

Sebott Solutions Limited

Global Social Care Services

Inspection report

Hoskins Community Centre
108 Hoskins Close
Victoria Dock
London
E16 3RU

Tel: 07882688144

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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

Global Social Care provides care and support to people living in 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. At the time of this inspection six people with learning disabilities were using the service living in two 'supported living' settings.

The inspection took place on 19 and 20 February and 8 March 2018 and was announced. One inspector carried out this inspection. At the last inspection in November 2016, the service was rated as 'Good' overall but we found the provider did not consistently record all quality checks of medicine records. During this inspection, we found improvements had been made.

There was a registered manager in 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.

People and relatives spoke positively about the service. The registered manager had systems in place to obtain feedback from people who used the service. The provider carried out various quality checks to make improvements on any issues identified. The registered manager had regular team meetings with the staff.

Staff knew about people's care needs and about developing caring relationships. Each person had a named care worker who had overall responsibility for their care. The provider included people and their relatives in decisions about care. Staff described how they promoted people's privacy, dignity and independence. Staff were knowledgeable about people's equality and diversity needs and how to support people with their relationship needs.

Care records were personalised and contained people's preferences and the goals they wanted to achieve. Staff were knowledgeable about providing person-centred care. People were able to engage in activities at home and in the community. The service had a complaints procedure and people and relatives knew how to make a complaint. The registered manager planned to discuss end of life care at people's next care reviews.

Staff were knowledgeable about safeguarding and whistleblowing procedures. The provider had safe recruitment processes in place. There were enough staff to meet people's needs. Risk assessments were done to mitigate the risks of harm people may face at home and in the community. Medicines were managed safely. People were protected from the spread of infection. The provider used accidents and incidents as a learning tool to improve the service and prevent a reoccurrence.

People and relatives told us the provider delivered effective care. Each person had an assessment of their care needs to ensure the provider could meet their needs. New staff received an induction and were offered

ongoing training during their employment with the service. Staff were supported with regular supervisions. People were supported to eat a nutritionally balanced diet and to maintain their health. Staff were knowledgeable about obtaining consent before delivering care.

We have made one recommendation about the provider's responsibilities under the Mental Capacity Act (2005).

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 remains Good.

Is the service effective?

Good ●

The service remains Good.

Is the service caring?

Good ●

The service remains Good.

Is the service responsive?

Good ●

The service remains Good.

Is the service well-led?

Good ●

The service improved to Good. Staff and people who used the service spoke positively about the registered manager. The provider had a system of obtaining feedback from people and relatives in order to shape the service.

The provider held regular meetings with staff and had various quality audit systems to help them to make improvements to the service.

Global Social Care Services

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.

The inspection took place on 19 and 20 February and 8 March 2018 and was announced. The provider was given 24 hours' notice because the location provides a personal care service to people in supported living settings and we needed to be sure someone would be in. One inspector carried out this inspection. At the last inspection in November 2016, the service was rated as 'Good' overall.

We usually ask providers to complete an annual Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. At the time of this inspection the provider had not been asked to complete a PIR. We took this into account when we inspected the service and made the judgements in this report.

Before the inspection, we looked at the evidence we already held about the service including notifications the provider had sent us. A notification is information about important events which the service is required to send us by law. We also contacted the local authority to obtain their view about the service.

During the inspection we spoke with the registered manager and two people who used the service at the head office. On the third inspection day we visited one of the supported living settings and spoke to one more person who used the service. We reviewed three people's care records including risk assessments and care plans and three staff records including recruitment, training and supervision. We also looked at records relating to the how the service was managed including medicines, policies and procedures and quality assurance documentation. After the inspection, we spoke with two relatives and two staff.

Is the service safe?

Our findings

People and relatives told us the service was safe. One person told us, "Staff do make me feel safe."

The provider had safeguarding and whistleblowing policies which gave clear guidance to staff on how to raise concerns if they suspected abuse. There had been no safeguarding incidents since the last inspection. The registered manager was knowledgeable about the protecting people from abuse and stated, "Our job is to protect [people who used the service]. Their welfare is paramount but we must respect them ensuring their liberty and their independence is promoted. We have one to one meetings with [people who used the service] to discuss safeguarding issues."

