Divine Global Health Limited

Divine Global Health Unique Care

Inspection report

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Tel: 02476447902

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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

Divine Global Health Unique Care is a domiciliary care agency which is registered to provide personal care support to people in their own homes. At the time of our visit the agency supported five people with personal care and employed six care workers.

We visited the offices of Divine Global Health Unique Care on 14 February 2017. The inspection was announced. We gave the provider 48 hours' notice of our inspection. This was to make sure we could meet with the provider of the service and staff on the day of our office visit.

Before our visit we had been informed by the provider they had moved the provider's address and the location address from which the service was operating. However, our records showed the provider had not completed the necessary forms to add the new location to their registration. This meant the provider was in breach of their condition of registration that allows them to operate from a specific location. The provider told us they would take immediate action to submit the required applications to us.

The information in this report relates to the service provided from the provider address at 4a Clements Street, Coventry and not the location, 9 St Catherine Close, Coventry as stated on the front of this report.

This was the first inspection of Divine Global Health Unique Care since they registered with us in June 2015. The provider told us following their registration they had provided a regulated service to people up to June 2016. There was then a period when the service was not operating until support for people currently using the service had been started from December 2016 onwards.

The service had a registered manager. A requirement of the provider's registration is that they have a 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 2008 and associated Regulations about how the service is run. The provider is the registered manager of this service and will be referred to as 'the provider' throughout this report.

Some staff had not been recruited safely because the provider had not requested all the required pre-employment checks prior to staff starting work. This meant people were at risk of being supported by staff who were unsuitable to work with people who used the service.

Care workers had not completed an induction when they started working at the service. Care workers had not received all the training required to meet people's needs effectively and their practice was not being checked to make sure they worked in line with the provider's policies and procedures. Care workers were not familiar with the provider's policies and procedures. This meant staff did not have a clear understanding of their role and responsibilities.

The provider had not established procedures to check and monitor the quality and safety of the service people received. This meant the provider was not aware of potential poor practice and areas where improvement was necessary.

People's care records lacked detail, and some were not up to date and therefore did not provide staff with information about how people should be cared for and supported. This meant staff did not always have the information they needed to support people safely and effectively. However, overall staff spoken with had an understanding of the needs and preferences of the people they supported.

The provider's systems to identify and manage risk associated with people's safety and well-being and to ensure medicines were managed safely were not always effective. However, people saw health professionals when needed. Support was given to people who required help with eating and drinking.

People and relatives told us they knew how to raise any concerns and felt these would be listened and responded to effectively. Staff felt supported by the management team.

There were enough care workers to provide care at the agreed times. People received their care and support from care workers who they knew and people and relatives were involved in planning their care. Care workers respected people's privacy and dignity.

The managers had some understanding of the principles of the Mental Capacity Act (MCA) and their responsibilities under the act. Care workers gained people's consent before they provided personal care and respected people's decisions.

People told us their care workers were caring and friendly and in their opinion had the right skills and knowledge to provide the care and support required. People were supported with dignity and respect. Care workers encouraged people to be independent where possible.

People and relatives told us they felt safe using the service and care workers understood how to protect people from abuse. People and relatives were involved in planning their initial care.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Some staff had not been safely recruited because checks to ensure their suitability to work with people who used the service were not carried out prior to them starting work. Systems to ensure the safe management of medicines were not effective. Arrangements to manage the risks associated with people's care were not effective. People told us they felt safe with care workers and there were enough care workers to provide the support people required. Care workers knew how to safeguard people from harm and understood their responsibility to report any concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not been inducted into the organisation or completed the training needed to ensure they had the knowledge and skills to deliver safe and effective care to people prior to working with people in their own homes. The provider had some understanding of their responsibilities under the Mental capacity Act (2005). Staff obtained people's consent before care and support was provided. Care workers supported people with their nutritional needs and to access health care when needed.

Is the service caring?

Good

The service was caring.

People felt supported by staff they considered to be caring and friendly. Staff ensured people were treated with dignity and respect. People were able to make everyday choices and these were respected by staff. People were encouraged to maintain their independence, and had privacy when needed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some care records had not been fully completed. This meant

care workers did not have the information they needed to support people effectively. Care plans were not person centred and lacked detail. Some care plans were not up to date and did not inform care workers how people wanted their care and support to be provided. People were supported by care workers they knew and who understood their individual needs. Care calls were provided at the times people needed to support them effectively. People and relatives were involved in planning their care needs. People and relatives knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider did not have systems and processes in place to assess and monitor the quality and safety of service provided to people. This meant that areas of poor practice in relation to the service had not been identified. However, people and relatives were very satisfied with the service they received. Care workers said the management team were approachable and supportive. The provider was the registered manager at this service.

