Servesoul Limited

Servesoul - Camden Office

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Servesoul – Camden Office is a large domiciliary care agency that provides support to people in their own homes. It provides a service to predominantly older adults. At the time of our inspection there were 102 people using the service. Most people using the service lived in a particular north London borough with a quarter living in two other boroughs in south London.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service:
Staff had received training about safeguarding and knew how to respond to, and report, any allegation or suspicion of harm or abuse. However, a safeguarding concern that arose in May 2020 had not been referred to CQC. This was subsequently notified to CQC by the provider but only after the issue was raised during this focused inspection. The local authority later closed the concern as they believed the service had taken steps to address the learning points from the incident.

The care and support provided to people was usually person centred. People's care plans and risk assessments were detailed and included information about their care and support needs and preferences. Care staff had the necessary guidance about the support each person required and how people preferred to be cared for.
The service's recruitment procedures were designed to ensure that staff were suitable for the work they would be undertaking.

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

People and their family were involved in decisions about their care, which was evident in the care plans we viewed and from the feedback we received from people using the service and relatives. During the Covid 19 pandemic reviews had stopped being held face to face and these had to be done using other means, such as telephone calls and online virtual meetings using computer.

Information about people's religious, cultural and communication needs was included in their care plans.

People were asked about their views of the care and support that they received using telephone calls and handwritten feedback questionnaires. The provider expected people to be asked for feedback every two months, although this had been a little haphazard during the pandemic, it was evident that views were sought.

Rating at last inspection:
The last rating for this service was good (published 14 November 2017).

Why we inspected:
We undertook this focused inspection to follow up on specific concerns which we had received about the service in relation to safeguarding, care practice and management of medicines. A decision was made for us to inspect and examine these potential areas of risk and how this may impact upon other people using the service.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Servesoul on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to Regulation 12 (Safe care and treatment), Regulation 13 (Safeguarding service users from abuse and improper treatment) and Regulation 18 of The Care Quality Commission (Registration) Regulations 2009. Changes to the needs for medicines support had not been recorded on medicines records for one person and potential changes to a person's care and support needs had not been notified to the commissioning local authority. In addition, an allegation of abuse had not been notified to CQC as required by regulation.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to inspect as part of our re-inspection programme.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Servesoul - Camden Office

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Our focused inspection of Servesoul took place on 14 September 2020.

Inspection team
The inspection team comprised of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They conducted telephone interviews with a selection of people using the service and relatives.

Service and service type:
This service is a domiciliary care agency. It provides support to adults living in their own homes in the community. At the time of inspection there were 102 people were using the service.

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

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because it is a domiciliary care agency and we needed to be sure that the registered manager would be in the office.

What we did before the inspection:
We reviewed information we held about the service, for example, statutory notifications. A notification is information about events which the provider is required to tell us about by law.

During the inspection:
We spoke with the registered manager, care manager and training provider. We attempted to contact fifteen

people using the service or their relatives. We were able to obtain feedback from ten people in total, four people using the service and six relatives. We also made contact by email with twenty care staff and received nine responses. We looked at a range of records. This included ten people's care records, staff recruitment and records relating to the management of the service such as monitoring records.

After the inspection:
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
•People were usually kept safe from avoidable harm. However, one substantiated allegation of neglect by reason of omission following a safeguarding investigation had been notified to CQC by a local authority. The service provider had not notified CQC of this concern when it arose in May 2020 but later did so when this was raised during our focused inspection. Please refer to the "Well-Led" section of this report for further details of action by CQC in response to this.
• The substantiated allegation of abuse involving one person resulted from poor moving and handling, failing to provide personal care by not changing clothing and possibly leaving the person in a wet bed. There had also been at least a single instance of the person's bedside table being left out of reach, so the person was unable to reach their breakfast and drink after the care worker had left. This posed a risk that the person was not being left in a safe way after care worker visits and potential changes to care needs had not been effectively communicated to the commissioning local authority in a timely way.

This is in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People using the service told us "I do not feel frightened of anyone or worried about my safety with the carers I have. They would only do something unsafe once as I would know exactly what to do about it if they did" and "The carers I have now are very nice but four months ago I had a carer who was not good. They had no manners, wasn't nice and wouldn't do what I wanted them to do. I contacted the office and they came to see me. I told them I didn't want her anymore and they haven't sent her again."
• Relatives told us "I have never had any doubts on Mum's safety with the carers" and "Yes [relative] is safe. The care worker is sweet, gentle, nice and takes good care of [relative]."
• The provider had detailed guidance for staff to use and refer to in respect of keeping people safe from harm or abuse. This guidance went on to describe what action care staff should take if they had concerns about the welfare of people they were supporting. However, in the specific case of the situation described above this had evidently not been followed for one person, although no other instances of omission in care had been reported by others using the service.

