Solsken Limited

Solsken Limited

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We carried out this short notice announced inspection of this service because at our last inspection in July 2021 we rated the service overall as inadequate and issued the service with a Section 29 warning notice indicating areas requiring significant improvement. We gave the service short notice the day before the inspection visit because it supports people across a large area, and we needed to be sure that the registered manager would be available.

This was a full inspection of the service whereby we reviewed all the key lines of enquiry within all domains.

Our rating of this service stayed the same. We rated the service as Inadequate because;

- At the last inspection, we issued a Section 29 warning notice to the service. It stated that improvements must be made to ensure people were protected from the risk of harm. At this inspection, we found that there were remaining areas of concern which had not been entirely addressed by the service.
- Substantial and frequent staff shortages posed increased risks to people who use the service. The service did not have enough staff to keep patients safe from avoidable harm and to provide care and treatment. There were not enough staff to cover all shifts meaning that family members often had to provide care for patients. Staff were working excessive hours and were unable to take breaks. The service continued to have a high turnover of staff which impacted on consistency of care.
- Staff did not feel respected, supported and valued and feedback from staff and families of patients was that managers were not always visible or approachable within the service.
- Managers did not ensure that staff responsible for training others within the service were competent, trained and appropriately qualified to do so, and did not ensure all staff had undertaken required competency training. Following our last inspection managers had enrolled senior support staff on adult care apprenticeships to support their development and role responsibilities but were not monitoring progress with this and we found a number of staff were behind expected targets.
- The delivery of high-quality care is not assured by the leadership, governance or culture. The service did not have an organisational risk register, or similar, to identify and mitigate risks to the service. There was no policy, procedure or oversight of staffing concerns including gaps in care provision and staff working excessive hours, effectiveness of contingency plans, sleep in shifts, and overall wellbeing of staff.
- There was little understanding of the importance of culture. There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated.
- The service used a combination of electronic and paper records and we found that records were not always up to date. It was unclear how important patient information was handed over when family members were providing care and it was unclear how lessons learned were cascaded amongst all staff following incidents.
- Whilst the service had made some improvements to their complaints process since our last inspection, some families still told us they had not received a response or resolution to a concern raised. The provider did not make it clear how complainants could escalate concerns beyond the service if they were dissatisfied with an outcome.
- Over half of the families we spoke with raised concerns with regards to staffing and told us they were regularly covering shifts due to lack of staff, and that this was having a detrimental effect on their own physical and mental health.

However:

- Care records were holistic, and personal to each individual patient.

Summary of findings

- Patients and their families told us, and we observed, that support staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They were focused on the needs of patients receiving care.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff controlled infection risk well. They used equipment and control measures to protect patients, themselves and others from infection. Staff managed clinical waste well.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Letter from the Chief Inspector of Hospitals

This service was placed in special measures in July 2021.

Insufficient improvements have been made such that there remains a rating of inadequate for any core service, key question or overall.

We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Solsken Limited

Solsken Limited is operated by Solsken Limited. The service opened in 2018. It is based in Sheffield, South Yorkshire but operates nationally. The service provides care to individuals with complex care needs in their own homes. At the time of our inspection the service provided care to 13 patients.

Solsken Limited are commissioned by eight clinical commissioning groups to provide care under the NHS continuing healthcare budget. The service has had a registered manager in post since 2018.

The service is registered to provide one regulated activity;

- Treatment of disease, disorder or injury

How we carried out this inspection

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about the location including information discussed at provider engagement meetings and monitoring calls as well as requesting feedback from service commissioners.

During the inspection visit, the inspection team:

• visited the registered office in Sheffield;

• undertook three home visits to people using the service;

• spoke with two patients who were using the service;

• spoke with seven carers or family members of patients;

• spoke with the registered manager;

• spoke with eight other senior staff; including clinical and operational managers and those responsible for recruitment and compliance;

• received feedback from 16 support staff members, either remotely or face to face;

• looked at three care and treatment records;

• spoke with commissioners about their experience of the provider;

• looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action the service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We told the service that it must take action to bring the service into line with four legal requirements.

