Care Quality Commission

Destiny Nursing & Care Agency Ltd

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Inspection report

5 Norfolk Gardens
Borehamwood
Hertfordshire
WD6 2LS

Tel: 07950461139

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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?	Requires Improvement

Summary of findings

Overall summary

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to people of any age, including those with dementia, mental health needs, or physical disabilities. At the time of this announced inspection, they were providing personal care and support to 13 people living in their own homes. This was the first inspection of this service at this location.

The service had 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.

People and their relatives provided good overall feedback about the service, particularly about the caring nature of their regular staff. However, some told us timekeeping was an issue as staff were not always arriving when they were expected. We found visit scheduling arrangements were not always robust enough to ensure people consistently received expected care visits on time. However, no-one reported visits were being missed, and it was clear that the service provided people with the same staff members where possible.

The service supported people well with ongoing healthcare matters. There was effective collaborative working with healthcare professionals, in part due to the registered manager's previous experience of community nursing. People were supported to have comfortable and dignified end-of-life care where this was needed.

The service assessed and managed risks relating to care delivery in people's homes. This included for safe support with medicines, hoisting, and nutrition where part of agreed the care package.

People were supported to express their views and make decisions about their care and support. Consent to care was sought in line with legislative principles. Care plans were in place to formalise the process.

People received care and support from staff who responded to their individual needs and preferences, and who had the knowledge and skills needed for their care roles. The service listened to and learnt from people's concerns and complaints, and responded well when further care support was needed as the registered manager knew people well and provided hands-on support at short notice where needed.

The service had systems to help protect people from abuse and ensure safe staff recruitment practices occurred.

The provider asked people's views on how the service operated so as to improve, and promoted a positive working culture for staff. Audits of care records had been embedded, to help ensure good quality care was

occurring. However, there were no documented arrangements for oversight of quality checks of staff and quality visits to people using the service, to ensure these covered everyone. In conjunction with the staff visit scheduling concerns, this demonstrated the service was not consistently well-led.

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

The service was safe. There were enough suitable staff to attend to keep people safe and ensure planned care visits occurred.

The service assessed and managed risks relating to care delivery in people's homes. This included for safe support with medicines and hoisting where part of agreed the care package.

The service had systems to help protect people from abuse and ensure safe staff recruitment practices occurred.

Is the service effective?

Good

The service was effective. Staff had the knowledge and skills needed for their care roles.

The service supported people with health care matters including through collaborative working with healthcare professionals. People were supported to eat and drink enough.

People's consent to care was sought in line with legislative principles.

Is the service caring?

Good

The service was caring. People and their relatives provided positive feedback about the caring nature of staff.

People were supported to express their views and make decisions about their care and support.

The service supported people to have comfortable and dignified end-of-life care.

Is the service responsive?

Good

The service was responsive. People received care and support from staff who responded to their individual needs and preferences. Care plans were in place to formalise the process.

The service listened to and learnt from people's concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Visit scheduling arrangements were not always robust enough to ensure people consistently received expected care visits on time. There were also no documented arrangements for oversight of service quality checks.

However, the provider sought people's views on how the service operated, and promoted a positive working culture. Audits of care records had been embedded, to help ensure good quality care was occurring.

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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.

The provider was given 48 hours' notice because the service is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be available.

The provider completed a Provider Information Return (PIR) in advance of the inspection. 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.

Before the inspection, we checked notifications made to us by the provider, safeguarding alerts raised about people using the service, and information we held on our database about the service.

The inspection was carried out by two adult social care inspectors and an Expert by Experience, which is a person who has personal experience of using or caring for someone who uses this type of care service. Their involvement was limited to phoning people using the service and their relatives to ask them their views of the service.

There were 13 people using the service for personal care support on the day of our inspection visit. During the inspection, we received feedback about the service from three people using it and five people's relatives. We also spoke with eight care staff.

