Serenity Integrated Care Limited

Serenity Integrated Care

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out this announced inspection on 13 November 2018. Serenity Integrated Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults with physical disabilities.

At the time of our inspection the service was providing personal care to one person. Not everyone using the service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At our last inspection in May 2018 we were unable to rate the service. Breaches of regulations were found. This was because the service was not safely managing medicines or following safer recruitment processes. Following the last inspection, we asked the provider to complete an action plan to tell us what they would do to address these breaches.

At this inspection we found that the provider was now meeting regulations. We have rated them 'good'. When services are rated 'good' we aim to return within 30 months to complete a further inspection. CQC monitors services and will return before this time if we have reason to think the rating of this service has changed.

The service had a registered manager. 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.

Staff were now recruited in line with safer recruitment standards. Staff rotas were planned in a way which allowed them to meet people's needs safely.

Risks to people's safety and wellbeing were assessed and mitigated through appropriate risk management plans. Where people had hoists, the provider took the right steps to ensure that this was done safely. People were safeguarded from abuse as care workers understood the possible signs of abuse and their responsibilities to report their concerns. People were screened for nutritional risks and suitable plans were in place to protect people from malnutrition.

Medicines were safely managed by staff who had the skills to do so. Care workers received suitable training and supervision to carry out their roles and the registered manager had checked that they were competent. Incidents were investigated in an open and honest way which promoted learning from when things had gone wrong.

People told us of the caring service that they received and care workers responded effectively to people's

needs. People's care needs were assessed and there were detailed plans to meet people's needs in a way which met their preferences. Care workers documented how they had met these and how they had worked to ensure that these were met and that people were safe and comfortable.

Care workers worked with health services to promote good health and to respond effectively to changes in a person's health status and to avoid hospital admission wherever possible. The provider had a policy in place to ensure that they worked in line with the Mental Capacity Act (2005).

The provider was not routinely recording as part of their assessments when people required information supplied to them in accessible formats in line with the Accessible Information Standard (AIS). We have made a recommendation about this.

Managers had worked to improve and develop the service and were accessible. The registered manager carried out regular checks to ensure people were happy with their service and could contact the manager if they had a concern or complaint.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to detect and report signs of suspected abuse. Risks to people were assessed with risk mitigation plans in place.

Care workers were recruited in line with safer recruitment processes.

Medicines were safely managed by care workers who had the right skills to do so.

Is the service effective?

Good

The service was effective.

Care workers received suitable training and supervision and the provider checked that they were competent in caring for people.

People were protected from the risk of malnutrition and received support to maintain their health.

There were processes in place to ensure people had consented to their care, but the provider didn't always verify why people were signing on their behalf.

Is the service caring?

Good

The service was caring.

People's views were obtained of their care. People told us their care workers were kind and dedicated.

Care workers recorded the actions they took to keep people comfortable.

Is the service responsive?

Good

The service was responsive.

People's care was planned in a way which met their needs and

preferences. Care workers demonstrated how they had met these and how they had responded to changes in people's needs.

The provider did not routinely flag up people's needs for information in accessible formats.

People were able to contact a manager to complain if they needed to.

Is the service well-led?

Good

The service was well led.

There were systems in place to ensure continuous improvement and promote accountability.

The registered manager reviewed the quality of the service and ensured people were happy with the care they received.

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.

Why we inspected. This was a routine comprehensive inspection. When we are unable to rate a provider we monitor their service and aim to return within six months of the first inspection. We had not received any information of concern about this service.

This inspection took place on 13 November 2018 and was announced. We gave the service two working days' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

In carrying out this inspection we looked at records of care and support of one person who used the service and records of recruitment and supervision of four care workers. After the inspection we spoke with one person who used the service and an advocate of the person who used the service. We spoke with two care and wellbeing workers.

Good

Is the service safe?

Our findings

People were protected from the risk of abuse. Care workers we spoke with had received training in safeguarding adults and were clear about their duties to report suspected abuse. Care workers were confident their managers would act on their concerns but understood how to report concerns to the local authority or to CQC if these were not acted on. There was a list of contact numbers for local safeguarding teams maintained in the office.

Risks to people's safety were managed through a system of risk assessments and risk management plans. These included assessing people's' risks around mobility, moving and handling, pressure area care and nutritional needs. People's risks relating to skin breakdown were assessed and reviewed monthly using the Waterlow scale. The Waterlow score gives an estimated risk for the development of a pressure sore for an individual. Risk assessment plans sought to determine the cause of any changes in the person's condition and were detailed in their scope.

People were protected from risks associated with moving and handling. A detailed handling plan was carried out by an external Occupational Therapist (OT) and the provider fed back regularly on how the person's needs had changed. The provider kept a record of all lifting and handling equipment that was in use, including when it was last serviced and when the next service was due. This also included factors to be aware of due to the person's changing needs and additional steps that care workers took to ensure the equipment's safety. Care workers told us they received training in this equipment and were confident using it safely. An advocate for a person using the service told us "They all know how to use the hoist and there's always two carers, they are very good on that."