Divine Global Health Unique Care

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 office visit took place on 14 February 2017 and was announced. We told the provider we would be coming so they could ensure they would be available to speak with us and arrange for us to speak with care workers. The inspection was conducted by two inspectors.

Before we visited Divine Global Health Unique Care we reviewed the information we held about the service, for example, the Statement of Purpose for the service and the Provider Information Return (PIR). A Statement of Purpose is a legally required document that includes a standard set of information about a provider's service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information in the PIR during our inspection.

We also contacted the local authority commissioners to find out their views of the service provided by Divine Global Unique Health Care. Commissioners are people who contract care and support services provided to people. They had no further information to tell us that we were not already aware of.

We conducted telephone interviews with four people who used the service and two relatives of people to obtain their views of the service they received.

During our inspection we spoke with the provider and the office administrator. Due to work commitments staff were not able to meet with us on the day of our visit. We were provided with staffs contact details and attempted to speak with all six staff over the next seven days. However, only two were available to talk with

us.

We reviewed five people's care records to see how their care and support was planned and delivered. We checked five staff files to see whether staff had been recruited safely and were trained to deliver the care and support people required. We also looked at other records related to people's care and how the service operated; including checks management took to be assured that people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

People were not protected by the provider's recruitment practices. This was because the provider put people at potential significant risk by not meeting their responsibilities to obtain the required pre-employment checks to ensure staff were suitable to work with people who used the service.

The provider had not requested pre-employment checks with the Disclosure and Barring Service (DBS) or obtained references for some staff prior to them working for the service. The DBS is a national agency that assists employers make safer recruitment decisions by checking people's backgrounds. This is to prevent people of unsuitable character from working with people who use care services.

Information in staff files showed the provider had not applied for the required DBS checks or DBS Adult First checks before some staff started working with people who used the service. An Adult First check can permit a person to start work, in exceptional circumstances, before a DBS certificate has been received. For example, one staff member started working with people in their own homes in December 2016. The staff member's DBS check was not completed until February 2017.

Another care worker told us, "I did a check [DBS] with my last employer and I brought it with me when I started working here in November 2016." The care worker confirmed they had worked unsupervised in people's homes. We asked the staff member if their DBS was 'portable' they told us it was not. A portable DBS checks allows applicants to carry their DBS check across different employers. This meant there was a risk people could be supported by staff that were not of a suitable character.

We immediately discussed our concerns with the provider. The provider said, "I know they [Staff] should have a DBS checks straightway but there are financial implications which have caused the delay." The provider explained this was because care workers paid for their own DBS checks and did not always have the funds available for the checks to be requested. The provider told us new DBS checks had 'recently' been completed. Staff confirmed this.

The provider could not give us assurance they had completed other checks as part of their safe recruitment process. Copies of documents the provider is required to check before staff employment begins were not available on some all staff files. For example, one file did not contain proof of the staff member's 'right to work' in the UK. Another file did not contain information to show the staff member's identification had been verified. The provider told us, 'I know I checked the documents, but staff have taken them home." They said they would ensure copies of all documents were available on staff files.

Detailed references for staff had not always been received prior to staff taking up employment. For example, five staff files contained 'telephone reference' records. These records only showed the name of the person providing the reference. There was no information about how long they had known the person or in what capacity they were providing the reference. This meant we could not be sure staff members' conduct in their previous employment had been confirmed.

Reference records also contained anomalies. We saw a 'telephone character reference' which stated the referee would re employ the staff member. A character references is provided by someone who knows a person personally outside of the work environment. This meant we could not be sure references contained accurate information.

We asked the provider if they had obtained written references to support those provided over the telephone. They told us, "We do telephone references then I send a hard copy request but they have not been returned." They added, "We only have the references you have seen." This meant the provider had not assured themselves staff were of good character before they started work.

We were very concerned about the way in which staff were being recruited and the risk this posed to people who used the service. We shared these concerns with commissioners of the service.

This was a breach of Regulation 19 (1) (a) (2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

On 20 February 2017 the provider informed us they were taking action to ensure staff were recruited safely. They told us these actions would be completed by 27 February 2017.

