Solace Community Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 11 November 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. At our previous inspection on 23 September 2014 we found the provider was meeting the regulations we inspected.

Solace Community Care Limited provides domiciliary care for older people and for those with learning and physical disabilities. There were approximately 50 people using the service at the time of our inspection.

There was a manager at the service. However, they were not registered with the Care Quality Commission at the time of the inspection and were in the process of completing their application. 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 majority of people using the service told us they were happy with the service, however we identified a number of areas for improvement.

The provider was not following its own guidance in relation to safe staff recruitment. Staff recruitment checks were not thorough and did not always include appropriate reference checks to ascertain the suitability of new recruits. We could not be assured that care workers received regular, ongoing training to enable them to meet people's needs effectively as training records showed that training was not always refreshed in line with the provider's policy. Staff supervisions and appraisals were not carried out in accordance with the provider's own policies.

Risk assessments were mainly focussed around risks in the environment and less in relation to people's support needs. They did not adequately identify assessed risks and risk management plans were not always in place to manage risks and keep people safe. Care records did not always document identified risks to people.

Although people did not raise any concerns about the support they received with medicines, support with medicines was not recorded in a way that promoted people's safety and ensured that people received their medicines as prescribed.

Care records were not person centred and contained minimal information about people's preferences and how they liked to be supported.

People were given information how to raise a complaint should they choose to do so.
There had been no recorded complaints about the service.

Quality assurance checks such as surveys were completed but some checks such as unannounced spot checks were not carried out with any degree of regularity.

We found breaches of the regulations in relation to safe care, fit and proper persons employed, staffing, notifications and good governance. You can see what action we have told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe.

Risks to people using the service were not appropriately assessed or managed to ensure that people were kept safe.

Staff recruitment checks were not thorough enough to ensure that care workers were suitable to work with people using the service.

Although people were supported to take their medicines, the provider did not maintain adequate records to ensure that people's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not effective in all aspects.

Staff training was not refreshed at regular intervals to ensure that their skills and knowledge were maintained and care workers did not receive regular supervision and appraisal of their work.

Care records contained limited information about people's health and dietary support needs.

Is the service caring?

Requires Improvement

The service was not caring in all aspects.

Although people spoke in positive terms about the attitude of staff, care plans were not written in a person-centred manner.

People and their relatives said that staff respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not responsive in all aspects.

There was an over-reliance on third party care plans that did not always take account of changes in people's needs.

Complaints procedures were in place, although the provider did not always follow its own guidance on recording informal complaints.

Is the service well-led?

Requires Improvement

The service was not well-led in all aspects.

The provider did not submit statutory notifications about some incidents.

Quality assurance checks such as audits and team meetings were not effective in picking up concerns.

Solace Community Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 8 and 11 November 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

We spoke with five people using the service, two relatives and six staff members including the director and the homecare supervisor. We looked at six care records, training records, five staff records, complaints and audits related to the management of the service.

Inadequate

Is the service safe?

Our findings

People's identified risks were not always effectively captured by the provider which meant that people may have been at risk of receiving unsafe care. Care records did not contain enough information about the risks to people and how these should be managed to help keep people safe.

Care records included an information sheet which provided an overview of risks and guidelines but these were often blank. The risks and guidelines in the information sheet for one person who had medical conditions that posed some risks care workers should be aware of was blank. This person's record contained an occupational therapist (OT) report which mentioned they had difficulties swallowing but this was not mentioned in the information sheet to ensure that care workers had the information they needed to support the person and manage this risk.

Different areas were risk assessed including communication and senses, staying well, finance, personal hygiene, dressing/undressing and dietary needs. Risk rating score guidelines were in place based on the impact and likelihood of the risk. However, some risk areas were not scored and the action required incomplete. In one example, the areas of identified risk were not scored and the response was either 'treat' or 'insure' which was not sufficient information for care workers to act upon. In some instances where action was required, staff training had been recommended. We saw that this training was not always being completed by staff members. Therefore we could not be assured that care workers had the appropriate support and guidance to manage risks to people's health and welfare.

The risk assessment in relation to personal injury and moving and handling for one person who required hoisting had not been completed. In this person's care plan it also stated 'assist with medication' but in the staying well section of the risk rating there were no details about the medicines that had been prescribed and in the 'service user information sheet' under medicines it said 'await carer to provide.' This was not sufficient information to ensure that this person received their medicines safely.