During our visit to the office premises we spoke with the registered manager and office manager. We looked at the care files of four people using the service, the personnel files of three staff members and various other

records relating to the care delivery and management of the service such as the staffing roster, training records and stakeholder surveys. The registered manager also sent us further information on request following the inspection visit, including copies of policies and visit schedules.

Good

Is the service safe?

Our findings

The service had enough suitable staff to attend to keep people safe and ensure planned care visits occurred. People and their relatives said care staff were reliable and delivered the care required. Most had regular care staff who they got on well with. One person told us, "I have my main care workers and they know me very well. Sometimes if there's a member of staff filling in when my usual people aren't available I may have to explain a bit to them but it's not a major problem." Another person said, "I see my care worker more as family than a member of staff." A relative told us, "It's one regular girl which is good because that provides continuity and stability; she's more like a friend now." Records of people's care and support confirmed people usually received the same staff member or small team of staff.

The service assessed and managed risks relating to care delivery in people's homes. The management team had implemented a new risk assessment template that enabled a carbon-copy to be left immediately in the person's care file in their home. The form covered a range of relevant topics including nutrition, skin care, mobility, falls, and the management of both medicines and finances. A specific section on the care environment considered safety matters such as sufficient space and lighting, tripping hazards, household equipment, and any fire risks including from smoking. The assessment concluded by identifying the key hazards found and what further action could be taken. Pertinent information from the risk assessment was then transferred to the person's care plan, often highlighted in red ink.

Some people and their relatives told us of hoists being used to help people move from bed to chair. Most were happy the staff were competent to do this safely. For example, one relative said, "I certainly couldn't use the hoist myself but they do it really easily." New staff told us of using hoists as part of their training. Moving and handling assessments included what equipment was used, and if appropriate, when it was last professionally tested. Resulting care plans guided staff on such things as which sling loops to use. Risks relating to supporting people with hoists were therefore properly managed.

The service was ensuring people received safe medicines support. A relative told us, "They make sure that she gets her medication." Records showed all staff had received medicines training. Medicines risk assessments included exactly what medicines each person was prescribed, where the medicines were kept, and how further supplies were acquired. The person's capability for all aspects of medicines management was looked at. We found medicines administration sheets matched the medicines lists and were completed in full.

There were safe staff recruitment practices in place. Staff files included checks of criminal records (DBS), identity, and the applicant's right to work. Where there was information on the DBS, the registered manager had recorded an assessment of risk to clarify whether or not that prevented employment. There were records of interviewing the applicant, which the registered manager told us was important to assess their character and to check any employment gaps. Written references were also acquired before staff started working in people's homes, for which there was sometimes an additional record of phoning the referee to confirm reference information. However, we found information on references sometimes varied from what applicants declared on their application forms. For example, one applicant stated they worked for a

previous care employer from 2012, but a reference stated 2014. The registered manager confirmed this had not been explored, but they would now clarify with applicants and for those staff checked on.

The service had systems to help protect people from abuse. Staff told us of receiving training on safeguarding and whistle-blowing, which records confirmed. They knew what could be seen as abuse, for example, one staff member said, "I need to check her skin to make sure she has not been incorrectly hoisted or treated roughly." They knew what their responsibilities were if they suspected abuse or had it reported to them. Expectations relating to preventing and reporting abuse were clarified in the staff handbook and within care files in people's homes, along with the agency's no-gifts policy. The registered manager told us there had been no allegations of abuse in the last year.

Good

Is the service effective?

Our findings

People and their relatives told us they were satisfied with the care they were receiving. For example, one person said, "I have a gentleman carer who does so much for me. I wouldn't want to be without him." A relative said, "I'm very pleased that the staff are with her because I know that someone is keeping an eye on her to make sure that she's okay."

People were supported to eat and drink enough. People and their relatives had no concerns about any support provided to eat and drink. For example, one person told us their staff member "always asks me what I want to eat and he will take the time to cook for me in the evening. He chats to me as he's preparing the meals so he provides me with company as well." Care records included what people ate, and for a few people, food and fluid charts were kept to help monitor intake. Staff described the individual support they provided people for food and drink if that was part of their care package, including for swallowing difficulties where choking was a risk factor. The registered manager told us of plans for supporting someone whose risk of choking was increasing, including liaison with a Speech and Language Therapist in terms of safe practices and further training for the involved staff. They explained how the person's preferred meals were still being provided despite them moving to softened food.

