Daughters of Divine Love Training and Assessment Centre (UK)

DDLTAC(UK) - LONDON

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 29 November 2018 and was announced. DDLTAC (UK) – LONDON is a domiciliary care service. The service is also known as Daughters of Divine Love Training and Assessment Centre (UK). It provides personal care to adults living in their own homes. There were five people living with mental health needs who were receiving care and support from the service.

This was the first inspection at the service since their registration in November 2017. Not everyone using DDLTAC (UK) – LONDON receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a registered manager in post. 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.

People were protected from the risk of harm and abuse. There was a safeguarding policy and guidance for staff. Staff knew how to manage and report allegations of abuse promptly.

Staff identified risks associated with people's health and wellbeing. Guidance for staff on how to manage those risks for people were written in a management plan. The provider had an infection control policy in place. Staff followed the guidance from the policy to reduce the risk of infection.

People had their medicines as prescribed and they were managed safely. Each member of staff had completed training in safe medicines management and had their competency assessed before supporting people with their medicines.

The registered manager deployed sufficient members of staff to meet people's needs. Newly employed staff had pre-employment checks returned before working with people.

The registered manager provided support to staff. There was a programme of induction, training, supervision and an appraisal. Staff reflected on their practice to identify their professional development needs.

The registered manager and staff understood the principles of the Mental Capacity Act 2005 (MCA). Staff completed training in the MCA which helped them identify when people lacked the mental capacity to make decisions for themselves. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Staff gave people enough information to support them to give staff their consent. Care records contained signed consent forms to receive care and support.

People had meals they enjoyed. Staff supported people with shopping and preparing meals that met their preferences and dietary needs. The registered manager contacted health care services when people's needs changed so they had access to appropriate service to improve and maintain their health.

Staff completed an assessment of need with people's involvement. Care records were personalised and recorded people's individual needs including their likes and dislikes. Care plans were developed and captured the support people required from staff to meet their assessed needs.

The registered manager and staff understood how to support people who required end of life care. At the time of the inspection, there were no people who needed palliative care support.

People said staff were respectful of them. Care workers treated people with compassion and kindness. People felt respected by staff because their care was carried out in privacy whilst maintaining their dignity.

There was a system to manage complaints. There was a complaints policy that gave staff guidance in the management of complaints about the quality of service. People were encouraged to make a complaint about the care and support received if they were unhappy about something.

Staff said the registered manager was open and honest and listened to them when they needed. There was a system in place for monitoring the service quality and improvement plans were put in place when a concern was found.

The registered manager asked people for their feedback on the service and the quality of care. Records showed and people told us that they were happy with the quality of care received. The registered manager kept CQC informed of events that occurred at the service.

Staff developed partnership working with health and social care professionals. The registered manager said they could request advice and support from health care services when this was needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe.

The provider's safeguarding policy gave staff guidance to follow to protect people from harm and abuse.

Each person had risks related to their health and wellbeing identified. Risk management plans were put in place that guided staff to mitigate those risks.

Medicines were managed safely. Staff were trained in the management of people's medicines.

Enough staff were employed to provide care and support to people. The registered manager followed safer recruitment processes to ensure suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff were supported through induction, training, appraisal and supervision.

The registered manager and staff understood the principals of the Mental Capacity Act 2005 (MCA).

Health care support was sought when people's health needs changed.

Staff provided people with meals that met their needs and requirements.

Is the service caring?

Good

The service was caring.

People said staff treated them with kindness and were caring.

People made decisions about their care and how they wanted this delivered to them.

Staff ensured care and support was delivered so people's dignity and privacy were respected.

Is the service responsive?

Good

The service was responsive.

Assessments were completed by staff that were personalised and identified care and support needs.

Care and support needs were monitored and reviewed. Changes in care and support were recorded to ensure these reflected people's needs accurately.

People were encouraged to make a complaint about their support if they were unhappy.

Is the service well-led?

Good

The service was well led.

Staff were complimentary about the registered manager.

Systems were in place that monitored and reviewed the service.

Staff were happy working with people and understood the ethos of the service.

People gave their views on the care they received.

Partnership working helped people to maintain their health and wellbeing.

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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.

This inspection took place on 29 November 2018 and was announced. We visited the office location on 29 November 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection was carried out by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider was given 48 hours' notice because the location provides a domiciliary care service. We needed to be sure that someone would be available to support this inspection.

Before the inspection, we looked at information we held about the service, including notifications. A notification is information about important events, which the service is required to send us by law. The provider completed a Provider Information Return (PIR). This 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.

Prior to the inspection we spoke with two people who used the service. During the inspection we spoke with the registered manager, looked at three care records, medicine administration records (MAR) for three people, three staff records and other documents relating to the management of the service.

