Salus Care Group Leicestershire Ltd

Salus Care Group - Braunstone

Inspection report

The Lodge
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Salus Braunstone is a domiciliary service providing care and support to people in their own home. The service supported 72 people at the time of the inspection.

People's experience of using this service and what we found
The service was unsafe. People had their care and support cancelled by the provider twice at short notice exposing them to the risk of unnecessary harm.

The provider, directors and registered manager were not open and transparent. Some of the information they provided us with could not be verified. The provider did not engage with the CQC to address the shortfalls identified.

The provider had not learnt lessons from previous shortfalls and there were no plans to make improvements to the quality and reliability of the service.

People were not always respected or treated in a dignified manner and complaints and concerns were ignored.

People's care and support was not person centred and frequently provided at times not to their preference. Care teams were not consistent so people were supported by multiple care staff they did not know.

Risks to people's health and well-being were not always assessed and managed safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
This service was registered with us on 14 April 2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to the provider cancelling 300 hours of care without notice or appropriate explanation. A decision was made for us to inspect and examine those risks associated to this cancellation of care packages.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Enforcement
We have identified breaches in relation to the provider and registered managers fitness and the management to operate a safe service.

We were not able to use our enforcement powers due to the provider closing the service during the inspection. If the service continued to be registered it would be placed in special measures.

Follow up
Due to the closure of the service we could not follow up any of our concerns with the provider. Considering our findings at the inspection CQC will monitor any future applications made by the directors and registered manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Salus Care Group - Braunstone

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and an 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 1 September 2021. We visited the office location on 1 September 2021 and 7 September 2021. We were unable to conclude our inspection activity due to the provider formally notifying us on 7 October 2021 the service had closed before the inspection ended.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used information we had received from the local authority and that submitted to us by the provider from the date the service was first registered with the Care Quality Commission. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and eight relatives about their experience of the care provided. We spoke with eleven members of staff including the two directors, registered manager, assistant manager, senior care workers and care workers.

We reviewed a range of records. This included four people's care records and medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

The registered manager also held the position of nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We were unable to fully validate evidence found during the inspection. Whilst we received some information during inspection activity, we required further information from the provider. Further information and explanations requested were not provided, so a further inspection day was planned. The provider closed the service prior to a further inspection visit so we were unable to obtain the information and explanations required to conclude the inspection.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment; Learning lessons when things go wrong

- Prior to the inspection site visit the provider had placed people at risk of harm. We were informed by the local authority commissioners, with less than 12 hours' notice, that the service could no longer provide care to 17 people due to reduction in staffing levels. However, the provider could not evidence the staffing level issues they said they had.
- During the inspection the provider then withdrew care and support from a further 72 people giving around 2 hours' notice. The provider notified the CQC they were closing the service with immediate effect. After the care and support was withdrawn, the provider proved difficult for local commissioners to maintain stable communications with, and did not share accurate information regarding names of service users and staff they held. This meant people were placed at significant risk of harm if arrangements could not immediately be put in place for continuity of care to people affected by the providers actions.
- Approximately 10% of calls we reviewed (100 care calls) for the 6 weeks prior to our visit identified staff arriving at people's homes before they had left the previous person's home. For example, on the 27th July 2021 the rota showed the care worker left one person's home at 06:50am but arrived at their next call at 06:41am. This meant these records were inaccurate.
- The provider told us these anomalies were caused by computer software maintenance, however, we discovered there had not been any software maintenance following contact with the IT company that provided the programme to the provider. We were unable to establish the cause of this anomaly and this meant our concern was left unexplained.
- The providers rotas confirmed between 26 July 2021 and 6 September 2021 approximately 10% of calls undertaken were provided between 30 minutes and 2 hours earlier than planned. This meant people could not be assured their care would be delivered as arranged. One person told us, "Call times are all over the place. We never actually know when they [care workers] would turn up." We requested to meet with the provider and commissioners to discuss and understand the issue, but the provider refused.
- We spoke to care workers regarding the duration of call times. One told us, "We were at times instructed to make shorter calls to people than were planned. For example, by reducing 45-minute calls to 30-minutes and 30-minute calls to 15 minutes because of lack of staff." This meant people were at risk of not receiving all the care they required.
- The provider had failed to ensure they learnt any lessons when things went wrong. For example, they were aware of the staffing issues and being unable to fulfil their contractual obligations to the local authority. However, they continued to take on new packages of care that they could not meet.

The provider failed to ensure that they had sufficient staff employed and deployed to meet peoples care and treatment needs. This placed people at significant risk of harm. These concerns constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care

and treatment.

● Safe recruitment processes were in place. For example, a Disclosure and Barring Service (DBS) check and previous employer references were obtained. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions.