The service supported people with health care matters. The registered manager told us, "People's well-being is promoted by working collaboratively with healthcare professionals." One person's care records showed staff supporting district nurse visits and repositioning the person regularly, in support of addressing the risk of developing pressure ulcers. Some staff told us of supporting people to attend community healthcare appointments such as with dietitians and neurologists. One staff member said the registered manager visited the person they were supporting one evening after the staff member reported concerns with a dressing. The registered manager checked it, and made arrangements for district nursing input. The management team gave examples of how they supported people's relatives to liaise with community healthcare professionals in support of better outcomes for their family members, such as for improving one person's end-of-life care.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We found the service to be working within the principles of the MCA.

People had signed consent to their care and treatment where possible. The registered manager showed us forms available to assess anyone's capacity to consent to specific decisions but told us they had had no need to use one as yet, as those people unable to consent to care and treatment were funded by health

authorities who would have had responsibility for those assessments. People's ability to consent was also assessed within the needs assessment process, including checking if anyone had a representative under formal procedures.

The registered manager showed us certificates from an external training provider demonstrating she had completed courses in the last year by which to train staff in certain topics. This included moving and handling, risk assessment, and the MCA. Training records showed she had subsequently provided a lot of staff training on these topics.

People told us they felt staff were well trained to look after them. One person said, "I think my carer is very well trained and intelligent, he picks up on things quickly and he's very capable." Staff provided positive feedback about the training provided, including having to pass written tests to demonstrate competency. The registered manager showed us recent food hygiene tests which staff had to complete to a sufficient standard.

Training records and certificates showed us staff had completed courses on training considered essential for their work, such as for a range of safety matters, dementia, person-centred care, and equality and diversity. Some staff had completed specific training on end-of-life care and risk assessment. Four had national training qualifications in care. This helped demonstrate staff had the knowledge and skills needed for their care roles.

Staff feedback indicated they spent a few days' shadowing experienced staff before working alone in the homes of people with complex needs. One staff member described this shadowing period as "invaluable and essential" in terms of meeting the person's needs. Another said the induction provided by the registered manager in the person's home "prepared me for every eventuality."

Good

Is the service caring?

Our findings

People and their relatives were complimentary about their care staff, told us they were very caring, and felt comfortable with the care being provided. One person told us, "I have a core team of about four different girls and they are all very nice. I really look forward to seeing the staff because they're a friendly face and it means I'm not on my own." Another person said, "It is a job to them but at the same time the staff are genuinely caring and do little extras. They don't get paid for it and most times no-one knows they're doing it, but I do and I'm grateful."

People's relative's provided similar feedback. One relative told us the regular staff member was "so gentle and understanding; her patience is amazing." Another family member said, "I've watched the carer with her and I'm impressed by her gentleness with my wife. The fact that my wife is stable and happy is testament to the care she receives."

The feedback from some staff showed the extent of their care and concerns for people. For example, one staff member told us, "This job is not all about the money, it is a passion for me." The registered manager told us it was important to only hire staff with the right attitude, which was assessed at interview. Staff interview records showed consideration of applicants' attitude and "caring skills."

The registered manager was proud of supporting one new person to come out of hospital before last Christmas so the person could celebrate at home. She explained she had to help a lot at the start, to assist staff on understanding the person's specific needs, such as triggers for certain behaviours. In time, a primary staff member was identified who showed particularly strong understanding of the person's needs. We received positive feedback from the person's relative confirming this.

People were supported to express their views and make decisions about their care and support. People and their relatives said they were asked about how they wanted their care and support to be provided. One person told us, "They ask how I want things doing." Everyone said their choices were respected. People or their representatives had signed care records to show their involvement.

