Solace Community Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 8 and 11 November 2016. Some breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to safe care and treatment, fit and proper persons employed, staffing, notifications and good governance.

We undertook this focussed inspection to check that they had followed their plan and to confirm that they now met the legal requirements in relation to the breaches found. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Solace Community Care Limited on our website at www.cqc.org.uk.

There was no registered manager in post at the time of the inspection. The director told us they were recruiting for the post. 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.

Solace Community Care Limited provides domiciliary care for older people and for those with learning and physical disabilities. There were 37 people using the service at the time of our inspection.

At our previous inspection we found that some risk assessments were not completed properly and care workers were not accurately recording the medicines they supported people with. We found that staff recruitment procedures were not always robust, staff training was not always appropriate and staff supervisions were not taking place regularly. We also found that the provider was not meeting its legal requirements with respect to submitting notifications about certain incidents and checks to monitor the quality of service were not always in place.

At this inspection, we found that improvements had been made in all of these areas.

All risk assessments and care plans had been reviewed since the last inspection. Control measures were in place to manage areas identified as high risk. However we found that some areas could be improved further to give care workers more information about managing risk.

Medicine record logs were in place which meant care workers recorded the medicines that people were supported with appropriately.

Care plans had been reviewed to capture more person centred information about people and their preferences.

All staff files had been reviewed to ensure they had appropriate references. All care workers had undergone

refresher mandatory training since the last inspection. An up to date training matrix was maintained and training records were retained. A schedule of staff supervision was in place and all care workers had received at least one supervision session since the last inspection.

The provider had undertaken work to remind care workers of their responsibilities in recording any incidents and accidents that took place whilst they were delivering care. This included discussion at team meetings and at individual supervision meetings.

Spot checks had been carried out which helped to ensure people were supported appropriately and feedback sought from people about the quality of service they had received.

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

We found that action had been taken to improve the safety of the service.

All risk assessments had been reviewed and areas of high risk had been identified.

Staff completed accurate records when supporting people with their medicines.

All staff files had been reviewed to ensure they contained appropriate references.

We have improved the rating from Inadequate to Requires Improvement.

Is the service effective?

Requires Improvement

We found that action had been taken to improve the effectiveness of the service.

All care workers had received refresher training in the mandatory topics.

All care workers had a supervision meeting since the last inspection and a schedule was in place for upcoming supervision meetings.

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

We found that action had been taken to improve the responsiveness of the service.

All care plans had been reviewed to try and capture more person centred information. They were more comprehensive in scope than previously found.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

We found that action had been taken to improve how well-led the service was.

Care workers had been reminded about their responsibilities for reporting incidents and accidents.

Feedback surveys had been analysed to try to help identify areas of improvement.

We could not improve the rating for well-led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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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 checked 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.

We undertook this announced focussed inspection on 4 August 2017.

This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection on 08 and 11 November 2016. We inspected the service against four of the five questions we ask about services: is the service safe? is the service effective? is the service responsive? And is the service well-led? This is because the service was not meeting some legal requirements.

The inspection was carried out by one inspector. The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During the inspection we looked at six care records, five staff records, training records, and audits related to the management of the service. We spoke with a Director who was overseeing the management of the service in the absence of a registered manager.

After the inspection we spoke with two people using the service, four relatives and three care workers.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection which took place on 8 and 11 November 2016, we found people's identified risks were not always effectively captured by the provider. This meant that people may have been at risk of receiving unsafe care. Care records did not contain enough information about the risks to people and how these should be managed to help keep people safe.

We also found the provider's systems for managing medicines were not safe. Medicine administration records (MAR) were not used and care workers recorded details of the medicines they supported people within their daily record sheets. These did not contain sufficient detail about the medicines that people were supported with. This was not in line with the provider's medicines policy.

The provider's staff recruitment processes were not followed in line with its policy with regards to reference checks. The provider did not always ensure that satisfactory evidence of staff conduct in previous employment was obtained to ensure care workers were suitable for employment.

At this inspection we found that some improvements had been made. The provider was now meeting the regulations.

All risk assessments for people using the service had been reviewed and new documentation was in place to capture risks to people. The Director told us that moving forward the expectation was for risk assessments to be reviewed twice a year.

The areas that were risk assessed included communication and senses, personal hygiene and dietary needs amongst others. All the areas had been risk assessed recently and a rating given as to the level of risk. Risk rating score guidelines were in place based on the impact and likelihood of harm. Areas of high risk had control measures in place so staff knew how to manage the risk.

There were some aspects of the risk assessments that could be improved, we spoke with the director about these during the inspection. They included capturing ways in which care workers could support people in a safe manner with regards to some of their health conditions. For example, introducing guidelines for care workers supporting people with diabetes and sickle cell to ensure that their individual needs were met.

Care plans had been amended to include details of people's current medicines regimes. This meant care workers had access to up to date information about the medicines people were taking in case of any emergencies.

The provider had also introduced medicine record logs for those people that were supported with their medicines. These clearly captured details about the medicines that people were supported with and when they had taken them. These records were retained within the daily log sheets that care workers completed and brought back to the office with them.