At our previous inspection we found that the provider was not meeting regulations regarding pre-employment checks. At this inspection we found the provider was meeting this regulation. The provider operated safer recruitment measures. These included obtaining proof of identity, right to work in the UK and obtaining a comprehensive work history and references from previous employers. The provider carried out checks with the Disclosure and Barring Service (DBS) before candidates started work. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

At our previous inspection we found the provider was not meeting regulations regarding the safe management of medicines. At this inspection we found the provider was meeting this regulation. There was a clear procedure for the management and administration of medicines including how to respond to a medicines incident or error.

Care workers recorded the medicines they had supported the person to take on a clear medicines administration recording (MAR) chart. This included details of the supplying pharmacist, a list of medicines currently prescribed and when there had been changes to the person's medicines. When a medicine was omitted for any reason, this was also recorded by care workers on a separate sheet. There was a risk assessment in place which recorded the level of support the person received with medicines and

arrangements for storage and disposal of medicines.

Spot checks were also used to monitor staff competency, including whether they had carried out the "six rights" of medicines management correctly, and whether any prompting or support had been provided by managers to promote this. Managers gave detailed feedback on care workers' understanding of medicines, including whether they had understood the risks of a person choking, and provided a development action plan.

There was a process in place for investigating and responding to incidents. There had only been cause to follow this on one occasion. This was when a staff member had made a conscious decision to omit a medicine due to concerns about the person, but had not sought appropriate authorisation for this. The registered manager had carried out an investigation and had an action plan in place which included additional training for the staff member, and intended to revise medicines recording to provide more information on the use and possible side effects of medicines. The provider had shown appropriate candour in informing all interested parties of what had taken place. An advocate told us "There was an incident where it showed they were on the ball, they are on the ball with medicines."

The provider assessed as part of a staff survey whether care workers felt there was always enough equipment in place to promote infection control. Care workers told us that managers ensured they had the right protective equipment and had training in how to use it.

Good

Is the service effective?

Our findings

People were supported by care workers who had the skills and knowledge to meet their needs effectively. Care workers received mandatory training in safeguarding adults, health and safety, risk assessment, manual handling, basic life support and fire safety. The provider maintained a training matrix to ensure that care workers remained up to date with refresher trainings. Care workers also received a detailed induction when they joined the service. This was not in line with the Care Certificate, but care workers had since signed up to undertake this. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if a staff member is 'new to care' and should form part of a robust induction programme. The provider had an instant messaging group with care workers to discuss issues of practice in line with those on the Care Certificate. A care worker told us "The training is sufficient, [the registered manager] is always on hand to say you need this. She runs training for staff which is handy for staff. It's encouraging us to go further in our career."

Care workers received regular supervisions from the registered manager. These were broad in their scope and included discussions of punctuality, quality of service and checking staff awareness of what to do in an emergency and how to promote infection control and health and safety.

There was a new system for carrying out spot checks of staff competencies. These included checking whether staff used proper infection control procedures, sought consent before carrying out care and demonstrated an awareness of how to work in an enabling way. This resulted in a personal development plan which was agreed between the care worker and the registered manager.

There were detailed processes for ensuring people received the right support to eat and drink. The provider followed a nutritional screening checklist, which picked up warning signs that a person may be at risk. This included whether the person had issues with their appetite, changes in their habits and whether they regularly missed meals or were losing weight. This was used to compile a nutritional plan, which included information on a person's current nutritional status and planned actions from care workers, such as referrals to a dietician. Where appropriate these plans illustrated how changes in a person's weight could impact on other areas of need. Care workers maintained detailed records of a person's food and fluid intake where a risk of malnutrition was identified.

The person using the service received support to prevent ill health. The provider told us how they worked to avoid hospital admission wherever possible. This was reflected in records of daily logs, where care workers recorded how they had communicated concerns and changes to health professionals and had called an ambulance when they were seriously concerned. The provider told us "I know that we have a great relationship with the district nurses; our care workers are trained to [carry out certain basic tests] and take these to the GP. It saves time and prevents the risk of sepsis."

The provider was working in line with 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.

People using the service were felt to have capacity to make decisions about their care and support and this was reflected in care plans. This included whether the person was able to make specific decisions about their care needs and lifestyle. However, in one case the person's advocate had signed their plan on their behalf, but it was not clear whether the person was doing so as the person was not physically able to do so or whether they were signing in a legal capacity.

Good

Is the service caring?

Our findings

People received care that reflected their preferences. Care plans contained information about how people liked to be supported. This included information about the foods and drinks people preferred and how to promote social inclusion. There was information on the day services people attended and activities they enjoyed, such as singing along with care workers and friends. A person using the service told us "They're really kind and want to do the best they can". An advocate told us of the dedication of the staff team and gave examples of what made it a caring service. Comments included "The carers are so close to [the person] they stayed day and night at the hospital…they wouldn't leave [his/her] side" and "When it was [the person]'s birthday they brought in a little loudspeaker and a microphone and got [him/her] singing as well, it was wonderful."