After the inspection, we contacted two care staff. We also contacted representatives from the local authority but did not receive any feedback from them.

Good

Is the service safe?

Our findings

People said the care and support they received was safe. People commented, "I'm safe with them" and "I'm safe with them. They don't do what you don't want them to do."

The provider had safeguarding policies and processes in place. Staff knew what abuse was and had gained knowledge through safeguarding training to help them protect people from harm and abuse. Staff we spoke with understood their responsibilities to report an allegation of abuse to office staff. The registered manager had systems in place to report abuse to the local authority safeguarding team for investigation.

Staff identified and managed risks associated with people's health and care needs. Staff looked at people's health conditions, mental health needs, walking ability, eating and swallowing needs. One person's risk assessment showed they had reduced mobility and were at risk of deteriorating mental health. The risk management plan gave staff guidance and included the actions to take to mitigate those risks.

The provider had an infection control process in place. Staff were trained in infection control and understood how to reduce the risk of infection. Personal protective equipment (PPE) was made available for staff use. PPE equipment included gloves and aprons which staff had access to and used to reduce the risk of infection.

People had their medicines managed as required. People said "Yes, [the prescription] goes through to the chemist. [Staff name] arranges the delivery" and "The chemist arranges the delivery. It's the right quantity. Now it is in a blister pack." Staff used the medicine management policy as guidance to support people to take their medicines. Staff received additional specialised training to enable them to administer controlled drugs in the community. The registered manager sought advice from the local health authority and followed NICE guidance on controlled drugs to ensure medicines were managed, stored, ordered and administered in a safe way. Medicine administration records (MARs) were in place for each person who required support with taking their medicines. Each MAR was checked by staff to ensure medicines were administered as prescribed. Each MAR we looked at was accurate and any gaps explained.

Enough members of staff were available to provide care and support to people. People told us that they had enough staff to support them. Staff rotas showed sufficient numbers of staff covered shifts so people had their care and support as required.

Safer recruitment processes were used to ensure staff were employed in a safe way. Pre-employment checks were carried out before new staff worked with people. This included obtaining staff references from previous employers and requesting an explanation for any gaps in their employment history. Information relating to staffs' right to work in the UK was collected and copies of proof of identity were taken. Each member of staff had a check from the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to meet their needs effectively. People we spoke with said they felt staff were trained to care for them. A person said "Yes, they seem to know what you want and are well trained."

The registered manager supported staff at the service. Staff were supported with an induction, training, supervision and an appraisal. Newly employed staff were supported to complete the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. Staff training included safeguarding adults, medicines management, basic life support, infection control and food hygiene. Each year staff completed refresher training to ensure they were kept updated with best practice. Supervision and appraisal meetings occurred on a regular basis. This provided staff with the opportunity to reflect on their role within the service and to identify their training and development needs.

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 with appropriate legal authority. No applications had been made to the Court of Protection and the registered manager told us that this had not been required. Staff were trained in the MCA which prepared them to support people who lacked the ability to make decisions for themselves.

People provided staff with their consent to receive care and support. People who used the service had the ability to make decisions and choices for themselves. Staff obtained consent before providing care. People said, "Yes, every time" and "They [staff] always ask me."

People had support from health services when their care needs changed. Staff knew people well and quickly recognised when they became unwell. Staff recorded in each person's care records the known triggers for when people were becoming unwell.

Another person's care record described the behaviour that challenged staff and others if they became unwell. Care workers knew to report any changes in health immediately to office staff for guidance.

Records showed that people's care and support was managed by health care professionals. Each person had a care coordinator who managed people's health care needs. Staff referred people for specialist care when this was required. For example, when a person's ability to walk and move around their home was limited a referral was made to an occupational therapist (OT). Guidelines provided by the OT were included in this person's care records following an assessment.

People had food and drink which met their needs. Staff supported people to shop for themselves. Where

people needed support with making and preparing meals this was provided in line with people's nutritional and dietary needs.

Good

Is the service caring?

Our findings

People received care and support from staff that treated them with kindness and were caring. People comments included, "Yes. They are understanding. Everything else is O.K." "They're chatty. We talk about the weather and about my care" and "Yes, they speak nicely to me. That means a lot."

People's dignity and privacy was protected by staff. Staff supported people with their personal care in the privacy of the bathroom or bedroom. This ensured people were respected and their dignity maintained while receiving care and support.

People were involved in and contributed to their assessment of care. Following the initial assessment staff developed and individualised plan of care. This identified people's specific needs and also outlined the support people required to meet those needs. People gave their opinions and views of their needs at each stage of the assessment and in their plan of care. People said staff visited them on a regular basis. They said, "Yes, they're [care workers are] good to you" and "[The registered manager] comes every week and cleans thoroughly in the kitchen."