The registered manager told us how they had guided one person's relative to contact advocacy sources so as to have their family member's needs assessment decisions re-assessed. This resulted in increased care funding.

The service supported people to have comfortable and dignified end-of-life care. The registered manager told us a local health authority had a history of requesting the service to provide palliative care in people's own homes. Based on her previous experiences working as a community nurse, she described ways in which she trained and supported staff to provide good quality care in those circumstances. This included specific mouth care and hydration matters, and ways of keeping the person warm and comfortable. She emphasised to staff and people's family members that she could be called for advice at any time. Feedback from people's family members and staff confirmed this. People's care files included individualised care plans on end-of-life care where appropriate.

Good

Is the service responsive?

Our findings

People told us of care and support that responded to their individual needs. For example, one person said, "I have to wear compression stockings and I can't put them on myself but the staff member does it very easily." Another person told us, "Over time me and my care workers have worked out our own ways of getting things done. Yes they do all my care for me but as important to me is sitting and having a chat over a cup of tea."

Our discussions with staff showed us they knew people well and provided responsive care. For example, one staff member told us of the importance of knowing the person they worked with well as they have "very limited speech and I need to understand his body movements to interpret what he wants." Another staff member said they had a "round table" discussion with the registered manager and the person using the service to agree a support plan.

People had individualised care plans in place based on their assessed needs and preferences. The service's needs assessment form prompted for considering a wide range of potential needs, including health matters, safety, nutrition, mobility, communication, medicines, cognition, and general daily support. It also captured preferences and cultural wishes, including for diet, enabling independence, and how staff should refer to the person. One person's assessment identified the need for a patient staff member due to their slow speech, and exactly what community support they required from the service. The registered manager explained staff were chosen based partly on their ability to avoid making assumptions on what the person was trying to say.

Care plans were based on the main support needs identified and agreed from the needs and risk assessments. They were set up promptly for new people. They emphasized safety, choice and independence, and for respectful care. They were quite precise about the personal care support to be provided, and for infection control procedures to be followed. However, our checks of four people's care plans in the office found one to be missing from their care files. The management team explained this was an omission but that the plan was in the person's home; a copy was subsequently provided.

In one person's case, their care delivery records had been personalised as a daily template to reflect activities they undertook and other specific support they were to receive. The registered manager explained this was set up to help ensure the care plan was being followed.

Everyone using the service and most relatives told us they had received care reviews from the service. One relative said, "We have visits from the boss every six months to check everything is going well and we've had a review recently." There were records of an informal review occurring after six weeks of providing a service for another person. The registered manager showed us carbon-copy forms now set up for formally reviewing care packages, which were about to be used.

The service listened to and learnt from people's concerns and complaints. People and their relatives told us of knowing who to contact if unhappy about their care, but most had had no need. One person said, "I've

never had cause to complain but I was given the phone number of the boss in case of any problems." A relative told us, "I complained once a while ago about lateness of a member of staff and it was dealt with immediately by the manager who went and picked the member of staff up and delivered her to us. I've never had cause to complain apart from that." The service guide given to people included details of the complaints procedure, and they were reminded of the process during the registered manager's occasional visits to check on service quality. The management team told us there had been no formal complaints in the last year, but there had been occasional concerns raised which they attended to. They showed us a text message they received as example.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. She demonstrated a good knowledge of the needs and preferences of people using the service. She told us this "personal touch" was an important aspect of the service which she would not want to lose by expanding the service to too many people.

Most people and their relatives told us the service was well-led and they would recommend it to others. One person described it as "a priceless agency." A relative said, "It's very well run in my opinion for what we need." Staff were also complimentary. A staff member told us, "This is one of the best companies I have worked for; they understand not only the needs of the client, but also of the care worker too."

However, some people and their relatives told us timekeeping was an issue as staff were not always arriving when they were expected. They explained staff travelled by bus and were therefore dependent on buses running to time. One person told us, "It sometimes feels as if they will miss anything they can to get away. I suppose they are in a rush to get the bus to the next person." Another person said, "They all come on buses so they're often late but what can you do?" A relative told us, "Timekeeping is not always brilliant but they come on buses so that's not their fault."