- The service must ensure that there are sufficient staff deployed in all packages of care and that appropriate contingency action, (which meets the needs, abilities and preferences of patients and their families) is taken when staffing is low. (Regulation 18)
- The service must ensure that staff receive appropriate support to perform their role safely, including access to appropriate human resources policy and procedure, that they are able to make contact with others in an emergency, do not work excessive hours and are able to take adequate rest breaks. (Regulation 18)
- The service must ensure that there are adequate systems and processes in place to ensure that staff training others have the appropriate skills, experience and ongoing clinical training to undertake this. (Regulation 17)
- The service must ensure that effective and embedded governance and risk management processes are in place to assess, monitor and improve the quality of the service. (Regulation 17)
- The service must ensure there is an appropriate policy or protocol in place to monitor the quality of care delivered where family members are employed to provide care to their relatives. (Regulation 17)
- The service must ensure the proper and safe management of medicines, including appropriate storage, documentation and administration records. (Regulation 12)
- The service must ensure that they assess and mitigate the risks to people using the service ensuring that there is oversight of the quality of care including regular spot checks, implementation of handover processes, and addressing closed cultures. (Regulation 12)
- The service must ensure that the system for responding to feedback and complaints by people using the service and their carers is timely, accessible and appropriate, and that actions are taken as a result of feedback. (Regulation 16)

Action the service SHOULD take to improve:

- The service should ensure all staff employed by the service have completed clinical competency training.
- The service should ensure that all patient notes, both electronic and paper-based, are up to date.
- The service should ensure there is a process in place for staff and family members to document care provided to patients.
- The service should ensure that the 'teamchat' application used to share patient information is secure.
- The service should ensure that staff have knowledge of the statutory duty of candour and that the service follows this legislation appropriately.
- The service should ensure that staff have access to policy and procedure which guides them to perform their roles safely and in line with national guidance.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Inadequate

Community health services for adults

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Inadequate

Are Community health services for adults safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, not all staff were compliant with additional competency training.

Staff received and kept up-to-date with their mandatory training. At the time of inspection overall compliance with mandatory training was 94% for support staff and 80% for office-based staff and managers. Compliance with mandatory training in 'communication' and 'oral health' courses were low, with 61% of support staff and 45% of office-based and managerial staff compliant in communication, and 55% of support staff and 45% of office-based and managerial staff compliant in oral health. However, managers explained this training was only implemented as mandatory nine weeks prior to inspection and that staff were on track to be compliant within the 12-week target set by the provider.

The mandatory training met the needs of patients and staff. It included courses such as safeguarding adults and children, infection control, Mental Capacity Act and basic life support. However, some staff told us that they found the training difficult to follow as the majority was taught via online modules with very little face-to-face support.

Staff also completed competency training dependent upon the tasks required for the individual care package to which they were assigned. This training is important to mitigate the risks to the highly vulnerable people who used this service, because they had complex needs. This included training in tasks such as catheter care, moving and handling, medicines management and non-invasive ventilation. Competencies were taught and assessed by one of the service's clinicians. However, we were concerned that the clinicians did not have any qualifications in teaching others and that the service did not have a system to record how clinicians maintained their clinical skills. Additionally, we found that for one package of care staff members, who were also family members, had not undertaken competency assessments despite the service being responsible for the package for over two months. We raised this as a concern at our last inspection of the service and this risk had not been addressed.

Managers monitored training and alerted staff when they needed to update their training. Since our last inspection managers had implemented spreadsheets to enable them to monitor and provide oversight of mandatory and competency training needs more succinctly.

Inadequate

Community health services for adults

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. At the time of inspection 95% of staff were compliant with training in safeguarding adults, and 97% in safeguarding children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.There was a safeguarding lead within the service who staff could approach for advice.

However, we were concerned that the service had not put into place additional safeguarding measures to protect patients and staff who were employed to care for their own family members. The service had not measured the risk of the development of closed cultures. Following inspection, the service demonstrated that they were introducing a risk assessment to address this concern.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and the premises visibly clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were PPE supplies stored at head office and within each client's home. Staff told us they would review PPE supplies weekly and send a request to head office for additional supplies when these were required. We observed staff wearing appropriate PPE during home visits. Appropriateness of staff clothing, including wearing of PPE, was reviewed during 'spot check' visits to patients' homes conducted by a more senior member of staff.

Staff told us they undertook cleaning duties as part of caring for clients and we saw examples of cleaning rotas during home visits.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Managers completed an environmental risk assessment for each client's home which included notable security processes in place such as alarms, checking smoke alarms were in working order, and identifying the location of things such as stopcocks which may be required in case of emergency.

However, we were concerned that staff were not given access to methods to contact managers or colleagues in an emergency. Staff were expected to use their personal mobile phones to contact others whilst at work. Additionally, lone working procedures were not robust, and detailed staff making their own decisions as to whether they needed to check-in with another member of staff after a shift, for reasons such as working in areas known for high crime rates.

Staff disposed of clinical waste safely. Staff could explain the processes for disposal and cleaning of used equipment.

Inadequate

Community health services for adults

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration but it was unclear how information was consistently handed over between those caring for the patient.

Staff completed risk assessments for each patient and reviewed these regularly.