Plans also highlighted where the person's views on their care needs differed from that of other professionals. There was information on people's plans on what they could do for themselves and how care workers could best promote independence. There was also information on how people communicated, which included any issues such as slurred speech or sensory impairments which could affect the person's ability to communicate, and how care workers could best facilitate this. Daily plans also highlighted other actions to promote the person's communication and independence including making sure they were able to reach their telephone. A person using the service and an advocate told us that at times they struggled to communicate with their care worker as the care worker had limited English. This was highlighted in a care worker's personal development plan and an advocate told us "I've told [the registered manager] and she has taken it on board.

Records of daily care contained detailed information about how care workers provided a caring service. This included the reassurance they had given to people, how they were supported to relax and to sleep and how they had acted to ensure the person was comfortable and warm. There was information on how they had supported the person to leave the house and access the community when possible. A care worker told us "We ask her what her needs are and how we can meet those; we talk a lot."

Spot checks were used to ensure that care workers communicated well with people and promoted privacy and dignity and involved people in making choices. A care worker told us of how they promoted people's privacy and dignity whilst providing care.

Good

Is the service responsive?

Our findings

People received treatment that met their needs. The provider had a good understanding of how the person's needs had changed and how the service had adapted to meet these needs. This included increasing the person's care to a 24-hour care package and working with the local authority to put this in place. A person using the service said, "They always come on time, and they do what I ask them to do."

The provider also had links with local maintenance services to support people with tasks that needed to be done in their homes. The registered manager told us "It's about the little things that enable people to live independently."

The person's care was planned in detail. This included detailed instructions for care workers on the support the person required to maintain their personal care, as well as the support the person received to maintain skin integrity and to eat and drink. Records of daily care showed that care was delivered as planned. These were completed in detail and to a high standard and described how care workers had responded to changes in the person's needs and health. Plans had dates for review to ensure they still met people's needs. A care worker told us "Everything about the client is in the care plan, what they need and how they expect to be taken care of."

The provider was not fully meeting the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. Plans and key information about the service were not routinely available in alternative and easy read formats and the provider's assessments did not flag up when people may need this.

We recommend the provider take advice from a reputable source about identifying people's needs in line with the AIS.

The provider's model of care involved allocating the person a link worker. This was a member of the team who was the first point of contact for health services and day services. The link worker took a lead role in co-ordinating appointments and recording and logging outcomes of these in the person's diary and kept a directory of services working with the person. Although the person required 24-hour care, the provider had a schedule to provide an additional worker to help with tasks that required two care workers, and these were scheduled around the person's needs.

Nobody using the service had had cause to make complaints. However, people were given a copy of the complaint form as part of the service user handbook. This included information on what people could expect when making a complaint and what actions the provider would take. There was a procedure in place for investigating complaints and how the provider should respond in the event the complaint prompted disciplinary action. The complaints procedure required the provider to respond in writing with a presentation of their findings, whether the complaint was upheld and to apologise where appropriate.

Nobody receiving a service received end of life care. The provider told us how they would seek advice from other health services on how to provide end of life care if this was required.

Good

Is the service well-led?

Our findings

Since our last inspection there had been changes to staffing in the office and how policies and procedures were applied. The registered manager told us "I feel we've progressed a lot and I feel more confident about the systems." The provider had processes in place to ensure continuous improvement. This included seeking out peer support from another agency in the area and responding to the findings of our last inspection report. There was an action plan for how to improve the service and prepare for growth, which included implementing a care planning system, starting regular audits and spot checks and seeking more feedback about the service. There were regular meetings of the office staff including allocation of clear roles and responsibilities and reviewing the implementation of the action plan.

The registered manager had developed a suitable governance structure. There was now an advisory board in place to improve accountability. The provider told us "We are looking at how we could incorporate an actual board; as sole director I need to have people to report back to. I'm keen to have this finalised by November." There was now a nominated data protection officer who was a member of the office staff.

People told us the registered manager visited to do checks. A person using the service told us "She is a very nice lady". The registered manager was visible within the service and often supported people herself. She told us "Our phone is now [transferrable] so I can pick up calls wherever I am. I've been very much hands on, it has helped to support the care workers." The registered managed used spot checks to ensure that care workers arrived on time, dressed smartly and followed plans of care. Comments from care workers included, "The management is always there to give us support. she comes to inspect and gives advice" and "It's pleasant working with Serenity, there are helping me to grow in the job" and "She's always on hand for advice." An advocate told us "We communicate [with the team] almost every day."

The provider had a model of care based around integrated practice. Central to that was simultaneously meeting people's needs across a range of areas, including working closely with other agencies such as Clinical Commissioning Groups (CCGs), district nursing and day services. The provider told us "integrated care is about a model; we're not designing a bog-standard care agency. It's about having a multidisciplinary context; we've been fortunate that we have a complex care package which allows us to do this."

The provider carried out regular telephone interviews with people using the service or their advocates. This included asking people to rate the quality of their care, their communication, the reliability of the service and any changes the provider could make to improve. These showed that people were happy with their service. There was also a questionnaire filled out with care workers to establish whether they felt the service was well lead. Care workers were asked to say whether they felt their training allowed them to safeguard people from abuse and provide a person-centred approach, whether they were trained to understand risk and whether they had sufficient access to procedures to guide their practice. Responses to these surveys were positive.