When we checked the service's visit schedule for one recent week, we found it sometimes expected staff to give care and support in a timescale that could make people feel rushed. This was because there were 11 instances where staff were assigned on that schedule to be in two different people's homes at the same time. The management team explained changes were made in practice in response to people's individual requests, and some visit times on the schedule were incorrect, so the visit schedule was not always an accurate record of when care visits occurred in practice. However, this did not explain why staff would initially be scheduled to attend to two people at the same time. This was most concerning where staff were recorded to attend to one person for four and a half hours but during that period, attend to another person for 45 minutes. This was scheduled four times that week. This demonstrated failures to maintain an accurate, complete and contemporaneous record in respect of each person's visit schedule decisions. We concluded the service's scheduling arrangements were not always robust enough to ensure people consistently received expected care visits on time and in a manner that avoided making them feel rushed.

The service promoted a positive working culture. Staff were positive about the supportiveness and responsiveness of the management team. Comments included, "People in the office are quick to answer the phone" and "They're always checking that there is nothing else we need." Staff told us the management team responded quickly when it was found the person they were supporting was running low on medicines, had health concerns, or they did not have enough disposable gloves and aprons for personal care tasks.

Records showed staff received developmental supervisions and appraisals that reflected their individual abilities, circumstances and plans. Supervisions included competency checks such as for catheter care and hoisting people. However, the management team could not show us anything to demonstrate oversight of how supervisions, appraisals and spot-checks were monitored, to ensure each staff member was up-to-date.

There were minutes of two staff meetings in 2017 which indicated staff received guidance on care standards, service updates, and opportunity to raise matters. However, the minutes did not record summaries of what was discussed for each agenda point, and so were almost identical bar minor changes to the agenda.

The registered manager showed us there was a contract of services in place between representatives of people paying for services privately and the provider. These informed the representatives of their rights and responsibilities, and included costs and invoicing processes. However, staff files we checked on had either unsigned contracts or none. The registered manager told us staff did not always return them; however, the provider's systems were not effective for ensuring valid contacts with staff were in place.

The provider enabled stakeholders be involved in how the service operated. Surveys had recently been sent to people, their representatives, and staff. We looked through those returned, which showed mainly positive responses. The management team had written a brief analysis of the overall findings, which had identified two areas for improvement, around ensuring staff always wore their identification badges, and making sure they always had disposable aprons for use when providing personal care. The registered manager told us this was being communicated to staff, and checked on.

We were shown records of quality checks visits to some people in the last few months. These focussed on people's views of the service, which were predominately positive but with occasional suggestions. However, the management team could not show us a documented process to ensure these covered every person using the service in a timely manner.

There were improving systems of governance at the service to help ensure good quality care. Staff reported many spot-checks occurring, which is when a member of the management team attends a care visit unannounced and checks on care quality. Spot-check forms included checks on staff punctuality and appearance, infection control, the care task, the approach of the staff member, and the views of the person using the service. The registered manager explained ongoing processes to ensure these covered every staff member.

People's care files included documented audits of their care records from the previous month. Where used, this included charts for medicine administration and repositioning the person to help address pressure ulcer risk. The audits were being used to improve care standards. For example, the registered manager told us these highlighted occasions when staff did not record their names. She knew which staff needed more support as a result of these audits, but said general findings were circulated to all staff in support of team-wide improvement. The audits also checked for evidence of the second staff member attending where two staff were scheduled to visit a person, and that specific parts of the person's care plan were followed. We noted care records provided appropriate detail of the support provided to people and their welfare. For example, where care was provided across the day, records showed what occurred throughout the day. Records usually included staff names and were accurately dated.

The registered manager informed us there had been no CQC-notifiable events in the last year relating to the provider's homecare service. A notification is information about important events the provider must inform us about by law. They provided appropriate examples of what needed notifying.