Staff knew about any specific risk issues such as pressure ulcers and malnutrition, and risk management plans were in place to mitigate risks identified. Staff could explain how they would identify a deterioration in a patient's health and the provider had a policy in place to guide staff on actions to take.

It was unclear if key information was consistently shared to keep patients safe when handing over their care to others. Managers told us that staff were required to put a handover on the 'workchat' online application at the end of each shift. However, some staff we spoke to told us they did not use the application due to confidentiality concerns because this application was located on their personal mobile telephones. Family members also did not have access to this application so there was no method of ensuring that information had been consistently handed over to and/or from family members when they were providing care.

Due to the nature of the service, people using the service were in receipt of care in their own homes. The service told us that regular managerial spot checks were made to check on the quality of care being provided and the welfare of people using the service and was therefore a tool to manage risk. We reviewed evidence of these visits and found that three patients had not received a visit from a manager within the last three months and visits to other patients varied in regularity, between once and three times a month, without rationale for the variance. We raised this as a concern with the service during our last inspection, and this had not been addressed.

Staffing

The service did not have enough support staff to keep patients safe and to provide the right care and treatment.

The service did not have enough support staff, and this meant there were unfilled shifts and staff working excessive hours and long shifts in order to try and meet the needs of patients. We raised this as a concern at our last inspection of the service, and the service had not acted to reduce risk.

The service put themselves forward to commissioners as being able to meet the needs of patients and their requirements for care. Staff were recruited for each individual package of care dependent on the needs of the patient and the number of hours of care allocated. Since the time of the last inspection, the service had taken on new packages of care, and we were concerned that the service was not able to meet the needs of these patients due to staffing and recruitment concerns.

At the most recent governance meeting on 2 December 2021 it was identified there were vacancies within eight of the 13 packages of care delivered by the service. Some gaps were covered by existing staff as an interim measure, but this was not consistent across packages. For example, in one package of care, day shifts could not be covered at all due to a lack of staffing and when we reviewed this during inspection two months later managers confirmed they were still unable to cover these shifts.

We reviewed staffing data from 27 December 2021 to 30 January 2022 for five packages of care. We found gaps in three of the packages. One package had a gap where half a day shift was not covered, another had gaps where three 12-hour

night shifts were not covered, and another had gaps where no day shifts had been covered, and there were a further twelve gaps where night shifts were not covered. We reviewed contingency plans for these packages of care and found that whilst plans detailed utilising staff from other packages or management staff, it was largely family members who covered any missing shifts.

Family members also raised concerns, with four families telling us they regularly covered shifts due to lack of staffing. Families told us whilst they were happy to help, they had not agreed to this being a regular fix for lack of staffing. One family were not detailed as being part of the patient's contingency plan but were covering daily shifts that could not be fulfilled by staff. During the inspection we also received a complaint from a patient and their family regarding unfilled shifts. We asked the service to provide evidence in relation to this and found that between 19 December 2021 and 14 February 2022 there were multiple missed shifts each week with the main reason given as staff sickness. The occasional shift was covered by the service's clinical nurse or a member of the management team, but the majority remained unfilled. Following inspection service managers told us they were recruiting a 'rapid response team' to attend unfilled shifts at short notice.

We also reviewed rotas for seven members of staff for the same time period. We found for two members of staff, working hours in one week totalled 60 and 78 hours respectively. Staff had signed working time directives, opting out of the maximum weekly working hours. However, at the time of inspection the service did not have a policy in place relating to staff working hours in this scenario in order to maintain the safety of staff and patient care. Additionally, we also found that two staff members on the same package of care had worked 30 and 36 hour shifts respectively in January 2022 without any break of duty bar a section of the shift allocated to sleeping hours at the patient's home.

Staff working in some packages of care worked 'sleep-in' shifts whereby they slept at the patient's home but could be woken to provide care when needed. The service's policy on this was not in line with what staff were required to work. Staff were allocated to 12-hour sleep in shifts by managers, but the service policy stated that only eight hours would be allocated. Managers also told us that staff could only be woken up to three times during a sleep-in shift, otherwise this would be classed as a waking shift. However, this was not documented in the policy and it was unclear whether duration of wake was a consideration or who had oversight of this to ensure staff were well-rested and safe to carry out further duties the following day. We were concerned that staff were told that if they were woken throughout the night, they could not complete the following day's shift and would be sent home, but not paid. This reduced the likelihood of staff reporting when they did not feel rested enough to complete their shift.

We spoke to 16 support staff during the inspection and six raised concerns with regards to staffing. Concerns included being asked to stay on when no staff were available to come in and relieve them, being expected to carry out moving and handling tasks alone due to a lack of staff, regularly being asked to cover other staff members shifts, last minute changes in rotas, and ineffective contingency plans meaning no cover, or family members having to cover. Following inspection, the service told us they were reviewing contingency plans to address some of these concerns.