One person had started using the service in May 2016 but there was no risk assessment in their care records, even though a number of areas were highlighted that required assessments to be carried out. For example, it stated the person used specialist equipment to support them with their nutrition and medicines and stated that they had a medical condition that affected their speech, mobility, swallowing and breathing and were at high risk of falls. We asked the homecare supervisor about the lack of risk assessment and they told us no risk assessment was available as this would be done after six months, not when the person first started to use the service. This was not sufficient as risk assessments should be completed when people first start using services to ensure that staff are equipped to do all that is possible to mitigate any risks and try to keep people safe.

The local authority social care needs assessment for another person dated 23 April 2016 identified them being at significant risk of falls as a result of health conditions. However, the provider's risk assessment and register was not clear about the risk of falls and steps that care workers needed to take to manage the risk.

In the dressing/undressing section of the risk assessment and register for one person it stated they were 'level 0' which meant they were unable to perform this task independently but there were no comments or guidance for staff to enable them to support the person safely. In the section relating to special dietary requirements, it said 'yes there were special requirements' but there was no other information provided to say what these were or how the person should be supported.

The issues identified in the above paragraphs demonstrate that the provider was not always assessing risks to people's safety or doing all that was possible to mitigate those risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The provider's systems for managing medicines safely was not effective. The homecare supervisor told us they were only administering medicines to one person using the service. In this person's records it stated that staff were to support this person to 'prepare (their) morning tablet and help (to swallow it)'. However, when we asked the homecare supervisor, they told us this was not the medicine they were supporting the person with. We were told care workers were only supporting them to take some pain relieving medicine. Therefore the records were inaccurate and we could not be assured that care workers had the correct information to ensure that they supported this person to administer their medicines safely.

The homecare supervisor told us care workers used the daily timesheets that were produced as a way of providing information to the care workers about the medicines they were to support people with. However, this contained only basic information, for example short statements such as 'assistance with medication.' They did not contain further information to guide staff about what to administer and how to ensure that people received their medicines as prescribed.

The director told us medicine administration records (MAR) were not used and that care workers recorded details of the medicines they supported people with in their daily record sheets. In one person's information sheet there was no mention of the medicine the person was to be supported with, however in the list of care services received one of the tasks was 'assistance with medication' and in the local authority's care and support plan it stated 'prompt with medication.' The daily record sheets that care workers completed simply said 'given medication.' This was not in line with the provider's medicines policy.

The policy stated, 'For self-medicating service users the date and name of the care staff who gave their supply of medication must be recorded in their medication administration record, as well as in the care plan.' And further on, 'Medication administration records must record, the medications prescribed for the person, the time they must be given, the dose of the medication and any special administration requirements.' Therefore we could not be assured that medicines were managed in a way that protected people from avoidable harm.

The issues identified in the above paragraphs are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The provider did not always ensure that satisfactory evidence of staff conduct in previous employment was obtained to ensure they were suitable to work with people using the service before they started working for the service. This was not in line with its own policy with regards to reference checks. The recruitment policy stated that a job offer, 'will be subject to the receipt of two satisfactory references, of which one must be from a previous employer, and that they cannot start work until those references have been received in writing.' It also stated, 'In no circumstances proceed beyond this point to offer a post to a candidate unless: 1. At least two satisfactory written employer references have been received for that candidate, including one from the last employer.'

In four of the five staff files that we looked at, there was only one reference in place and in the fifth one there were no references. In some cases, the referees contacted were not those that were listed on the application forms. We therefore could not be assured that the provider's staff recruitment processes protected people from staff unsuitable to work with them.

The above issues are a breach of Regulation 19 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Staff files contained application forms and evidence of identity and right to work in the UK such as passports, national insurance details and proof of address. They also contained offer letters and contracts signed by care workers. We saw evidence that Disclosure and Barring Service (DBS) checks were completed for care workers. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

People and their relatives told us they felt safe in the presence of care workers. Care workers were familiar with safeguarding procedures. One care worker told us, "Safeguarding is about keeping people safe from harm." There was a safeguarding policy in place.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff who received appropriate training and support to ensure they were able to meet their needs effectively. Induction training for new care workers was completed in one day and included going over support needs and care plans, an explanation of the fundamental standards of care, policies and procedures and competencies.