The provider did not have an effective procedure to identify and manage risk associated with people's care, such as risks in the home or risks to the person. For example, the provider used a risk assessment form designed to assess how to move equipment and objects when assessing the support people may need to move safely. This meant the provider had not identified potential risks to people or put plans in place to reduce any risks to people and staff.

Other known risks associated with people's planned care had not been assessed. For example, risk assessments had not been completed for two people who were known to be at risk of falling when walking inside their home. We asked the provider why these risk assessment had not been completed. The provider told us, "I am in the process of reviewing everything and updating records."

We asked care workers about the risks associated with people's care and how these were to be managed. One care worker said, "The manager telephones us to let us know." Another care worker told us they read people's care plans so they understood how to support people and minimise risk. However, care records we viewed lacked detail and did not provide staff with the information they need to support people safely. For example, one person required the use of oxygen to support their breathing. We saw an initial assessment record which said an 'oxygen' risk assessment was in place. We asked to see this risk assessment but it could not be found. When we asked care workers about this risk assessment they told us they had not seen it. This meant we could not be sure staff had the information they needed to support people safely.

We looked at how people's medicines were managed. At the time of our visit most people we spoke with managed their own medicines or had a family member who supported with this. One relative told us, "I deal with all the ordering and giving of tablets. It's just something I have always done. I think they [Care workers] would do it if needed."

We found where care workers supported people to manage their medicine, information was not always recorded clearly in care plans. For example, the care plan for one person included the need for staff to 'prompt medication' but did not contain any further detail to inform staff what medicine the person was prescribed, when it should be taken and the level of support the person needed. We asked to see the medication administration records [MAR] for this person. The provider told us the MAR was not available in

the office. We asked the provider what checks they completed to ensure staff supported people to take their medicine safely. They told us, "I have just started to do audits on medicines." We asked to see an audit but were told it had not been completed. This meant we could not be sure people's medicines were being managed and administered safely.

Records showed some staff had completed 'medicine' training. The provider's medicines management procedures detailed the requirement for care workers to have their competency assessed on the first occasion they 'handled' a person's medicine and at three monthly intervals, thereafter. We asked staff if their competency to manage and administer medicines was regular checked by the provider. They told us it was not. We asked the provider if they completed observations of staff practice, including observations of medicine administration. They told us they had completed 'some' but these had not been recorded. The provider added they were in the process of planning to complete observations with all care workers.

Information in the PIR stated, 'We train staff to use medication policies and procedures that meet all legislative and professional requirements and recommendations.' We asked staff about these policies and procedures. One care worker said, "I know we have policies but I haven't read them yet."

This was a breach of Regulation 12 (1) (2) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Despite the lack of risk management people told us they felt safe with their care workers. One person said, "Just knowing someone is going to visit me makes me feel safe." A relative told us, "If I wasn't sure [Person's name] was safe with the carer's I wouldn't leave them. I have absolute confidence [Person's name] is safe."

There were enough care workers available to support people at the times they preferred, and people received the support they needed. One person told us, "My carers come nice and early each morning. They never leave me before all the jobs are done." Another person said, "On the odd occasion the carer's are later than normal, but they always ring if it's going to be more than ten or fifteen minutes." A relative told us they were 'pleased' with the service because it was provided by a 'small team' of same care workers who were reliable.

The provider confirmed there were enough care workers to allocate all planned calls people required at the times needed. They provider was also available to cover care calls when required, for example to cover any unplanned staff absences due to sickness.

Care workers who had attended safeguarding training told us they understood the importance of keeping people who they supported safe. When we talked with these care workers, they were able to explain how people might experience abuse. One care worker said, "It could be physical, sexual, financial or even emotional." Another care worker told us they would report any concerns to the provider. They said, "If [Provider's name] did not deal with it then I would inform the social worker or CQC."

Requires Improvement

Is the service effective?

Our findings

The induction to Divine Global Health Unique Care and the training care workers received did not fully equip or support them to provide the care people required safely and effectively.

We found some staff had not completed an induction when they started work at the service. For example, an induction record for one care worker showed they started their induction in December 2016 three months after they started working at the service. Another care worker had received their induction and been signed off as competent 10 months after their employment start date.

We asked care workers about their induction. One told us their induction involved talking with the provider about the people they would be supporting and how to complete tasks. Another care worker said their induction had also included a discussion about the provider's policies and procedures. However, they told us, "I didn't see, or read any of the procedures but I was told about them." The care worker added, "Recently I was given a 'profile' (list) of all the policies, but I haven't read them yet."

