Soma Healthcare Limited

Soma Healthcare (East London)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Soma Healthcare (East London) provides personal care to people in their own homes in the community. At the time of our inspection, 46 people were receiving personal care from the service.

People's experience of using this service and what we found
During this inspection, we found the service failed to make sufficient improvements to address the concerns identified at the last inspection and comply with our regulations. There was unclear information in relation to the support people received with their medicines. Risks to people's health and safety were not effectively assessed. Although the majority of people and relatives told us staff were punctual, there were some instances of lateness and staff not staying the full duration of their calls. People's care records did not reflect the appropriate support needed in accordance to people's specific needs. The current systems in place were not effective enough to ensure complete and contemporaneous records were held in relation to people's care.

The majority of people and relatives spoke positively about the quality of service they received. They told us they felt safe and staff knew their needs well. Staff followed appropriate infection control practices. The provider had systems in place to record and respond to accidents and incidents. Any lessons learnt were used as opportunities to improve the quality of service.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 22 July 2019) and there was a breach of regulation in relation to medicines management.

The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment.

At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Soma Healthcare (East London)

Detailed findings

Background to this inspection

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

This was a focused inspection to check on breaches of legal requirements found at the last comprehensive inspection.

Inspection team
The inspection team on site consisted of one inspector. After the site visit, an expert by experience made telephone calls to people and relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Soma Healthcare (East London) is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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

Notice of inspection
This inspection was announced. We gave the service 48 hours' notice of the inspection visit as we needed to be sure that they would be available. Inspection site visit activity took place on 5 August 2021. We visited the office location to see the registered manager and office staff; and to review management records.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We reviewed and discussed five care plans, five staff files and medicines records. We also spoke with the registered manager.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at care documentation and quality assurance records. We spoke with 7 people and 9 relatives to gain their views about the service.

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 requires improvement. At this inspection this key question has remained the same. 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.

Using medicines safely
At our last inspection the provider had failed to implement systems and processes to ensure the safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• Since the last inspection, the provider implemented an electronic system to manage medicines. Electronic medicines administration records (MAR) were in place to record the medicines support provided, staff had received medicines training and medicines audits were undertaken. However, we could not be assured that the records accurately reflected the medicines support being provided to people and that people received their medicines as prescribed.
• For example, for one person who was at risk of forgetting to take their medicines due to short term memory problems, there were instances on the MAR dated 30 and 31 July 2021 which was recorded as 'P' which stands for prompted. However, there was no further information detailing whether the medicines had been administered or not. We also reviewed the daily task records for the 30th and 31st July 2021 but there was no information recorded that any medicines support had been provided to the person on those days.
• The MARs for some people showed medicines were administered at times which were not during their allocated call time visits. For example, for one person showed on the 1 August 2021, medicines were prompted at 11.20pm at night. For another person, the MAR showed on the 30 July 2021 medicines were administered at 11.24pm.
• One person was required to take a medicine four times a day, however the MAR showed occasions when this was administered without a gap between doses to ensure their effectiveness. For example, on the 28 July, the medicines were recorded as administered at 1.52pm, 1.53pm, 1.54pm and 5.46pm. Another medicine taken by this person was to be taken at night. However, on the 26 July 2021, the medicine was administered at 11.01am and on the 27 July 2021, the medicine was administered at 11.19am.
• The care plans for two people contained inconsistent information in relation to the medicines support they required. For example, both people required the medicines to be administered, however the care plans stated the medicines should be prompted.

We found no direct evidence that people had been harmed as a result of the concerns we found. However, records did not accurately reflect the medicines support being provided to people therefore we could not be assured people received their medicines as prescribed. This is a continuing breach of regulation 12 (Safe

Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager told us the discrepancies were due to the ongoing lack of connectivity issues with the electronic system staff used to record when they had administered medicines. The registered manager advised they were working with the service provider to resolve these issues and ensure records were accurate.
• The registered manager also showed us examples of checks they were able to conduct to review any discrepancies and ensure people had received their medicines as prescribed.
• People and relatives raised spoke positively about the support they received with their medicines.