The provider's induction pack and the recruitment policy stated that all new care workers were to be interviewed once they had worked at the service for three months to check their competency and identify any development needs, we did not see any evidence of these checks and care workers we spoke with told us that this had not taken place. Therefore we could not be assured that care workers competency in their role was checked to ensure they were able to meet people's needs.

Staff files contained evidence of training that care workers had completed. However, we were not assured that care workers received appropriate training at intervals which ensured they maintained their skills and knowledge to meet people's needs effectively.

The director told us the majority of training was delivered through DVDs which care workers watched and then answered competency questions to test their knowledge. In the staff files we looked at, these competency questionnaires which included infection control, medicines and moving and handling were not always present or were not fully completed or signed off by a manager.

We looked at training records and noted that care workers had not completed refresher training in line with the provider's policy.. For example, care workers had completed training in death, dying and bereavement, moving and handling, safeguarding, managing challenging behaviour, infection prevention and infection control, medicines and food hygiene. However, these were all due to be refreshed in March 2016.

Staff supervision was not carried out as regularly as stated in the provider's policy. This was acknowledged by the director as being an area where improvement was required. One care worker who had started working for the service in August 2014 had two supervision records one file, one dated April 2015 and the other dated November 2016. Another care worker who had started work in July 2014 had no recorded supervision records. A third care worker who had started work in December 2013 had one recorded supervision in April 2016. The provider's guidance on supervision meeting stated that they were to be carried out monthly and recorded. It also stated that a more formal review of agreed objectives and the staff member's training and development plan was to be carried out on a quarterly basis. We found that staff appraisals were not taking place. This was not in line with the development appraisal policy and procedure which stated 'each employee will be appraised annually.' Therefore, we could not be assured that staff were receiving the support required to enable them to meet people's needs effectively.

The above identified issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in domiciliary care agencies are to be made to the Court of Protection.

Care workers told us of the importance of asking for people's consent before supporting them with personal care. One care worker said, "Although I do the same tasks on each visit, it's always important to ask people first."

Care records did contain evidence that people using the service and their family members (where appropriate) were involved in planning their care. The risk registers for people where completed were done so in the presence of people using the service, their next of kin and staff.

People told us they were satisfied with the dietary support they received. They said that food was often prepared by family members and care workers helped them to eat. Care workers told us, "In the evening, I cook dinner. [Person] likes fresh food. I make them pasta, curry or spaghetti", "The family prepare the food and I feed them", [Person] tells me what [they] would like for breakfast, usually porridge or a fried egg" and "[Person] makes [their] own breakfast."

Despite these comments, we found that care records did not always contain sufficient detail in relation to people's dietary support needs. The dietary needs section of the risk assessment was blank for one person and not completed although the timesheet and the care plan stated they needed assistance with lunch and in a previous risk register it stated they had problems swallowing and were on a liquid diet. This meant that care workers were not always provided with adequate information to ensure that they were able to meet people's nutritional needs effectively.

Care records contained minimal details in relation to people's ongoing health conditions apart from the details as provided in the local authority referral forms or care plans. However, care workers were familiar with people's support needs and told us they knew what to do if people's health was a concern. For example, one care worker told us, "I've got contact details of the GP and community nurse if I need to get in touch with them."

Requires Improvement

Is the service caring?

Our findings

People using the service told us that care workers treated them well and were considerate.

They said that care workers respected their privacy and dignity. One person said, "The carers are nice, yes respectful." They told us care workers took care when supporting them with personal care such as ensuring any doors were shut.

Care workers demonstrated an understanding of people's support needs and told us they encouraged their independence by allowing them to do things for themselves as much as possible. They told us, "We encourage [person] to do (their personal care)", "[Person] is independent, I prepare the bath for [them] but [they] are able to bathe themselves" and "They enjoy preparing and helping with food so I encourage them."

The provider had a 'client bill of rights' which provided people with a list of their rights and expectations from the service such as the right to be treated with dignity and respect, the right to refuse care, the right to express feelings and the right to look at their care records.

We found that care plans did not always contain enough detail about people's preferences or how they liked to be supported. Care records were task oriented and had limited information, for example in the care records we looked at there were often single word prompts such as "prepare breakfast", "personal care" and "prepare snacks." This meant that we could not be assured that care and support was provided in a person centred way that took account of people's individual preferences and likes and dislikes.

Requires Improvement

Is the service responsive?