The director told us they had gone through all of their contracted care workers records to ensure sufficient references were in place. This included obtaining references for existing care workers who did not have sufficient references in place beforehand.

We checked four staff files, these contained two references as per the policy. We found that some application forms had a gap in employment history which had not been explored at interview and some dates of employment were missing. We highlighted the importance of verifying gaps in employment history for future applicants to the director at the time of the inspection.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection which took place on 8 and 11 November 2016, we found people were supported by staff who did not always receive appropriate training and support to ensure they were able to meet their needs effectively. The majority of training was delivered through DVDs which care workers watched and were then required to answer competency questions to test their knowledge. In the staff files we looked at, these competency questionnaires were not always present or fully completed and signed off by a manager. Training records showed that care workers had not completed refresher training in line with the provider's policy. We also found that staff supervision was not carried out regularly.

At this inspection we found that some improvements had been made. The provider was now meeting the regulation.

People using the service and their relatives said they were happy with their care workers and felt they were competent to carry out their duties as required.

Care workers confirmed they had attended mandatory training since the previous inspection. They also said they had received supervision with their manager. One care worker said, "We discussed policies, any problems with the work or clients, training."

An up to date training matrix was available which showed that all care workers had attended mandatory training since the last inspection. The training schedule showed that all mandatory training was due to be refreshed annually.

Although training was still being delivered through DVDs, each course had an associated questionnaire with it that care workers were now completing. The director also told us that a member of the management team was available during the training sessions to answer any queries that attendees had about the training they had seen.

Staff files contained training certificates for the mandatory training that had been completed by care workers along with their associated questionnaires, which were used to test their understanding.

Some care workers felt that some of the training such as first aid would be better delivered face to face as a practical exercise rather than watching a DVD to support their understanding.

A schedule of supervisions had been completed for all care workers which showed that each care worker had received at least one supervision session since the last inspection. A timetable of upcoming supervisions was seen. Staff files had documented records of care workers previous supervisions. Supervision records included details about the needs of people using the service, work performance, incident reporting and safeguarding, medicines and training needs amongst others.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection which took place on 8 and 11 November 2016, we found care records were not always reflective of current status; this was partly because the provider relied on and used the care plans that were produced by local authorities instead of producing their own care plans. Where the provider had their own care plans, we found these often contained very basic information and insufficient detail about people's individual needs and therefore we could not be assured that person centred care reflecting each individual's needs was provided.

We made a recommendation to the provider to seek advice regarding person centred care planning to ensure that people's individual needs are reflected and met.

At this inspection we found that some improvements had been made and the provider had acted on our recommendation.

People using the service and their relatives told us they were generally happy with the service. They all confirmed that since the last inspection, their care plans had been reviewed. One relative said, "The reviews were done a few months ago. Someone came to the home and did a risk assessment and checked the medicines." A person using the service said, "They came a few months ago to make sure everything was OK."

Since the last inspection, all care workers had attended training in principles of person centred care.

There was a care plan in place for every person using the service which had been produced as a result of carrying out new needs assessment.

We looked at six care plans. These all contained an up to date needs assessment. We saw one file for a person who had recently started to use the service and saw that the provider carried out a needs assessment as soon as the referral had been accepted.

Care plans contained an information sheet with details of the duration and overview of tasks to be carried out. These also contained a short summary of people's health conditions and a summary of their care needs. People's preferences were included in the records that we saw.

Care workers that we spoke with told us that they found the care plans easy to follow and informative about people's support needs.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection which took place on 8 and 11 November 2016, we found the provider failed to submit statutory notifications to the Care Quality Commission (CQC) as required and did not always accurately record incidents and accidents that occurred. The lack of a long standing registered manager had resulted in some aspects of the service not being well managed. We found that quality assurance monitoring checks were not effective in picking up areas of concern.

At this inspection we found that some improvements had been made. The provider was now meeting the regulation.

The director told us that they were still recruiting for a registered manager and had found it a challenge to recruit the right person. Some care workers told us the lack of a registered manager did impact their work in some aspects but the director overseeing the service was easy to get hold of and communicate with if they needed to speak to someone.

There had been no safeguarding concerns or any incidents since the last inspection. However the provider had undertaken work around incident and accident reporting and the process for care workers to follow when reporting concerns. This included discussing the correct procedures during team meetings and individual supervisions.

Team meetings were held every quarter, topics discussed included sickness, medicines records, out of hours procedure, reporting incidents and accidents and feedback.

Spot checks were carried out for all people using the service. The first round of spot checks had been carried out in line with the needs assessment but moving forward the director planned to do them at varying intervals. Care workers confirmed that someone from the management team had come to observe them whilst they were delivering care.

The director had gone through the previous annual survey and analysed the results of the feedback to try and make improvements. We saw the results and analysis which showed that people were satisfied with the care they were receiving and had not identified any major areas of improvement. They had also started the 2017/2018 telephone and postal survey.