People's care records recorded their cultural and religious needs. For example, one person said they were a catholic, and although they did not attend church their religion was important to them. Records showed staff gathered information so they could support people to meet their religious needs and to respect people's choices to practise a religion if they chose. Staff supported people to prepare meals that met their cultural needs. One person's care records detailed that they were unable to eat some foods because of religious reasons. They were supported to prepare meals that met their cultural needs, they said "They make a note of what I eat, like rice or chapati." Staff shopped for people and encouraged them to prepare a meal which they enjoyed.

People had care records at home. These contained people's assessments and care plans. There were records for staff to complete during a care visit. The records were used by staff to record the care and support delivered to the person. Care workers entered information that reflected their assessed care needs. This ensured people received appropriate care and staff were delivering care as expected.

People were supported to be independent. Staff encouraged people to manage their care and support as they were able. People were supported to keep their home environment clean while being supported by staff with other domestic tasks.

Good

Is the service responsive?

Our findings

People had and assessment of their care and support needs. Assessments took place before people received a service. Assessments enabled staff to decide whether care workers could meet people's individual needs. Care assessments gathered information from people, their relatives, health and social care professionals and detailed how people wanted to receive their care. For example, a person's care record detailed the frequency of care visits, including the days and times the person requested. Care records looked at people's individual needs which included people's health needs, their hobbies, education, employment, interests and friendship groups. This information helped staff to provide person centred care that met their specific needs.

Staff supported people to access activities they enjoyed. One person was supported to attend a daycentre, however due to increased difficulty in walking they no longer attended. Staff provided people with additional support to access their local community. One person went out of their home with staff support because they requested this. Some people wanted to take part in activities that mattered to them and staff facilitated this in line with people's choices.

People's private information was recorded in line with the Accessible Information Standard (AIS), for example; providing documents using large print books to ensure these were accessible. The AIS makes sure that people with a disability or sensory loss are given information in a way they can understand. We saw care records were written in a format that people could understand.

The provider had a complaints procedure available for people. A copy of the complaints process was given to people so they could make a complaint about any aspect of their care. One person said, "I had a complaint once, [care worker] fell asleep at the table and was also on her mobile phone a lot. I told [the registered manager]. Now [care worker] is not coming anymore." People said they felt comfortable discussing any concerns they experienced with the staff or the service. People said they would call the office and speak to the registered manager directly if they wanted to make a complaint. There had been no formal complaints recorded.

End of life care decisions were discussed with people. However, the people using the service at the time of our inspection did not require end of life care. Staff understood how to support people who required end of life care and knew which health and social care professionals would be contacted if specialist palliative care was required.

Good

Is the service well-led?

Our findings

People received care and support from a service that was well-led. People said the registered manager was friendly, helpful and resolved their concerns. People's comments included "It is easy to talk to her [registered manager]. The [registered manager] in charge comes every week."

Staff attended regular team meetings. The registered manager updated staff on events that happened in the service. Training for staff was also discussed and any practice issues were shared with colleagues. There was a record made of the meetings and staff who could not attend had access to the meeting minutes and were aware of the discussions that had taken place.

Staff enjoyed working at the service. They understood the vision and ethos of the service. The provider placed people's needs at the centre of the service. Their shared vision was to support people into work, through qualification and to deliver care and support to people in need. The service is run by a religious order of nuns but people who received services were not required to have particular religious beliefs.

There were systems in place to review the quality of care. Staff carried out regular reviews of the quality of care records and medicine management records. Staff audited care records so they were accurate and reflected people's assessed needs. Records we looked at accurately reflected people's needs and changes to care and support were recorded promptly. The quality of care records was good and they captured people's needs and any identified risks appropriately.

Staff reviewed and monitored the quality of the care delivered by staff. Each care worker had regular checks to ensure they provided safe care. Spot checks reviewed staff's competency in the delivery of care. Any areas of concern in staff practice were discussed with individual staff and additional training provided if this was necessary.

People gave their opinions on the care and support they received. Staff requested people's feedback through home visits, telephone calls and an annual written questionnaire. The feedback provided demonstrated that people were satisfied with the level of care received. People praised the service and said they would recommend the service to friends or relatives that required this type of care.

The registered manager understood their registration requirements with the Care Quality Commission (CQC). The registered manager had sent CQC notifications of events that occurred at the service as required by law.

The registered manager developed good working relationships with health and social care services. Regular meetings took place and information was shared at the meeting, this enabled staff to gain advice and support for people from services when required.