We also received feedback from the commissioners of six packages of care. All raised concerns in relation to staffing including; packages being short-staffed, staff working long hours, staff leaving at short notice and not being replaced, and staff not receiving essential competency training in a timely manner.

In the six months prior to inspection there were 43 staff leavers and 45 new starters. Since our last inspection the service had begun to complete exit interviews with staff leavers who consented to this and had collated a spreadsheet to identify any themes of feedback given. We saw evidence of 16 exit interviews conducted since our last inspection. Poor communication with management was identified as a theme in four interviews.

Following our last inspection, the service had begun to monitor staff sickness rates. The service told us there had been 46 periods of staff absence due to sickness in the six months prior to inspection. The service was using a tool to monitor individual staff absence to allow them to act where required. However, a small number of staff told us that managers had asked them to come in when they had called in sick. When we raised this with managers, they told us that this had only occurred when they had noticed a pattern in staff reporting sickness. The service's action plan for improvement detailed that staff sickness would be monitored in monthly governance meetings but we could not see that this was done in the minutes reviewed.

Managers told us they could use bank and agency staff where necessary and they were detailed as options on several patient contingency plans. However, patients and family we spoke to told us that agency staff had never been used, even where this had been agreed to and where there were gaps in staffing. Managers told us they did not use agency staff as families often rejected this as an option, so it was unclear why they were still detailed as a contingency option. Following inspection, the service told us they were reviewing contingency plans.

Records

Staff kept records of patients' care and treatment. Records were easily available to all staff providing care but were not always up-to-date.

Patient notes were comprehensive, and all staff could access them easily but they were not always up-to-date. Computer tablets were located at patient's homes, allowing staff to update records throughout their shift. A back-up paper file including a copy of the patient's care plan and other documents was also stored in patient homes.

We found that documentation in relation to the administration of medicines was not always clear.

Staff were required to complete Medical Administration Record (MAR) charts on paper forms and then upload results onto the tablet. Some staff we spoke with told us that they felt it was cumbersome to record the same thing multiple times and felt that the tablets were sometimes difficult to log onto. We reviewed MAR chart audits for all patients from October to December 2021 and found that there were multiple medicines detailed as 'missing' that had been documented on the paper chart. This had been picked up in audits, but we could not see that actions had been taken to ensure improvement. Following inspection managers told us they were implementing new MAR charts and audit forms.

We were also concerned that family members did not have access to electronic records unless they were paid employees of the service, and so could not document updates to handover important information when they were caring for patients.

Medicines

The service used systems and processes to safely administer and store medicines but did not always complete records accurately.

Medicines were prescribed and reviewed by each patient's GP. Staff told us they could raise any concerns with regards to medicines with one of the provider's clinical staff members who would then liaise with the relevant GP. Medicines administration formed part of a patient's care plan where this was relevant.

Staff did not always complete medicines records accurately and kept them up to date. Staff completed paper Medical Administration Record (MAR) charts which were audited by clinicians within the team. We reviewed audits for all patients from October to December 2021 and identified concerns within four patients' records. For one patient there

were 13 occasions in December where medicines were identified as 'missed' but no rationale was given, and no actions taken. In October and November there were four and five signatures missing respectively. There were no actions detailed. For another patient there was a missing signature in December, staff retrospectively assured the auditor it had been given but no further action was taken. For another patient there were five occasions in December where medicines were identified as 'missed' but again no rationale was given, or actions taken. For four patients the auditor had also stated 'yes' in response to questions around whether changes to the patient's care plan or medicines regime identified, but there was no further detail around what these changes were. We were also concerned that when family members were caring for patients, they would not complete these charts as they were not trained to do so unless taken on as a paid employee of the service. One family raised concerns around medicines potentially being given more regularly than they should be due to them not being able to complete these charts.

During home visits we saw that medicines were stored safely. However, three support staff told us that they had concerns around storage of medicines and told us they had been asked by managers to go against original pack dispensing advice for two patients when medicines were not stored in their original packaging or liquid medicines were combined from different bottles. This goes against the provider's medicines management policy which states that medicines should always be given from the original, labelled container they were dispensed in.

Incidents

Staff recognised and reported incidents. Managers investigated incidents but it was unclear how lessons learned were shared within the wider service.

The majority of staff knew what incidents to report and how to report them. Some staff told us they were unsure whether to report certain things as incidents, such as behavioural issues when a patient had known behavioural risks, but these staff told us they tended to over-report rather than not report.