Assessing risk, safety monitoring and management
● Risks to people's health were not always safely managed. Some people's risk assessments did not reflect their current needs and placed them at risk of receiving unsafe care.
● One person's health risk assessment did not take account for all aspects of their daily living including, continence needs, communication difficulties and sensory impairment. There was no behaviour support risk assessment in place despite previously recorded incidents of aggression toward staff, with one incident causing harm.
● Another person's risk assessment stated they did not have any special dietary needs, but their nutritional needs were met by way of a Percutaneous Endoscopic Gastronomy method (PEG). If this method is not safely monitored there is a risk of infection, bleeding, perforation and aspiration pneumonia and misplacement of the PEG.
● Furthermore, one person did not have a risk assessment for their diabetes, and another person who was hoisted to support them with personal care did not have a moving and handling risk assessment.
● Whilst a director told us they would update people's risks assessments to reflect their current risks, no evidence was provided to assure us this had been undertaken.

The provider failed to ensure that risk assessments to ensure people's needs were safely managed were in place or robust enough to protect people from the risk of unsafe care and treatment. This placed people at risk of harm. This was also a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicine risk assessments were not always accurate. For example, one risk assessment stated, '[Name] did not use prescribed or non-prescribed medicines' However, other records confirmed the person was supported by staff with prescribed medicines. This meant people may be at risk of not receiving the support needed to take their medicines.
● Staff were trained in medicine administration, and their competency was checked.

Preventing and controlling infection
● Staff adhered to regular COVID-19 testing and supported those staff who tested positive to self-isolate. However, they failed to ensure that other staff who may have come into contact with those staff were informed.
● We spoke to staff regarding COVID-19 testing and isolation arrangements. One member of staff told us, "I found out a colleague had tested positive from [Named Service User] after they overheard a conversation between two other colleagues whilst they were delivering care there." This meant the transmission of COVID-19 was at an increased risk from ineffective communications within the service.
● Information provided by a director regarding staff who had tested positive for COVID-19 was incorrect. One member of staff was recorded as testing positive for COVID-19 on 22 July 2021. They continued providing care up until 29 August 2021 and informed us they had never tested positive for COVID19.
● People and their relatives told us staff wore personal protective equipment (PPE). One person told us, "They [staff] always wear masks, gloves and aprons."

● Staff had received training in infection control, including COVID-19 and donning and doffing of PPE. Staff confirmed there were never any incidences of not having access to PPE supplies.

Systems and processes to safeguard people from the risk of abuse

● Policies and procedures were in place to protect people from the risk of abuse. All of the people we spoke with told us they felt safe. One person told us, "Yes, they [staff] make me feel safe." A relative told us, "[named person] feels safe with their carers."

● Staff received safeguarding and whistleblowing training and knew how to recognise signs of abuse and who to report their concerns to. One staff member told us, "If I saw something didn't look right, I would document it and report to my manager.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Four assessments and care records we reviewed were of poor quality and did not always fully consider or accurately reflect people's needs and preferences. For example, assessments had not considered people's behaviours, continence, mobility and communication needs. This meant there was a risk people's needs and outcomes would not be met.
- We discussed this with the provider who accepted the assessments and care records were not accurate and informed us they would update them. We did not receive any feedback from the provider informing us the shortfalls had been addressed.

Staff support: induction, training, skills and experience

- There was mixed feedback from people on staff competency to carry out their role. Whilst most people told us staff were well trained and competent others did not. One relative told us, "They [Care worker] don't put [Name's] incontinence pad on correctly. On numerous occasions they are always wet, and the bed is soaked in urine when I arrive. I've told them [managers] but it still carries on." Other people praised staff with one person commenting, 'no faults at all with the carers, they are really good'.
- The service inducted staff into the service and provided mandatory training to support them in their role. Refresher training was planned, and staff competence was monitored during unannounced 'spot' visits made by senior staff. However, when shortfalls in staff practice was identified no action was taken to make necessary improvement.

Supporting people to eat and drink enough to maintain a balanced diet

- Call times were not always undertaken at the planned time to support people's specialist diets. For example, one person with a diagnosis of diabetes told us their morning call were regularly late. This meant their blood sugar levels may be negatively impacted placing the person at risk of a hypoglycemic event.
- Records confirmed people's basic nutrition and hydration needs were met. Care workers told us they reported any nutritional concerns they had for people to their managers.
- People told us staff supported them with their meals and drinks.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's assessment and care plans included any health care needs, and external agencies and contact details for health care professionals involved in their care.
- Managers told us they would contact the relevant professionals if people in their care required further

health or social care support.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.
● Staff understood the principles of the MCA and supporting people to make choices. Mental capacity assessments had been completed. Everyone was able to decide their day-to-day choices and did not need any assistance in doing so. No best interest decisions were needed.
● People and their records confirmed staff always asked for consent before providing care to them.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People did not always receive their care at the agreed time. A significant number of calls were earlier than planned and people told us the provider did not act when they raised the issue with them.
- One care worker told us they had previously been instructed by the provider to reduce call times by up to half of the planned time allocated because there was not enough time to complete the full call time. This meant people did not receive all their care at the planned time. One person told us, "The 'girls' [Care workers] are caring but timings aren't always right but not their fault. I don't really want support from them [Salus] anymore but I need to make arrangements with another service first before I tell them."
- Some staff did not have access to accurate assessments and care plans for people who received support to inform them of their needs and preferences. Care workers knew most people well but often relied upon their relationships with, and knowledge of, people to know the support required.
- We received mainly positive feedback about the care people received from care workers. One person told us, "Yes, they are all kind and caring towards me." A relative told us, "The staff are all kind to [Name] and seem very caring in their nature."
- Some people benefited from positive relationships with care workers. One relative told us, "I know they [Care workers] aren't meant to become emotionally attached but the ones [Name] gets on with well have a good rapport between them which relaxes them when they are being cared for."