Records of staff inductions which had 'recently' been completed were limited in detail and had omissions. For example, records contained a list of tasks which had been demonstrated, by the provider, to enable care workers to understand how to complete the task correctly. However, the section on the induction record to evidence the staff member's competency had been assessed and reviewed was blank. This meant we could not be assured staff had a clear understanding of their role and responsibilities. We discussed this with the provider. They acknowledged care worker inductions had not taken place when they joined the service. The provider told us this was because they were 'playing catch up' due to 'other priorities'.

The provider had not maintained a record to show the training care workers had completed. This meant we could not be sure staff had completed the training they need to support people safely and effectively. The provider told us they were in the process of 'inputting' staff training information into an 'electronic staff management system'. They said, "Once all the data is inputted we will be able to see what training has been done and when refresher training is due." The provider told us they were still 'being trained' on how to use the system but were aiming to complete this work over the next few weeks.

Training information that was available showed some staff had not received all the training needed to ensure they had the skills and knowledge to meet the health and social care needs of people who used the service. This included training in safer people handling, safeguarding adults, and health and safety. When discussing training with care workers one staff member who was recruited in November 2016 said, "I haven't done my training yet but I think it is being planned." Another told us they had not completed any training since working at Divine Global Health Unique Care. They said, "…but I am an experienced carer and have done lots of training in other jobs." The office administrator told us, "I bought them in [Care workers] so I could sit with them whilst they did their training because they hadn't completed it. But we didn't have time to do it all." The provider told us they had been encouraging care worker to complete 'mandatory' training but this had proved challenging they said, "I sent the training (electronically) to staff but they did not do it. Now I am calling the staff into the office to make sure they do it." Records confirmed this.

The provider told us staff had started to complete on- line training which the provider considered essential to enable staff to support people effectively. Certificates for this training showed staff had completed multiple training courses in one day. For example, one staff file contained 15 certificates for diverse and different topics, such as Safeguarding (adults and children), Health and Safety, Moving and Handling (theory and practical), Equality and Diversity and Mental Capacity. We had concerns about the quality of the training and the knowledge and understanding care workers would gain from completing so many courses in such a short period of time. We discussed this with the provider who told us they accepted 'it was a lot to take in' but felt as staff were 'very experienced' this would not be a problem.

The provider told us the 'induction' training being provided was in line with the requirements of The Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. Training certificates on some staff files were linked to the care certificate standards. However, there was no process in place for new staff to have their practice assessed in line with requirements of the care certificate. The provider told us they were introducing a formal process to address this as part of their 'quality management system'.

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

People and relatives told us that in their opinion, care workers who visited them had the skills and knowledge needed to support them effectively. One person said, "All my carers know what they are doing. They are very good." A relative told "I would say as it stands [Person's condition] at the moment they [Care workers] have the right skills to deal with things."

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. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way 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 application procedures for this are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The provider had a basic understanding of MCA, their responsibilities under the Act and how they should put this into practice. None of the care files we reviewed contained information about whether people had capacity to make decisions. The provider told us this was because people being supported by the service were able to make decisions independently or had a relative who supported them to do this. It was not clear from the information available if relatives had the legal right to make complex decisions on the person's behalf.

When speaking with staff about the MCA care workers who had completed training demonstrated they had some understanding. For example, one care worker told us, "Evaluating someone ability to make decisions is what it's all about. So if a client can't make decisions someone else can do it for them. It would be someone like a family member." Care workers said everyone they supported could make everyday decisions for themselves or had someone who could support them to do this. Care workers who had not received training had little understanding of how this could affect their practice. However, all staff we spoke with understood the importance of receiving consent from people before they undertook any tasks to support people. One care worker told us, "It's only respectful to ask clients what they want us to do. We should follow their instructions."

People and relatives told us care workers obtained their consent before assisting with care and support. One person told us, "Every morning when they [Care workers] come they ask me what I want them to do." Another person said, "Nothing happens without my agreement. They [care workers] always ask and they go with what I say I want."

People told us care workers supported them with food and nutrition to maintain their health if it was part of their plan of care. One person told us, "At lunchtime they [Care workers] tell me what's in the freezer so I can tell them what I fancy. Some days I just want a sandwich which they [Care workers] make." Another person explained how care workers prepared the person a drink before they finished the care call. The person said, "The last thing my carers do is make a drink. They leave it on the table by my chair so I have a drink if I want one between my visits."