Since our last inspection the service had introduced a central monitoring log where incidents were detailed including any lessons learned. The log had been introduced in November 2021 and as such was not yet embedded but allowed managers to have oversight of incidents that occurred across the service. We saw evidence from minutes that incidents were discussed during governance meetings and in specific team meetings relevant to individual patients and staff told us incidents were discussed during supervision if specific to an individual member of staff.

It was unclear whether staff understood the duty of candour. Staff behaviours demonstrated they were open and transparent, but it was unclear whether patients and families were given a full explanation if and when things went wrong. Families we spoke to did not feel that managers took responsibility when things went wrong, such as low staffing levels and unfilled shifts, and did not feel respected by managers.

Are Community health services for adults effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

Staff delivered care according to best practice and national guidance but did not have access to up-to-date service policies to guide care and treatment. Each patient had personalised care plans indicating how staff should provide care and treatment for particular needs such as tracheostomy care and percutaneous endoscopic gastrostomy (peg) care

and managers told us these were based on guidance from NHS trusts and the National Institute for Health and Care Excellence (NICE). However, the service did not have their own overarching policies around specific care needs and it was unclear how NHS and NICE guidance was shared with staff or whether they could access this independently within the service.

We reviewed three care records and found that care plans reflected good practice guidance and were personal to the individual patient. Care plans were written collaboratively with other healthcare professionals where appropriate.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients that required them had specific nutrition care plans which were detailed in terms of how and when feeds should be delivered.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice however it was not always appropriately recorded

Staff followed personalised pain relief care plans for patients which were detailed in terms of alternative strategies including repositioning, as well as medicines to be used. We were concerned that staff did not always administer and record pain relief accurately as there were missing signatures with no rationale for medicines including pain relief in a number of patients' records.

Patient outcomes

The service did not use outcome measures, but care plans were regularly reviewed and updated to ensure care was provided in the best way to meet the individual needs of patients.

Competent staff

Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, managers did not always make sure staff were competent for their roles.

Managers gave all new staff a full induction tailored to their role before they started work. Staff undertook both an induction to the service and a clinical induction more specific to requirements of the role.

Since our last inspection we saw improvement in the numbers of staff receiving supervision and appraisals. The service's policy stated that new starters should receive their first supervision within six weeks of commencing employment. As of 28 February 2022, 94% of new starters had received this. Additionally, the service's policy stated that

staff should receive supervision every 12 weeks on an ongoing basis. As of 28 February 2022, 84% of eligible staff had received supervision. Additionally, 98% of staff had received an annual appraisal. Managers accessed a weekly report indicating where supervision and appraisals were due or overdue. We could see that managers had taken action in a timely manner where this was the case.

We were concerned that the responsibility for the learning and development of staff in relation to clinical competencies was mainly allocated to one senior member of staff, as this member of staff did not have any specific skills, training or experience in providing training to others. we raised this as a concern following our last inspection and told the service they 'must ensure that staff training others have the appropriate skills, experience and training to undertake this' but we could not see that any action had been taken.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The majority of staff told us they attended monthly meetings with staff within the package of care to which they were assigned. However, three of the 16 support staff we spoke with told us meetings did not take place as regularly as they should, and that they were not regularly invited to meetings. We reviewed the last two team meeting minutes for three patients and found that whilst there did not appear to be a set structure to meetings the discussions held were relevant to the individual patient and staff members on that team. Managers told us that they had increased regularity of team meetings since the last inspection and agreed this was still being embedded.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers told us they could arrange additional training for staff where necessary, such as in conflict management where patients were exhibiting behavioural challenges. Staff also gave examples of being involved in training with staff from local hospitals in order to increase their knowledge and confidence. However, some staff told us that training opportunities were limited, courses were inaccessible due to travelling distance, and if they were unable to attend a set date this was not always rearranged. We were concerned that where patient's family members were employed as support workers, essential competency checks were not always completed.

Managers identified poor staff performance promptly, but we did not see evidence that managers always supported staff to improve. For example, we saw that errors were identified through medicines administration audits but there was not consistently any learning identified or actions taken.

Multidisciplinary working

Those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

We saw within care records that staff communicated with other professionals involved in the patient's care, including GPs and specialist services, and with commissioners.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Inadequate

Community health services for adults

Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of inspection staff compliance with this training was 98% for support staff and 88% for office-based staff and managers.

Are Community health services for adults caring?

Requires Improvement

Our rating of caring stayed the same. We rated it as requires improvement.

Compassionate care

Support staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We conducted two home visits where staff were present and we observed that staff were discreet and responsive when caring for patients and interacted with patients in a respectful and considerate way. Feedback from patients and family members was positive with regards to support staff interactions with patients. We saw examples in records of staff taking patients out on visits to local areas and places of interest to them. Staff we spoke to were clearly very passionate about their roles and the support they could offer patients.

