they did not know they were classed as abuse and therefore had not notified the CQC. The provider's failure to submit notifications as required by law meant the CQC did not have oversight of and could not fully monitor any risks associated with the service.

This failure represents a breach of Care Quality Commission (Registration) Regulations 18 (Notifications of other incidents) 2009.

Since our previous inspection in August 2017, the number of people using the service had increased significantly. The provider did not have a clear strategy to deliver good quality to care to the increased number of people using the service or to improve the quality of care people received. Consequently, many areas of the service which were previously good now required improvement. Since our last inspection there had been a lack of robust auditing and monitoring of the quality of the service in relation to medicine records, incidents and accidents, staff punctuality, and training and supervision. This meant there was a risk of people receiving care or treatment that was not safe.

We saw that staff training and supervision had been audited and the provider was aware that these were not up to date but there was not a plan in place to bring staff training and supervision up to date. Accidents and incidents were recorded but there was not an audit system in place. This meant we could not be assured the provider had a good overview of accidents and incidents so as to identify any trends which would enable them to put measures in place to prevent reoccurrence. A local authority representative told us that the provider's systems did not enable the provider to quickly spot issues, understand trends and take relevant action, and their practices did not always match their own policies and procedures.

The provider was aware that there was an issue with staff punctuality and staff not attending scheduled visits. However this continued for several months. The registered manager was hopeful that the planned electronic log-in system for staff would remedy the lack of staff punctuality and non-attendance. However, it was clear from speaking to the management that they had not considered that this system alone might not

be sufficient to ensure better staff time-keeping.

Staff supported forty people with their medicines. According to the provider's policy and procedure, people's MAR charts were to be returned to the office monthly by staff for auditing. Seven of the forty MAR charts were at the registered office at the time of our inspection. All seven MAR charts had gaps in the recording. Neither the fact that the MAR charts had not been returned to the office or the gaps in recording had been identified by the provider's auditing system.

Had there been more effective quality assurance and governance processes in place, the provider would have identified the issues we found during our inspection and had the opportunity to devise and implement an action plan to make the required improvements. Management acknowledged this area required further work to ensure effective, robust quality assurance systems were in place. Although a quality assurance lead had been appointed recently, they had not been in post long enough to have had an impact on the auditing processes in place.

We requested a variety of records relating to people, staff and management of the service. Some of the information requested was not available at the time of our inspection and we had to wait for several weeks for it to be sent to us by the provider. For example, on the final day of our inspection we requested evidence of staff training. We were advised by the deputy manager that the information was held on their computer system and that it was not working. We asked for the information to be sent to us within 48 hours of the inspection but did not receive it until three weeks later.

There was limited contact between the management and staff. Staff meetings were not held routinely and the main contact between management and staff was at supervision meetings which had not been taking place as frequently as they were meant to. Staff were not involved in the development of the service and felt disconnected from the management.

Although feedback we received suggested that the quality of care had improved in the weeks before our inspection, we found that some aspects of the service were disorganised and that there was a lack of effective systems in place to assess and monitor the quality of care people received.

These issues amount to a lack of good governance and is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had opportunities to give feedback and comment on the quality of care they received. The provider conducted annual surveys to obtain people's feedback on different aspects of the service provided. The care co-ordinator also obtained people's feedback during day time visits to their homes, when staff were also observed providing care. The feedback obtained included a range of issues such as whether people were happy with the staff and whether they were treated with dignity and respect.

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not always notify the Commission, without delay, of any allegation of abuse, or abuse of people using the service. Regulation 18 (1) and (2)(e)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always provide safe care and treatment to people because there was a lack of proper and safe management of medicines. Regulation 12 (1) and (2)(g)

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 The provider did not establish and operate effective systems in order to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) and (2)(a).

The enforcement action we took:

We issued a warning notice.