All the people we spoke with managed their own healthcare or had relatives that supported them with this. Care workers said they would inform the office if a person needed a visit from their GP but said family would usually do this. 'Daily records' [records completed by care workers in people's homes] confirmed they involved other health professionals with people's care when required including district nurses and GPs. Where needed people were supported to manage their health conditions and had access to health professionals if required.

Good

Is the service caring?

Our findings

People told us care workers who visited them were caring and friendly. One person explained how they enjoyed the company of their care workers and 'looked forward to their visits'. Another person described the care workers who visited as 'very respectful and considerate." A relative told us, "All the carers are very caring and make time to have a chat. They are absolutely perfect."

We asked care workers what being 'caring' meant for them. One care worker told us, "It's looking after someone. Helping make their life better according to their needs." Care workers told us even though they had only been visiting people for a short period of time; they were building relationships with the people they supported. One care worker told us, "If you talk to clients and listen to them you can learn about their life and what the like. This helps to build a friendship."

People's privacy and dignity was respected by care workers. One person told us, "It can be embarrassing having to have a wash with help but they [Care workers] cover me up which makes me feel more comfortable about it." A relative described how care workers protected their family member's privacy and dignity by ensuring doors and curtains were closed before assisting with personal care. Care workers understood the importance of promoting people's dignity and privacy.

People and relatives told us they were involved in making decisions about their care and the support they received was flexible to their needs One person said, "The main one [Care coordinator] came and visited me to ask about the help I needed." A relative told us they had identified the need for additional calls for their family member. They said, "It was discussed with the social worker and the agency [Divine Global health Unique care]. The extra call is working really well."

People told us care workers supported them to maintain their independence and the support they received was flexible to their needs. For example, one person had limited mobility. The person told us,"… care workers 'work with me and involve me' when helping me move around." The person told us this helped them maintain 'a level of independence'. A relative described how their family member's needs could change on a daily basis. The relative said, "They [Care workers] are very good they will give as little, or as much help as is needed." Another relative told us their family member's morning visit time had been changed because the person enjoyed 'a lie in'.

People said they received care at their pace and care workers stayed long enough to complete all the tasks required of them. One person told us," My carers even take the time to chat with me when they have finished everything. It's is lovely." Care workers said they were allocated sufficient time to carry out their calls and had flexibility to stay longer if required. One care worker said, "We have enough time to do what is needed. If we needed to stay longer we would just let the office know."

We saw records in the office that contained personal information were secured and kept confidential. Care workers told us they understood the importance of maintaining people's confidentiality. One told us, "I would never discuss anything in a person's home. If I needed to discuss something urgently I would go

outside."

Requires Improvement

Is the service responsive?

Our findings

During our visit we reviewed the care records for all the people using the service. We found some records were incomplete. Other records lacked detail and did not inform staff how people preferred their care and support to be provided.

Prior to the service starting, people were assessed by the provider to ensure their needs and expectations could be met by the service. However, there was inconsistency and omissions in the information obtained. For example, one record identified the person's next of kin's as the main contact. However, the relatives contact details or home address had not been documented. This meant the service did not have the necessary information to contact the person's family member if the need arose. Other sections of the record, including the 'service user risk assessment' was blank. However, further on in the assessment it was recorded the person needed 'assistance' when standing and walking which suggested a potential risk to the person had not been assessed.

Care plans had not been written in a personalised way to included information about people's backgrounds, likes and dislikes, spiritual or general support needs. Care plans were task focused and did not provide staff with the detail they needed to provide care and support in a way that met the person's individual needs and preferences. For example, one care plan stated care workers needed to support the person each morning with 'washing, dressing, personal care, grooming and breakfast'. There was no explanation about how the person preferred their care and support to be provided or the number of hour's support the person should receive at each care call.

Care plans lacked detail and did not include important information staff needed to support people effectively. We reviewed the care plan for one person who we were told had dementia. We did not find any confirmation of this in the care plan. This information is vital so care workers understand if, or how the person's dementia affects the way in which their support should be provided so they can offer a consistent approach.