Staff followed policy to keep patient care and treatment confidential. However, we were concerned that the 'workchat' application used by staff to discuss patient care was not secure as it was downloaded to their personal phones and did not require a log-in each time it was used. Following the inspection, the service told us that they had addressed this and additional security measures had been applied to the application.

Emotional support

Support staff gave patients and those close to them help, emotional support and advice when they needed it. However, three of the families we spoke with told us that they did not feel supported by senior managers and did not feel their wellbeing was considered.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Care plans were holistic and personal to the individual patient.

Understanding and involvement of patients and those close to them

We spoke with seven family members both in person and over the phone. Family members gave positive feedback about the support staff who directly cared for patients. We were told staff were caring, polite, and often felt like part of the family. However, family members gave mixed feedback about communication with managers within the service. Four of the families we spoke with told us that managers could be difficult to contact and didn't always respond when queries or concerns were raised with them.

Inadequate

Community health services for adults

Managers told us that patients were always involved in the recruitment of new staff and that 'meet and greets' took place before a staff member was allocated to a package of care to ensure they were a correct fit for the patient and family. However, three families we spoke with told us this was not the case and that new staff had started without them meeting them first, and managers had not acted on feedback when families did not feel staff were the right fit for the package of care.

Four of the families told us about concerns in relation to staffing, including rotas being changed at short notice so they did not know who was attending for shifts, staff not being replaced when they left the company, and ineffective contingency plans which detailed contingency staff who were never able to work shifts. These families told us they were regularly covering shifts due to lack of staff, and that this was having a detrimental effect on their own physical and mental health. Two of the families we spoke with were worried about support staff leaving due to lack of care and support from managers.

Staff generally talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw an example of a care plan being translated into another language to support the patient in accessing this document.

Some patients and their families told us they could give feedback on the service and knew how to complain. However, others were unsure how to formally raise a complaint and told us they had not been asked to give feedback in the last year. Two families told us that they had informally raised concerns with managers recently but had not received a response or attempts to resolve their concerns. Managers told us that feedback forms were regularly placed in each patient's home, but that few families chose to use them. Following inspection, the service provided evidence of client feedback assessment forms for six patients. These contained very little information and were not dated so it was unclear what timeframe any feedback related to.

Are Community health services for adults responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service worked with others in the wider system and local organisations to plan care. The service did not provide care that met the needs of local people and communities.

Facilities and premises were appropriate for the services being delivered. Care was delivered within patients' homes across the country and environmental assessments were completed to ensure these were safe.

Care packages were planned in collaboration with commissioners in order to meet individual patient's needs. Staff liaised with professionals external to the organisation in relation to medicines, equipment and training.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Inadequate

Community health services for adults

Each package was bespoke and staff requirement was individually planned. Patients and families could be involved in 'meet and greets' prior to staff being taken on as employees of the company to ensure they would be a good fit for the package of care. However, some families and carers told us this didn't always happen, and their feedback on staff was not always acknowledged or considered. Managers recruited staff geographically local to the location of the package of care to minimise difficulties in staff being able to attend for shifts. However, managers told us this could be difficult in certain areas of the country where they struggled to recruit and told us this could be a problem in remote or affluent areas.

Access and flow

People could not always access the service when they needed it and did not receive the right care in a timely way.

The service designed bespoke care packages for each individual patient and provided care in their homes. However, for some packages of care the service struggled to source adequate numbers of staff. For example, five of the families we spoke with told us there were regular unfilled shifts due to a lack of staff employed by the service. We reviewed rotas from 27 December 2021 to 30 January 2022 for five patients. Within one package of care where the service was commissioned to provide day and night-time care, no day shifts had been fulfilled and 12 night shifts were unfilled. Within another package, two 12-hour nights shifts were left unfilled and within another package there was one day shift unfilled. Each package of care had an associated contingency plan in place which detailed what should happen if shifts could not be filled by core support staff. Families told us that they regularly had to cover shifts because these contingency plans were ineffective. We reviewed contingency plans for the same five patients and found them to be generic. Some detailed the use of agency staff, but families told us agency staff were never used.

Learning from complaints and concerns

The service had improved its complaints process since our last inspection. We reviewed three complaints and found that policy had been followed in order to manage and respond to these complaints. The service had introduced a new letter template in order to provide a more formal, standardised response to complaints, as previously many were dealt with via email contact. However, although the response template detailed how complainants could appeal to the provider if they were unhappy with the outcome, it did not detail any further escalation, such as to the Parliamentary Ombudsman.