Assessing risk, safety monitoring and management
• People using the service had person centred risk assessments. The risk assessments covered a range of safety and wellbeing needs, such as eating and drinking, assistance with medicines, moving and handling and environmental risks.
• People's risk assessments included guidance for staff on how to manage and minimise the risks identified.

Staffing and recruitment
• The service's recruitment procedures ensured that staff members were suitable for the work they were undertaking. Checks of criminal records (DBS) and references had been carried out before staff started work.

• Some people told us that they had infrequently experienced late or missed visits. The service monitored care visit times and late or missed calls had occurred on eight occasions in the last six months. This had, however, been addressed by the agency in consultation with the local authority where this had almost exclusively occurred, which the local authority confirmed with us.
• Relatives told us "[Relative] gets the same carer most of the time unless the care worker is away" and "When [relative] went into hospital I called and let the agency know and when they came home luckily they restarted their care with the same care worker which was really good."

Using medicines safely
• We had been informed by a local authority that a person using the service had missed nine doses of medicines which had been identified by a relative of the person. We looked at care records for the person and it was evident that care staff had not initially been required to assist or monitor that the person was taking their medicines. Subsequently, at the request of the person's family, staff had started to monitor that the person was taking their medicines. This change was not recorded on care plan or medicines records. The service provider had not informed or agreed this change with the commissioning local authority before implementing it.

This is in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The medicines policy was detailed and described what action the service would take if medicines support was required. The service had the necessary medicines administration records, aside from the situation we described above.
• People using the service told us "Yes they do give me my medication on time. It comes in a Dosset box. I know what my medication is and is for, but I can't remember if they do record what I have taken" and "They do give me my medication and at proper times and record what they have given me in a book left here."
• Signed consent to support people with medicines and details of the medicines that people were taking were included on care records.
• Care staff had received medicines training as a part of their induction programme and a programme of refresher training was in place.

Preventing and controlling infection
• People were protected from the risk of infections. Staff received infection control training. Disposable personal protective clothing including gloves were available.
• Feedback to CQC by the local authority that mostly commissioned the service commented that the authority believed that the service had managed well at mitigating risks to people and staff. The service had been able to continue to provide care to people using the service during the Covid 19 pandemic without interruption.

Learning lessons when things go wrong
• Staff had guidance about reporting any concerns about people's welfare. Systems were in place to monitor and review any incidents or other welfare concerns to ensure that people were safe. We noted that, aside from the concern we refer to earlier in this report, no other significant incidents had occurred.
• The registered manager showed us the system in place that was used to respond to complaints or other

incidents which included what could be learnt from them.
• The registered manager told us, and we were shown, that people's risk assessments and care plans were updated if there were any concerns arising from an incident or complaint. We saw how this had taken place as the result of a complaint that had been made.

Good

Is the service effective?

Our findings

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

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments of people's needs had been carried out before they started to receive care and support from the service. The assessments considered a range of areas such as people's physical care needs, their day to day life and activities as well their heritage, religion and family support.
• People using the service told us "They tend to know what to do and always ask me what I want doing" and "They do ask my permission before doing anything. They are very nice people and so caring." We were also told "They always ask what I want doing for example they used to ask if I would like a wash rather than a shower, but I told them I wanted a shower every day. They do it the way I want things done."
• Relatives told us "I told them exactly what to do with my [relative]. They will do whatever [relative] asks them to do and [relative] has never said they are unhappy with the way care workers do the care." We were also told "The care worker does ask permission. They ask how [relative] would like things done and what needs doing."

Staff support: induction, training, skills and experience
• All care staff that were new to the service had received an induction. The care staff induction had been provided by a Skills for Care accredited trainer and all care staff had completed their induction before commencing their work with people.
• A programme of refresher training was in place and the agency's training provider described how the training programme was managed and delivered.
• A staff supervision and appraisal programme was in place and staff told us how well they felt supported by this. It had been a difficult six months prior to this inspection due to the Covid 19 pandemic and staff we were in contact with complimented the work that their managers at the agency had done to support them through this time.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported by staff to eat and drink if they needed help although this was only infrequently required for most people. However, we refer to a concern earlier in this report about one person who may not have always had food or drink left for them correctly so they could reach it.
• Information about people's eating and drinking needs and preferences was included in their care plans and risk assessments.