Information on another person's care file indicated the person had a 'Do Not Attempt Resuscitation' [DNAR] in place. A DNAR is a document telling medical professionals not to attempt cardiopulmonary resuscitation (CPR) and acts as a tool to communicate to healthcare professionals involved in a person's care that CPR shouldn't be attempted. Information about the decision not to attempt resuscitation was not recorded in the person's care plan. We were concerned this meant staff did not have important information about a person's wishes. However, the provider assured us that the original copy of the DNAR document was available for staff to view at the person's home.

Care workers told us they had time to read people's care plans. One staff member said, "When we first go to a visit we must read the care plan because it tells us what we need to do." Another care worker told us if a person's needs changed the provider would telephone them to share information. They said the provider then updated the care records in people's homes.

We reviewed the care records for all people using the service and found none had been reviewed or updated. The provider told us this was because care records were not due for review because people had only been using the service since December 2016. However, information on some care files indicated people's needs had changed. One person had experienced a fall which had been investigated by the local authority safeguarding team. We looked at the person's care plan and saw this had not been reviewed or updated following the fall. We were concerned this meant staff did not have the information they needed to respond to people needs effectively. We discussed our concerns with the provider who acknowledged records were not up to date. They told us they would be reviewing all records as part of the process of introducing their 'quality management system'. Following our visit the provider informed us all care plans would be reviewed and updated by 27 February 2017.

People told us they were satisfied with the service they received because the service was reliable and support was provided by care workers they knew. One person said, "I've only had them for a few weeks but already I am finding the support helpful." Relatives agreed. One told us, "So far I have been impressed with the service."

Despite shortfalls in care plan documentation, care workers spoken with had an understanding of people's care and support needs. They told us this was because they had a set rota which meant they visited the same people. One care worker told us, "We visit the same clients [People] which really helps. It helps the client [People] because they know who is coming and it helps us because we get to know them [People]." Another care worker explained the way their work was planned meant they had time to get to know people which they said was 'very important'.

We looked at the call schedules for all people who used the service and the care workers. These confirmed care calls were planned in advance, at the times agreed and people were allocated regular care workers. The provider told us, "We have small teams who work together. This ensures clients [People] know the staff who are going to visit even when staff have a day off. Continuity is very important and the way we plan our work ensures this."

People told us their care workers usually arrived on time and stayed long enough to complete all the tasks required. One person said, "My carers turn up on time every day and they don't leave until everything is done." Another person explained they had only been receiving support from the service for a few weeks. They said, "Already it is making a difference, in a good way. It stops my family worrying about me because they know the carers are calling."

We looked at how complaints were managed by the provider. People and relatives told us they had no complaints, however they knew how to complain and would be confident to raise any concerns with the provider if they needed to. One person told us, "If I had a worry I would tell [Care coordinator] and I've got the number for the office if I need to call."

Care workers knew how to support people if they wanted to complain, we were told, "Information about how to make a complaint and the number to ring is shared with clients [People] and their relatives when the service starts." Care workers told us they would refer any concerns people or family members raised to a member of the management team and they were confident concerns would be dealt with effectively.

Records showed the service had recently started to record comments and complaints. One complaint had been received which had been managed in line with the provider's policy and procedure.

Requires Improvement

Is the service well-led?

Our findings

The provider had not assured themselves that people consistently received high quality care that was safe, effective and responsive to their individual needs. This was because the provider did not have systems and process in place to assess and monitor the service provided to people. When we asked to see copies of audits and quality checks undertaken by the service the provider told us these were not available. The provider told us they were in the process of introducing a 'quality management system'. They said, "I am doing training on the system so I am exploring how to use it. I have one more training session." The provider added, "I know I don't have much evidence to show you. What I do have is lots of good feedback from relatives and I have wonderful staff with lots of years of experience." We asked to see this feedback and were told by the provider, "I didn't record it. This is something I need to do."

This meant shortfalls we identified during our inspection, including safe staff recruitment, staff training, risk management and care records had not been addressed.

The provider told us as they had already identified some areas where improvement was needed and were identifying additional areas as they introduced each stage of their 'quality management system'. They said, "The area I think I need to improve is compliance, recruitment and possibly risk assessments." We asked the provider if they had an action plan detailing where improvement was needed and when these would be made. They told us, "Most of it is in my head, but I will do one." We were concerned the lack of documented planning meant required improvements to the safety and quality of the service provided would not be completed in a timely manner.

The provider had policies and procedures in place. However, these had not been consistently followed. Staff told us since working at the service they had not had individual meetings (supervision) with the provider to discuss their role, any training needs or concerns. Some staff had worked at the service since September 2016. The provider's supervision' policy required each staff member to have four supervisions each year. We asked the provider about staff supervision. They told us they had 'recently' completed one supervision and were planning to arrange meetings for all other staff in the next 'few weeks'.