Since our last inspection the service had also introduced a central monitoring log where all complaints were recorded, and detailed aspects such as who was responsible for investigating the complaint, the date of resolution, and whether there were any lessons learned. We saw evidence of complaints being discussed in relevant governance and team meetings.

Despite these improvements, four of the families we spoke with still told us they had not received a response or resolution to a concern raised. One family told us that they received an abusive response from managers when trying to raise a concern.

Are Community health services for adults well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Inadequate

Community health services for adults

Leadership

The delivery of high-quality care is not assured by the leadership, governance or culture. The registered manager was supported by managers of operations, business development and clinical services. These staff then supported area operations managers and clinical case managers who managed packages of care and were responsible for staffing including training and supervision. The service also had staff managing compliance and recruitment.

Leaders did not have the skills and abilities to run the service. Leaders had not taken timely action to address the need for significant improvement since our last inspection.

Following our last inspection, we raised concerns that senior support workers did not have the knowledge and support needed to carry out some aspects of their role. As a result, the service had removed some of the additional responsibilities, such as supervision of other staff, and had enrolled senior support workers on relevant adult care apprenticeships to support their development. However, of the 18 members of staff enrolled on apprenticeships, eight were 20-40% behind target and four were over 40% behind target, including one senior manager who had been enrolled on a course in July 2020 but had failed to begin the course. It was not clear whether managers had oversight of this or were taking any action to ensure enrolled staff undertook this learning.

Managers were not always visible and approachable in the service for patients and staff. We received mixed feedback, with some staff, patients and their families telling us they felt well supported by managers and could communicate with them effectively, and others telling us that managers didn't return their calls, didn't respect them or listen to them, and didn't provide support when required. We reviewed evidence relating to managerial visits to patients' homes for all patients. Managers told us visits should be conducted once every three months as a minimum, but we found that three patients had not received a visit from a manger within the last three months. Visits to other patients varied in regularity between once to three times a month and it was unclear why this was. However, all patients had received a visit from a clinician in the last three months to review aspects of their health and care plan including skin integrity, nutrition, medicines and pain management.

Vision and Strategy

The service did not have a defined vision, but managers could explain to us their desire to provide patient-centered high-quality complex care. The plan was for the service to keep taking on care packages through collaboration with clinical commissioning groups. Managers told us that they always tried to find ways of providing care when approached about new packages.

Culture

There remains limited understanding of the importance of culture. There are low levels of staff satisfaction, high levels of stress and work overload. Staff do not feel respected, valued, supported or appreciated.

During inspection we conducted several face-to-face discussions with staff, as well as receiving telephone and email feedback from staff unable to meet in person due to geographical location. In total we received feedback from 16 support staff and eight office-based staff including managers, clinicians and staff in charge of recruitment and compliance.

Feedback from staff was mixed with six support staff telling us that they didn't feel respected, supported or valued by managers. We also reviewed feedback given anonymously to the service by 13 members of staff on 1 November 2021 as part of a feedback questionnaire. Staff cited communication with management as a concern, including not receiving

feedback when issued were raised and not feeling valued. Staff also raised concerns about training and staffing levels. Following our last inspection managers told us that staff would be given feedback to their concerns on an individual basis via a written response but as responses to this questionnaire were anonymous it was unclear how any feedback would be given as this was not detailed.

We also reviewed feedback from exit interviews completed by staff who had left the service since our last inspection. Reasons given for staff leaving the service were reflective of those raised via the feedback questionnaires including lack of communication with management, lack of training and lack of work-life balance. The service had not consistently addressed concerns raised through exit interviews in a timely manner. For example, five feedback responses provided in November and December 2021 had not been assigned for review and therefore no actions had been taken as a result.

Feedback from patients and family members was also mixed. Two family members told us they did not feel respected by managers and did not feel that their welfare or wellbeing was considered. Several staff and family members told us they had raised concerns to managers but had not received a response. Four families told us about concerns related to staffing which they had shared with managers but had either not received a response, or actions agreed had not been put in place.

Governance

Since our last inspection leaders had made some improvements to governance processes, but we continued to identify areas of concern.

We were concerned that staffing was an issue within the service, with gaps in care provision, staff working excessive hours, with some staff working up to 78 hours a week and 36-hour shifts, ineffective contingency plans, lack of oversight of staff working sleep shifts, inability for staff to take breaks, and lack of oversight and attention to staff wellbeing. Managers acknowledged they did not have policies in place or effective oversight of these concerns and told us they were working to address this.

Managers also did not ensure that all employed family members of patients had undertaken competencies in a timely manner in relation to one package of care. This has been addressed as a need within two clinician visits to the family home, but no plans had been made to rectify this.