Assessing risk, safety monitoring and management
• Risks to people's safety were not always assessed. Risk assessments did not have clear guidance on how to keep people safe, prevent or mitigate risks to people.
• For example, the care plan for one person stated they had epilepsy and needed support from staff outdoors due to the risk of having an epileptic seizure. However, there was no risk assessment in place for epilepsy or information which detailed the symptoms the person would experience if they suffered from a seizure and actions staff needed to take in response. The care plan for this person also stated they were at risk of choking. However, there was no choking risk assessment in place detailing guidance for staff to minimise the risk of choking and what actions staff should take in case the person did choke.
• A person using the service was diabetic, their care plan and risk assessment stated, 'not to give them sugar, care workers should look out for signs of hypoglycaemic shock and should be reported to 999'. However, there was no further information detailing the signs staff should look out for and the support to provide to maintain the person's safety in a timely manner.
• For one person, the risk level assessed for nutrition, personal hygiene and eating and drinking was rated high and moderate for washing and dressing. However, the remaining part of the risk assessment was blank and did not detail what the risks were, and the support required by staff to minimise the risks.
• There was contradictory information in relation to the nutritional risks for a person and the support they required from staff to ensure their nutritional needs were met. For example, the risk assessment stated the risk for nutrition was 'low' and the person 'eats well'. Despite this, the risk assessment went on to state the risk level for the person to cook/feed self was 'moderate' and 'Prepares own food.' However, the care plan contradicted this and stated staff were to 'support with making sure [person's] nutritional needs are met by making [person] a ready meal dinner and a cup of tea'

We found no direct evidence that people had been harmed as a result of the concerns we found. However, risks to people's health and safety were not always assessed or guidance available to reduce possible risks and maintain people's safety. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• When speaking to people and relatives, they told us staff were aware of their needs and provided them with the support they needed to keep them safe from harm. A person told us "I use an electric chair and the carers know how to operate this very well". A relative told us, "The carers know what signs to look out for because [person] is epileptic". Another relative told us "[Person] has been in a wheelchair for a long time… but the carers are aware of their instability and know what to do."

Staffing and recruitment
• Some improvement was required with the deployment of staff. Although the majority of people and relatives told us staff were on time and stayed for the full duration of the visit, we received feedback of instances in which this was not the case.
• For example, a relative told us "The carers always arrive on time, but not always on the second shift. On the

first shift they give [person] breakfast, and the second shift can be very late for them to get a wash. Sometimes this is because of previous calls running late. The office should let us know when they are going to be late". Another relative told us "The carers are in and out of the door in 5 to 10 minutes, so they never stay for duration of their time. The carers come to make [person] a cup of tea but because they are so late, they have already had one".
• Since the last inspection, the provider had put in place an electronic system to monitor staffing levels and timekeeping. However, there were instances call monitoring records did not accurately reflect the times staff had attended calls. We reviewed monitoring records for July and August 2021 which showed some instances of lateness and staff not attending at the agreed call times.
• For example, one person received a morning call at 7:00am - 7:30am, however the call monitoring report showed the actual start and end times for staff were 10:51am - 11:18am. Another person who received a call at 9:30am - 10:00am, the monitoring report showed the times attended by staff were 07:36am - 08:05am. We found further examples of poor timekeeping
•We discussed this with the registered manager who told us the issue was in relation to lack of connectivity with the system which resulted in times being logged at a later time rather than reflecting the actual time. These issues had been reported to the service provider to be resolved.
• The registered manager, however, did advise and records showed the system did flag up when staff were late, and actions were taken in response. Records also showed that people and relatives were routinely asked about staff punctuality and time keeping through surveys and telephone monitoring calls and feedback was positive.
•The provider followed safe recruitment practices and had ensured appropriate pre-employment checks were completed satisfactorily before staff were employed.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse. People and relatives told us they felt safe using the service. A person told us "I definitely feel safe with the carers I'm getting". A relative told us "My [family member] feels very safe in the care they receive".
• There were systems in place to protect people from the risk of abuse. There were safeguarding and whistleblowing policies in place and staff had completed safeguarding adults training.
• Records showed safeguarding concerns were logged and monitored which included working with relevant healthcare and social care professionals such as the local authority and safeguarding teams.

Learning lessons when things go wrong
• Systems were in place to respond and monitor accidents and incidents.
• Any lessons learnt were used to improve the quality of service which were relayed to staff to embed good practice.

Preventing and controlling infection
• The service had an infection control policy in place. Staff had received training and were aware of safe infection control practices.
• People using the service and their relatives told us staff always wore protective clothing when providing them with personal care. A person told us, "They all wear protective clothing." A relative told us, "The carers wear all the protective clothing like masks and aprons, and I feel they have good standards of hygiene".
• During the pandemic, people and relatives told the service had kept in regular contact with them. A relative told us "I think the service have kept both of us very safe and informed during the pandemic". Another relative told us "I feel the service has been good at keeping the same carers visiting during Covid."

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 requires improvement. At this inspection this key question has remained the same.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering which achieves good outcomes for people;
• Since the last inspection, the provider had taken some actions in response to concerns identified in relation to medicines management including implementing MARs, medicines training for staff and implementing an electronic system to manage the quality of service being provided to people.
•Despite these actions, we could not be assured information recorded in relation to people's care were accurate and complete. During this inspection, we found multiple discrepancies with MAR sheets, call monitoring records and risk assessments did not have clear guidance for staff to mitigate risks.
• People's care plans were task focused and did not contain information on how people were to be supported appropriately and person centred care delivered. For example for a person who was at risk of poor personal hygiene, unable to weight bear unaided and used a wheelchair, shower seat and a seat near the sink, the care plan stated 'strip wash [person] on the bed, cream them and get them dressed.'
•There was a number of audits in place to monitor the quality of service including call monitoring, medicines and record keeping. However, these were not robust enough to identify the issues found during this inspection.

We found no direct evidence that people had been harmed as a result of the concerns we found. However, the current systems in place were not robust enough to assess and monitor the service and accurate and contemporaneous records of people's care and treatment were not maintained. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager told us there have been ongoing IT issues with the electronic system and connectivity which they had informed the service provider to ensure these issues were resolved. In the interim, the registered manager showed us an example of a review of the discrepancies in relation to medicines administration and call monitoring to ensure people were receiving the care and support required.
• People and their relatives spoke positively about the service they received and the positive impact this had on their daily lives. A person told us "The carers are very pleasant and talk to you about things that are happening in the world and makes me feel more connected". Another person told us "Before I had the

carers, I hadn't felt well at all and they have made a difference to my wellbeing." A relative told us "[Staff member] doesn't see people as clients because they sit and talk to [person] like a good friend."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;

• The provider obtained feedback from people and relatives about the service via telephone monitoring calls and surveys. Feedback from surveys were analysed to ensure they improved the service where needed. A person told us, "I've been contacted by the office to check my wellbeing, which is a good idea to keep in touch with people." A relative told us "[Person] is improving all the time as a result of the carers and I can't see how you can improve on that."

• Staff meetings were held to discuss the management of the service. Minutes of these meetings showed aspects of people's care were discussed and staff had the opportunity to share good practice and any concerns they had.

•The registered manager and provider understood their responsibility under the duty of candour and took responsibility when things went wrong. We noted communications to people and their relatives showed the registered manager provided apologies and reassurances that action was being taken to minimise the risk of any reoccurrence of such events and any issues were resolved.

Working in partnership with others

• The service worked in partnership with key organisations including the local authorities that commissioned the service and other health and social care professionals to provide effective joined up care such as the district nurses and occupational therapists. A relative told us "Carer is very good at calling the nurse when [person] feels unwell".

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 Risks to people's health and safety were not always assessed or guidance available to reduce possible risks. Records did not accurately reflect the medicines support being provided to people.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The current systems in place were not robust enough to assess and monitor the service. Accurate, complete and contemporaneous records of people's care and treatment were not being maintained.