The PIR stated, '…the provider uses team meetings and staff surveys… to create an innovative and motivated workforce'. Staff we spoke with told us they had not attended a team meeting or completed a staff survey, including a care worker who had been employed over six months. We asked the provider if staff had been invited to attend team meetings or if they had been asked to complete a survey to establish their views about working for the service. They told us staff had not. The provider said staff were supported 'informally' through daily telephone contact and the 'formal systems' referred to in the PIR were in the process of being introduced. This meant information the provider submitted prior to our inspection was not an accurate reflection of the way the service was being managed.

A lack of auditing procedures meant the provider was not identifying areas where improvements needed to be made, and was not ensuring the service was safe and continuously improved.

We were concerned the lack of effective systems to monitor the quality and safety of service provided to people had the potential to put people's safety and wellbeing at significant risk.

This was a breach of Regulation 17 (1), (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

The provider was not operating within the conditions of their registration. Before our visit we had been informed by the provider they had moved the provider's address and the location address from which the service was operating. However, our records showed the provider had not completed the necessary forms to add the new location to their registration. This meant the provider was in breach of the condition of registration that allows them to operate from a specific location. The provider told us they had submitted an application to add and remove locations but had not realised this had been rejected because it was incomplete. The provider took immediate action to submit the required applications to us.

The service had a registered manager who was also the provider for the service. The provider told us they were responsible for the day to day operations of the service and for the development of the business. The provider was supported by a care coordinator who was responsible for undertaking care calls, planning staff rotas and supporting care workers when they were working out in the community. Care workers knew the management structure and understood who to report concerns to.

When we asked people and relatives if the service was well managed we received positive comments including, "Yes, I think they do a good job organising everything.", "The manager came out to introduce themselves. That was very good. ", And, "It all works quite well."

All the people and relatives we spoke with told us care workers had sufficient time to carry out care calls without having to rush and had flexibility to stay longer if required. One person told us, "I can say I have never felt hurried. They even [Care workers] chat as we go along." When discussing the time allocated for calls with care workers we were told, "We have allocated time slots and time to travel in between calls, so we have plenty of time." Another care worker told us if they thought they needed more time to do a care call 'properly' they would report it to the office. They added, "If I felt rushed I would explain why and ask for more time. "

People had limited opportunities to put forward their views about the quality of the service they received or suggestions about how things could be improved. One person told us, "I don't recall ever being asked for my thoughts." Another person said, "Perhaps no one has asked because they [Service] have only been coming a few months." The provider confirmed support for people currently using the service had started in December 2016 onwards. They told us there was no formal system in place to gather feedback about the service such as 'quality' surveys but this was something they were planning to introduce by March 2017.

Staff described Divine Global Health Unique Care as a good place to work. One care worker told us they 'enjoyed' working for the service because they met lots of different people and the staff worked as a team. Another told us, "Everyone [Staff] is really friendly and the provider is there if you need anything." Staff told us they felt supported by the management team. One care worker said, "The coordinator is very good and if you have a query you can ring the office to get help. If the office is closed we have [Provider's name] mobile number." Throughout our visit we observed the provider speaking with care workers on the telephone providing advice and support, when required.

We asked the provider about their responsibility to submit statutory notifications because we had not received any notifications since the service was registered. A statutory notification is information about

important events which the provider is required to send to us by law. The provider demonstrated they had some understanding of the requirements.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment. 12 (2) (a) The provider had not ensure risk assessment associated with people's care and support were completed. (2) (b) The provider had taken all reasonable steps to mitigate risk.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance. 17 (1) The provider had not established and was not operating effective systems to ensure they assessed and monitored their service. (2) (a) The provider was not conducting regular audits of the service to assess, monitor and improve the quality and safety of the service. (2) (b) The provider had not ensured risk to people who used the service was continually monitored.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed 19 (1) (a) The provider had not ensured staff were of good character prior to them working for the service. 19 (2) The provider did not have effective recruitment procedures. 19 (2) The provider had not ensured required pre-employment checks were completed prior to staff starting work at the service.
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing (2) (a) The provider's induction programme did not prepare staff for their role. The provider had not ensured staff completed an induction when they started working for the service. The provider had not ensured staff had completed the training required to support people effectively.