Staff working with other agencies to provide consistent, effective, timely care
• People's care records showed that staff liaised with other professionals to ensure that people's needs were generally met.

• People's care plans included information about other health care professionals involved with their support. Staff had developed links with these professionals to ensure that effective and consistent support was provided.
• Care staff were provided with guidance by the registered manager to ensure that people's needs were met in liaison with other professionals as required.

Supporting people to live healthier lives, access healthcare services and support
• Information about people's health and wellbeing was included in their care plans and risk assessments.
• People were registered with their own GPs and received support from other community health services when they needed this.
• If concerns arose about people's health, care staff were provided with guidance about what to do. Changes to people's needs were usually reported.

Ensuring consent to care and treatment in line with law and guidance
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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• People's care needs assessments included information about their ability to make decisions. Care plans included guidance for staff about the decisions that people could make for themselves. Staff members received training about the MCA.
• Most people currently using the service had capacity to make decisions. Family members had been involved in best interests' discussions about their relative's care if the person was unable to do so for themselves. This information was included in their care plan.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• A concern about safeguarding a person using the service in May 2020 had not been reported to CQC as required by regulation. This is in breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009. When we discussed this during this inspection the registered manager understood their role and responsibilities to ensure notifiable incidents were reported to the appropriate authorities as required. However, the registered manager accepted that in this situation they should have notified CQC about the safeguarding concern and not delayed this until the outcome was reached.

• People using the service told us "I don't know the manager, but the agency seems well run" and "I know the manager's name and feel it is a good well led company. He is approachable; he listens and takes on board what is said." One other person suggested better communication was needed and others told us that usually they felt they were responded to if they had ever needed to contact the service head office.

• The registered manager worked at the service daily and on call arrangements to provide advice and support for care staff was available outside of normal office hours. Staff told us about the ease with which they could contact the agency for advice.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• Arrangements were in place to ensure that the service was operated on the basis of the needs of the people using the service. The local authority that mainly commissioned care from the service told us that the service and care staff team had managed to support people well during the Covid 19 pandemic.

• Information about the aims and objectives of the organisation was available. The guide for people using the service clearly outlined what the service could or could not provide.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

• Care staff usually had the cultural and linguistic knowledge necessary to respect and address people's heritage and communication needs. However, some people we spoke with did raise an issue regarding poor English language skills of some staff. We were told by the registered manager that in most cases this had been addressed although some people still believed there were occasional issues about this from time to time. The registered manager accepted this comment and agreed to explore this further.

• The majority of comments that people and relatives made referred to how readily they were able to get in

touch with the service and, with few exceptions, they had received a suitable response to whatever they had raised.
• Meetings with care staff took place to share information and provide opportunities for them to share and discuss issues related to their care practice. Staff told us that meetings, via online meetings and telephone calls, had continued since the beginning of the pandemic.

Continuous learning and improving care
• The registered manager kept up-to-date with best practice and information was shared with staff. An ongoing programme of staff training, and development was in place.
• A formal spot check system was in place although visits to see people in their own homes had not been possible in most cases due to the Covid 19 safety measures the agency had established.
• Phone calls to people using the service and relatives had continued and we were shown evidence of what people had fed back to the agency and any subsequent action taken as a result. Almost all feedback that had been provided was positive, aside from minor issues, and almost entirely highly complementary about the caring attitude of staff.

Working in partnership with others
• The service usually liaised effectively with other health and social care professionals to ensure that people's needs were met.
• Care staff were provided with advice and guidance by the registered manager. The agency was clear about the expectation that care staff would contact the agency if there were any matters that needed to be raised in order to continue to care for people safely and well.
• Care workers we had contact with all told us that the systems in place enabled them to easily get in touch with the service and received support. They also told us that they were contacted regularly by senior managers at the service to check how they were managing, not least during the pandemic.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that changes to the support a person required with taking medicines was discussed or agreed with the commissioning authority and had not recorded this support on the medicine's administration record.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not reported potential changes to a person's care and support needs to the commissioning local authority. In at least one instance a care worker had left a person in a potentially unsafe situation.