Our findings

The homecare supervisor told us the majority of people were referred from local authorities. They said they usually received a referral which included the support required and also a breakdown of the risks involved. They then carried out their own assessments; however we found that these were not always in place in the records that we saw. Risk assessments were completed but these were more in relation to environmental risks within the home rather than risks associated with the person's support or health needs.

Care records were not always reflective of current status; this was partly because the provider relied on and used the care plans that were produced by local authorities instead of producing their own care plans. For example, there was a local authority support plan for one person which said they needed two visits a day for seven days. However this had changed and the person's risk register dated June 2016 stated they were getting four calls per day.

Where the provider had their own care plans, we found these often contained very basic information and insufficient detail about people's individual needs and therefore we could not be assured that person centred care reflecting each individual's needs was provided.

Care workers completed records of their visits and we saw that these were completed in a timely manner consistently.

We recommend that the provider seeks advice from a reputable source regarding person centred care planning to ensure that people's individual needs are reflected and met.

People using the service told us they had not needed to make any complaints previously but would "contact the office" if they had concerns.

There had been no recorded complaints in the past year. The director told us that most concerns were dealt with informally over the telephone and these were not recorded. However, the provider's complaints policy noted that informal complaints were to be documented in the 'informal complaint log.'

Each person using the service was given a 'service user guide.' This contained details of how people could contact the office including an out of hours number that was operational on evenings and weekends. There was a complaints policy in place which gave people using the service and their relatives' information on how they could raise a complaint and who they could contact if not satisfied with the response received.

Requires Improvement

Is the service well-led?

Our findings

People using the service and their relatives told us they were generally satisfied with the service. During the inspection, we looked at the results of a postal survey sent to 15 people asking for their views of the service and the feedback received was largely positive. Telephone surveys were completed for 26 people.

Care workers told us they felt supported, especially since the new director had started. Comments included, "I've been here a while now, everyone is approachable" and "I call the office if there are any problems. They usually sort it out."

Despite these positive comments, we found that aspects of the service were not well managed.

The provider did not always accurately record incidents and accidents that occurred. One person using the service had fallen four times between 27 August 2016 and 8 October 2016 and the related incident forms were not fully completed. For example, one of these incidents was not documented in the incidents and accidents folder. In addition, the forms completed for the other occurrences had missing information. For example, the manager notes and recommendations section were not completed and some were not signed off or dated by the manager or other responsible person. Therefore we could not be assured that these incidents appropriately managed and responded to.

We also saw that although two of the incidents had been raised as a safeguarding, the provider failed to submit statutory notifications to the Care Quality Commission (CQC) in relation to these as required.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 Care Quality Commission (Registration) Regulations 2009.

The director told us unannounced spot checks were carried out on care workers, however these were not seen in all the care records or staff files that we saw. These checks looked at the timeliness of care workers, whether they were dressed appropriately, if daily reports were completed correctly, and whether appropriate support was given in relation to personal care, moving and handling, medicines and food. We found that quality assurance monitoring checks were not effective in picking up the issues we identified during our inspection.

The above identified issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

There had been a number of changes of registered manager and office based staff historically which had an impact on the management of the service. The homecare supervisor was in the process of applying for the post of registered manager with the Care Quality Commission (CQC).

The director told us there was a current vacancy for a full time administrator and a full time homecare supervisor after the previous one had left after a short period. She said the homecare supervisor was

responsible for carrying out the needs and risk assessments, supervision of care workers and the day to day management of the service.

Staff meetings did take place, the director told us that care worker meetings took place every quarter and we saw the minutes from the meetings that were held in January and May 2016. Topics that were discussed included working practices, improving performance and actions from previous meetings. A managers/office based staff meeting was held on June 2016.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Commission without delay of some incidents related to abuse or allegations of abuse in relation to a service user; whilst services were being provided in the carrying on of a regulated activity. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to the health and safety of service users of receiving the care or treatment and did not do all that was practicable to mitigate against identified risks. Regulation 12 (1) (2) (a) (b) The provider did not carry out proper and safe management of medicines. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not operated effectively to ensure compliance with the requirements in this Part. Regulation 17 (1)

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

	proper persons employed Recruitment procedures were not established and operated effectively. The information specified in Schedule 3 was not available in relation to each person employed. Regulation 19 (2) (3) (a)
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity did not receive appropriate training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)