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- Whilst some people raised minor concerns most care workers treated people with respect and dignity. One relative told us, "They [Care workers] seem to know how to react to [Name] moods and just treat them in a dignified manner." Another relative told us, "They [Care workers] show [Name] respect.
- The provider was aware of the importance of keeping people and employee's confidential information safely stored.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.
Improving care quality in response to complaints or concerns
● The provider did not always follow their own complaints policy. The policy stated, 'on receipt of a written complaint an acknowledgement will be sent to the complainant within 5 working days and an investigation concluded in 28 days'.
● One relative provided us with a copy of their written complaint from May 2021 and told us, "I sent this [Letter] regarding a particular carer I didn't want to come anymore. I received no response. I then contacted the office and a manager told me 'you will have the care worker I [obscene word] send'.
● The registered manager told us they had received a complaint similar to this. However, records showed no follow up action had been taken to this complaint.

The provider failed to follow their complaints policy by investigating and taking the necessary and proportionate action to resolve any issues. This is a breach of regulation 16 (1) (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● Care and support was not always person centred. For example, call times were often not undertaken at the planned time. One relative told us, "[Name] doesn't want to go to bed at 8.30pm but they [care workers] often turn up at this time so they have little choice but to go along with it." Provider rotas confirmed care workers frequently arrived between 8.00pm and 8.30pm.
● Four people raised concerns regarding the lack of regular carers and not being informed when they were changing in advanced. One relative told us, "Many different carers come. We have to keep showing them everything again and again and it causes all sorts of issues for us."
● Whilst care plans were in place and identified most people's choices they were not always followed. For example, one person told us, "I was involved in my care plan, but it is certainly not obeyed! I do mention it, but they still mess me about and don't follow it. I like my breakfast at 9am to manage my diabetes. I have had it as late as 2.30pm before."
● Other feedback we received was more positive. One relative told us, "They seem to know [Name] well and they [Care workers] are learning her likes and dislikes." One person told us, "My care plan is done over the phone and carers have a copy of it on their work phones. Things are going ok."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Not all people's communication needs had been considered or assessed. For example, one person's care plan stated 'no communication difficulties' despite the person having a diagnosis of dementia who presented with behaviours that had previously led to a care worker being harmed due to their distressed state.

End of life care and support

● No end of life care was being delivered by the service at the time of inspection. Care plans did not show this area of care planning had been offered or considered during the care planning process with people or their representatives.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The service was not well-led and the management systems in place were not being followed to give people the care and support they needed in a timely manner. This placed people at serious risk of harm.
- The provider had cancelled people's care without warning and failed to support the local authority to source a different agency to provide the care. During the inspection the remaining people had their care cancelled at extremely short notice. The provider informed partner agencies they would no longer provide care for 72 people they were supporting.
- A director of the company and registered manager provided us with conflicting information and evidence during the inspection. For example, an e-mail from a software company and a report indicating a complaint had been resolved with a relative when it had not. This cast doubt on the validity of other evidence reviewed during the inspection, and the openness and transparency of the director and registered manager.
- Following the inspection the provider and registered manager failed to engage with the rest of the inspection process and respond to any requests for further information that would enable us to form a judgement on the service being provided to people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider failed to safely govern and manage the service. The service was unable to provide people with continuity of care to meet their needs. When shortfalls were identified the provider closed the service and left people at serious risk of harm.
- Some of the evidence obtained during the inspection could not be corroborated. The provider closed the service during the inspection, and we were unable to establish if further evidence we obtained was reliable.
- The provider failed to work in partnership with CQC and commissioners. Meetings were declined and information and evidence requested was not provided.
- Lessons were not learnt from previous failings and no systems and processes were implemented to prevent reoccurrence.
- There was a lack of systems and processes to ensure effective management oversight and quality assurance of people's care.
- The provider failed to effectively engage people, relatives and staff in the running of the service to address shortfalls in the service. When complaints and concerns were raised these were not always investigated or

followed up and no improvement made.
● Legally required notifications to the CQC had not always been made, for example, an event that stopped the service from operating and a safeguarding matter were not reported to us as they are legally required to do so.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
● The provider failed to effectively engage people, relatives and staff in the running of the service to address any shortfalls.

The provider failed to ensure they had effective systems and processes in place to manage the service and ensure that people received safe care that was assessed, monitored and well managed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The provider failed to ensure that they had sufficient staff employed and deployed to meet peoples care and treatment needs. Robust assessments to ensure people's needs were safely managed were not in place to protect people from the risk of unsafe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to follow their complaints policy by investigating and taking the necessary and proportionate action to resolve any issues.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they had effective systems and processes in place to manage the service and ensure that people received safe care that was assessed, monitored and well managed.