It was also unclear how learning from audits, incidents and feedback from managerial, clinician and spot visits would be actioned. Managers told us feedback from incidents would be shared with all staff via online bulletins, but we did not see any examples of this. Additionally, staff conducted a range of visits within patients' homes, including managerial and clinician visits and spot checks of support staff. It was unclear whether managers had oversight of all visits and the outcomes and it was not evidence how learning or feedback was shared with relevant parties. We saw that where audits had taken place there were not improvements as a result.

Following our last inspection, we raised concerns that governance meetings were not taking place regularly to allow managers to have oversight of the service and to monitor required actions. During this inspection managers explained they had introduced a new structure for monthly governance meetings but this had only been introduced in the two months prior to the current inspection and both sets of minutes we reviewed had a different structure, with a chart for reviewing previous and current actions only implemented within the last month.

Additionally following our last inspection we raised concerns that there was no service wide staff meeting, meaning that support workers did not engage in team meetings attended by managers and did not engage in regular discussion about the wider service or other packages of care from which there may be learning. Managers explained that such information would be shared via the 'teamchat' application in the form of bulletins, but we did not see any examples of learning being shared in this way.

The service had not made adequate changes to ensure that staff were safe and felt respected in their work. Staff concerns raised were similar to those raised at our last inspection and whilst the service was attempting to gain more feedback, such as from staff exit interviews and anonymous surveys, it was not always clear what actions were taken as a result. Staff retention was also still a concern, and it was unclear how the service was using feedback to drive improvement in this area.

Similarly, carer feedback continued to be mixed, with some families having negative experiences associated with poor communication and staffing problems. It was unclear why some families reported such difficulties engaging with managers whilst others spoke positively about this aspect of the service.

There continued to be a lack of policy and guidance for staff. This included policy in relation to staff working hours and in relation to guidance and process on patient care. For example, there was no policy that detailed the maximum number of hours staff should work over a given time period, and no guidance as to how to protect the wellbeing of staff should they work excessive hours. There was also no guidance in relation to additional safeguarding measures and the risk of the development of closed cultures when patients' family members were employed by the service.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify relevant risks and issues and as such did not identify actions to reduce their impact.

At the time of inspection, the service did not have an organisation risk register, or similar, in place to identify and mitigate risks to the service. The clinical lead managed a risk register detailing clinical risks such as staff knowledge and experience and oversight of clinical procedures, but there was no oversight of risks affecting the service as a whole. Managers could explain the main risks affecting the service, such as staffing, but these were not documented so it was not evidence what mitigation, if any, was in place. Following our inspection, we gave feedback to managers that this was an area of concern and as a result the service told us they would begin implementing an organisational level risk register.

The service had a system to allow oversight of managerial visits to patients which was accessed through individual patient records. However, when we reviewed evidence of managerial visits to patients' homes for all patients, we found that three had not received a visit from a manger within the last three months. It was unclear whether the service's system alerted them to this effectively as no rationale was provided for why visits were missed. Additionally, whilst managers told us visits should take place every three months as a minimum, there was no standard operating procedure or documented guidance relating to this for managers to follow.

The service did not adequately assess risks relating to lone working. The service's policy indicated that staff should make their own decisions as to whether checking-in with another member of staff at the end of a shift was required. The service's policy did not make it clear who staff should check-in with if this was deemed necessary, and there was no oversight or management of this to ensure staff safety.

Inadequate

Community health services for adults

Information Management

Staff were in the process of embedding new systems to enable them to more easily find the data they needed, to understand performance, make decisions and improvements.

Since our last inspection the service had introduced a central monitoring log to allow managers oversight of areas such as incidents, safeguarding referrals, and complaints. They had also introduced a training matrix to allow oversight of staff training in one place, whereas previously training compliance was collected and stored at the level of each individual care package. Whilst this was an improvement to the management of information it was not yet embedded, and managers explained they were still working on using this effectively.

We were concerned that information systems were not always integrated and secure. Staff used a 'workchat' application on their personal phones to discuss individual patient care. We were concerned that staff did not have to sign in to use this application once it had been downloaded to their phones, and some of the staff we spoke with were concerned about having this application on their personal phone in case it was accessed by other family members. Following feedback to managers they told CQC changes were made to make the application more secure, such as requiring staff to sign-in each time they opened the application and restricting the ability to copy any data or images. Managers also shared a policy with CQC on the use of 'workplace and work chat'. This policy was not dated and not available at the time of the inspection.

Additionally, we were concerned that staff were required to use their own phones for work purposes and did not have means, other than their own personal phones, of calling others in the event of an emergency.

Data or notifications were consistently submitted to external organisations as required. The service sent regular updates to commissioners and made statutory notifications to the CQC as required.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment -

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints -

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance -

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing -