Serenity Integrated Care Limited

Serenity Integrated Care

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out an announced inspection of 'Serenity Integrated Care' on 26 March 2018. This was the first inspection for this provider since they registered with the Care Quality Commission in May 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own houses. It provides a service to older adults, people with physical disabilities and complex health needs. At the time of our inspection the service had been providing care to one person for less than two months, and two other people receiving end of life care from the provider had recently died. This meant that although we were able to carry out an inspection we could not rate the quality of the service as we had insufficient evidence on which to do so.

The service had a registered manager who was also the company director. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People we spoke with told us they were impressed by the caring nature of the organisation. Care was planned in a way which met people's needs and care workers routinely stayed longer than required, particularly when people were unwell. People received the right support to eat and drink and this was monitored when there were concerns. There were measures in place to ensure people received good quality, dignified care at the end of their lives.

There were shortfalls in the way the service operated. Suitable tools were not in place for assessing people's capacity to make decisions or documenting people's consent to their care.

The provider did not carry out suitable pre-employment checks of care workers, and managers did not have the right systems in place to make sure that this was done.
Staff received suitable training to carry out their roles, but there was a lack of formal supervision and observation to ensure that staff continued to apply best practice in care.

People and their relatives and friends were invited to give feedback about the quality of their care.

Risks to people using the service were assessed, and prompt action was taken in response to concerns. People's moving and handling risks were assessed and there were suitable numbers of staff made available to do this safely. The provider monitored when injuries and falls had occurred, but as only a small number of incidents had occurred we could not say whether these systems were effective. Medicines were not consistently managed safely, and managers were not checking this in a way which would detect errors.

People's care packages were monitored and reviewed by managers; there were also formal review processes in place but it was too early for these to be applied.

We found breaches of regulations relating to the safe recruitment of care workers and medicines management. You can see what action we told the provider to take at the back of the full version of this report. We will continue to monitor the development of the service and aim to return to rate the quality of the service when we are able to do so.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

We did not have sufficient information to rate the service's safety.

There were systems in place to safeguard people from abuse. Risks to people's safety were assessed and there were measures to mitigate these risks.

The provider did not operate safer recruitment processes, and did not collect sufficient information on staff to ensure that they were suitable for their roles.

Medicines were not safely managed, as there were not clear and complete records of when medicines were administered or sufficient oversight of this.

Is the service effective?

Inspected but not rated

We did not have sufficient information to rate the service's effectiveness.

There was evidence people had consented to their care and were involved in its planning, although recording of this was not always clear. The provider lacked tools for assessing people's capacity to make decisions.

There were systems in place to ensure that staff received the right training to carry out their roles, but there was a lack of formal systems of observation and supervision to ensure that this was applied consistently.

People received the right support to eat and drink with appropriate action taken when there were concerns about people's nutrition.

Is the service caring?

Inspected but not rated

We did not have sufficient information to rate whether the service was caring.

People we spoke with praised the caring nature of care workers and the organisation, and gave examples of when people had been treated with kindness.

There were systems in place to monitor people's views and preferences for the service, but limited information on care plans on people's wishes.

Is the service responsive?

Inspected but not rated

We did not have sufficient information to rate the service's responsiveness.

Care was planned and delivered in a way which met people's needs. Care staff regularly attended for longer than was required in order to do this. People received suitable support to meet their needs at the end of their lives. Care packages were reviewed regularly.

There were systems in place to handle complaints but none had been received.

Is the service well-led?

Inspected but not rated

We did not have sufficient information to rate whether the service was well led.

Managers monitored the implementation and changes to people's care packages. There were systems of audit in place, but some of these were yet to be applied, and there were not suitable systems to check the recruitment and supervision of care workers.

Serenity Integrated Care

Detailed findings

Background to this inspection

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

This was the first comprehensive inspection for this provider. We were not aware of any information of concern about the service.

This inspection was carried out on 26 March 2018. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Prior to carrying out the inspection we checked whether we held any information about the service, such as notifications of significant events the provider is required to tell us about. We also reviewed the provider's registration with the Care Quality Commission and Companies House. The inspection was carried out by a single adult social care inspector.

In carrying out this inspection we looked at records of care and support for the one person who was using the service and for two people who had used the service but had recently died. We looked at records of recruitment and training for five care workers, three of these were currently working for the provider. We reviewed the provider's policies, procedures and team meetings.

We spoke with three friends or relatives of people who were using, or had used, the service. We spoke with the registered manager and two care workers.

Inspected but not rated

Is the service safe?

Our findings

We did not have sufficient evidence to rate the safety of the service. The service had measures in place to help ensure people's safety, however due to the limited number of people who had used the service, we could not see enough evidence to demonstrate that these were being implemented to protect people from avoidable harm.

The provider did not follow safer recruitment measures. The provider had obtained proof of people's name and address They also gathered proof that people held UK passports, which evidenced people had the right to work in the country. We found that the provider had not obtained a full work history for the three care workers who were actively providing care. There were not always references in place for these care workers. The provider told us that two of these care workers had previous employment in health and social care, but without references or a work history were unable to demonstrate satisfactory conduct in this employment. One care worker was subscribed to the update service of the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. The other two care workers had DBS checks which were carried out by a previous employer, including one which dated from 2015. However the provider had not checked whether the person's status had changed since this time. The provider told us they would take urgent action to address our findings in this area.

This constituted a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had processes in place to record the management of medicines. However, we saw that information on these plans was not consistent. Assessments and plans stated that the person was assisted with medicines. However, staff recorded that they had administered the person their medicines. The provider confirmed that in practice they were administering medicines. There was a list of medicines on the person's medicines plan, but medicines administration recording charts (MAR) showed the person's medicines had changed since this time.

When medicines were administered, only the dates and times medicines were administered from a blister pack were recorded on a form. Staff did not record what medicines were being administered. The service could not be certain which medicines had been administered to people using the service or that they were given as planned. We also noted that on four occasions care workers had not recorded medicines being given at a time they were due; we compared this to care logs, and found only one occasion where medicines were referred to. This meant we could not be certain that medicines were given as prescribed. There was no audit carried out of this sheet which may have detected these gaps in signing.

This constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an appropriate safeguarding policy in place, which was clear about the need to report

suspected abuse. Staff received training in safeguarding adults and children. Care workers we spoke with were able to identify the signs of suspected about and understood their duties to report this.

The provider had measures to assess risks to people using the service. This included assessing risks such those relating to mobility as part of their assessment. The provider had a risk assessment tool which was used to assess people's dependency on care workers and the level of support required. The tool highlighted risks in areas such as eating and drinking, behaviour and possible agitation, and those relating to tissue viability and choking. This tool was used to highlight risks, such as those relating to pressure sores. There was also a Waterlow assessment completed monthly. The Waterlow score gives an estimated risk for the development of a pressure sore in a given patient.

We saw that there were measures in place to manage the risks of pressure sores, including to check skin integrity and that pressure relieving equipment was in working order. There was generic information made available on the prevention of pressure sores and their recognition. Care workers noted issues of concern regarding pressure sores, such as broken equipment or skin redness which was recorded on a suitable body map, and took prompt action to address these.

As the person needed the use of a hoist to make transfers, there was a suitable and detailed plan for how to do this safely completed by an occupational therapist. The provider had worked with the supplier of the equipment to ensure that this was safe for its purpose. Where two people were required to safely transfer a person, daily recording sheets and showed that this was taking place.

There were systems in place to monitor when incidents had occurred such as injuries or falls, including a description of the incident and the action taken, but a very small number of incidents had occurred so we could not assess the effectiveness of these systems.

Inspected but not rated

Is the service effective?

Our findings

Prior to carrying out care the provider carried out a detailed assessment of people's care needs. The provider also made use of assessments from other teams, such as continuing care teams and occupational therapists.

There were processes in place to ensure care staff received the right training. A care worker told us "The connection with [training provider] has helped, [the manager] is lining me up with lots of training."

Care workers received an induction course around policies and procedures of the organisation. Care workers received mandatory training in areas including safeguarding adults and children, health and safety, equality and diversity, first aid and food hygiene. There was also a session on safe moving and handling, including examples of good and poor practice. The registered manager told us that they carried out observations of staff practice, including moving and handling, but did not have records of this. The provider had not implemented a formal process for staff supervisions.

Plans contained information on the support people needed to eat and drink. Care workers recorded the foods and drinks people had, which showed evidence of varied diets. Where there were concerns about a person's nutrition or they had a limited appetite, staff had recorded the exact amount people had had, including the number of sips of a drink. There was detailed information on the person's health needs and how these could be met. An advocate for the person told us that when they had developed a serious health condition "They way they sprung into action was amazing, in a week [he/she] was on the way to recovery."

The provider did not have procedures in place to work within the Mental Capacity Act 2005 (MCA). The Act 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.

In one case, we saw that a person had been assessed by the referring agency as having capacity, but their relative had signed their care plan on their behalf. The provider told us this person's capacity had deteriorated, but did not have a system for assessing people's capacity to make decisions for their care. Where a person had capacity but was not able to sign, an advocate had signed on their behalf and a care planning meeting had taken place in which the person was involved, which was evidence that the person had consented to their care. However, there wasn't a clear procedure for documenting a person's consent to care when they were physically unable to sign documents. The provider told us they would develop a framework to ensure this was documented.

Inspected but not rated

Is the service caring?

Our findings

Relatives and friends of people who used the service were very positive about the caring nature of the service. A relative of a person who had recently died told us "They were very good at looking after [my relative], we were very pleased….they are very kind and helpful." Friends of a person currently using the service told us "It's not been robotic, there's been some genuine care there and it's been really appreciated.

People using the service and their relatives were invited to give feedback about the quality of their care, including the communication of care workers and their reliability, but it was too early to judge the effectiveness of this system.

Plans included some, but limited information about people's wishes and preferences for their care. We saw that information from friends and advocates contained more detailed information, and this was kept prominently in care files. However, care plans lacked detail on how to ensure that people's privacy was respected.
People we spoke with told us their friends and relatives were treated with dignity. An advocate told us "They're wonderful (regarding dignity), they've look at [the person's] needs as an individual." One person said "They talk to [my friend], they get [him/her] singing, and they ask 'is there anything else you would like to do?'"

Inspected but not rated

Is the service responsive?

Our findings

People we spoke with told us that care staff regularly stayed over their allocated time to support people as required. Comments from relatives or friends included "They come for two hours, but sometimes are still there and helping [the person]" and "They are superb, if they run over time they don't leave if the person wants something or needs something. They don't charge because the clients are more important than anything else." We discussed an example where care workers had provided additional support when a person was unwell to prevent a hospital admission, and a friend or relative told us "They never left [the person's side]".

The provider told us that they were regularly providing more care than allocated, and there was evidence they had met with the local authority to review the person's care package. This meant the provider was responding to people's needs and reviewing these regularly.

Care plans were clear about the support people required. This included a detailed breakdown of the support people required, for example with personal care tasks and food, and whether two staff were required at particular times. Care workers maintained detailed logs of the care that they had provided, which showed that care had been delivered as planned. Additionally, staff maintained a daily checklist of the tasks that may need to be carried out, although these were not personalised to the individual and were not clear on when a particular task was carried out.

The provider had carried out several updates of people's care packages, including challenges and risk implications, which were used to discuss the person's changing care needs with the local authority and friends and family. There were systems developed for reviewing people's care, but due to the timescales involved we were not able to judge their effectiveness.

Where people had terminal diagnoses, this was clearly recorded, and there was evidence that people's conditions were monitored and recorded, including details of end of life medicines which were prescribed to the person. Care workers had observed changes in people's conditions and delivered care in a sensitive fashion, providing personal care when the person's health permitted this. A relative we spoke with told us that their family member was treated with dignity and respect at the end of their life.

The provider had a policy in place for recording and responding to complaints, but as no complaints had been received we were not able to judge its effectiveness. People we spoke with told us they had had no cause to complain about the service.

Inspected but not rated

Is the service well-led?

Our findings

People we spoke with universally praised the provider. Comments included "I have never come across an agency like this one, they are superb", "I can't praise them enough, I highly recommend these people", "I took an automatic liking to the manager, we were quite impressed…They said 'we don't want to run before we can walk.'"

The provider had worked to provide a specific model of care. The registered manager said "Our model of care is looking at complex patients… we try to work with everyone involved to avoid duplication."

Managers had monitored the implementation of people's care. This included compiling update reports to show how a person's care needs had changed and had sent these to advocates and care managers. Managers had also reviewed whether the current provision of care was adequate to meet a person's needs, and had made a case to the local authority on why this needed to be developed.

Team meetings had been held on two occasions; one was about developing the marketing and strategy of the organisation and one was used to discuss the single care package that they had in place and how to monitor its progress. There were also weekly briefings held in order to discuss plans for the week and who was responsible. The registered manager maintained a record of telephone calls made to the office from people using the service, their friends and family and professionals, including any actions that needed to be carried out as a result of these, and signed these off when completed.

The registered manager had an audit tool in place for checking that care plans had met people's needs, but had not yet had the opportunity to apply this. This included checking that the person had consented to their care and whether the care plan was complete. There was also a quality assurance report book, which included checking that care workers had completed logs appropriately, and that suitable records had been maintained of medicines and financial transactions. This did not specifically check whether care was being delivered in line with care logs, but included a space for an action plan in response to findings. However, this had not yet been implemented due to the short period in which they had been providing care, and the registered manager had not detected issues relating to the management of medicines.

There was not a system in place to ensure that care workers had undergone appropriate pre-employment checks, supervisions, observations and training, which meant that the provider was breaching requirements relating to safer recruitment and that we could not always be certain staff received the right supervision to make sure they were carrying out their role appropriately.

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 did not ensure the proper and safe management of medicines 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not established and operated effectively to ensure that persons employed were of good character, as the provider did not obtain the information specified in Schedule 3 19(1)(a)2(a)3(a)