Staff were knowledgeable about how to report safeguarding concerns and whistleblowing. One staff member told us, "I have to tell the manager if I suspect somebody is being abused or I can report it to the CQC [Care Quality Commission]." Another staff member said, "I have to fill out a form and report it to the senior support worker. Whistleblowing is telling on [staff] to the social worker or CQC." This meant the provider had systems in place to safeguard people from abuse.

People had risk assessments as part of their care plans regarding their care and support needs and accessing the community. Risk assessments included clear actions for staff to mitigate the risks. People's risk assessments included self-harm, compliance with medicines, food preparation, absconding, damage to property, nutrition, fire and stranger danger.

For example, one person had behaviours that could challenge the service. The guidelines for managing the behaviours stated, "[Person] to be talked to and calmed down. The house has been made safe by removing things that could harm [person]. Staff to advise other [people] to move out [of the room] and stay in a safe place. [Person] will be encouraged not to isolate herself. Reward good behaviour and give zero tolerance to physical abuse towards staff and [other people]." The risk assessment also listed the known triggers to this person's behaviour so that staff could be aware of and try to avoid. For example, one trigger was listed as, "[Person] does not like spontaneous surprises, loud and pop music." The end of the risk document stated this person was aware of the risk assessment and was in agreement with it. Risk assessments were reviewed and updated on a monthly basis. This meant the provider had taken steps to mitigate risks that people might face.

The provider had a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. Staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had been given written references. New staff had criminal record checks (DBS) to confirm they were suitable to work with people and the provider had a system to obtain regular updates. This meant a safe recruitment procedure was in place.

Staffing levels were determined by the number of people using the service and their assessed needs. Records showed there were enough staff to meet people's needs and this included people who needed one to one staffing. Relatives and staff confirmed there were enough staff on duty.

We checked the medicine administration records (MARS) and saw appropriate arrangements were in place for recording the administration of medicines. Staff had signed to say the medicines had been administered. There were no gaps in signatures indicating people had received their medicines as prescribed. Records showed medicines were given to people by appropriately trained and competent staff. The provider had a comprehensive medicines policy which gave clear guidance to staff of their responsibilities regarding medicines management. This meant the provider had a system in place to ensure that people received their medicines safely and as prescribed.

The provider had an infection control policy which gave guidance to staff on how to prevent the spread of infection. Records showed that staff had received training in infection control. Staff confirmed they were provided with sufficient personal protection equipment such as gloves and aprons to provide care. This meant people were protected from the risks associated with the spread of infection.

The registered manager kept comprehensive records of accidents and incidents. Details of the accident or incident were documented as well as the actions taken. Records showed incidents and accidents had been reported to the local authority and the Care Quality Commission as required. For example, one person had tripped over her shopping trolley following a shopping trip the incident was discussed with staff. The agreed resolution was that when the person returned from a shopping trip staff would put the shopping straight in the kitchen and the person put the items away themselves in their own fridge. The outcome was the person's excitement was managed and the risk of the incident occurring again was minimised. This showed lessons were learnt when accidents or incidents occurred to prevent them happening again.

Is the service effective?

Our findings

People told us they were happy with the support they received. One relative told us, "Yes I am happy with the service. We like to think they have the skills needed [to provide care]" Another relative told us the service their family member received now was better than the previous placement.

The provider carried out a comprehensive care needs assessment before a person began to use the service. The information gathered included the person's history, relationship needs, culture and religion. For example, one person attended a place of worship with their family and this was noted in their assessment and incorporated in their care plan. Another person's assessment noted they were separated from their significant other and the care plan incorporated the support they needed to deal with this on an emotional level. This meant the provider ensured they could meet the person's needs before accepting them into the service.

The registered manager told us that new staff received an induction when they began working at the service. This consisted of one week at the head office which included reading the policies and procedures and discussing with the registered manager the standards they were expected to work to. The registered manager explained that for one month new staff shadowed experienced staff and completed mandatory training. Records showed that new staff had to complete a three month probation period, which could be extended to six months if needed, before being confirmed in post.

Staff confirmed they were offered training opportunities. Records showed staff were up to date in relevant training including first aid, health and safety, fire safety and food hygiene. Staff had completed training specific to their role in managing challenging behaviour, mental health and learning disability. This meant the service was provided by suitably qualified staff.

Records showed staff received regular supervisions every two months. Staff confirmed this was the case and they found them useful. Topics discussed during supervision meetings included people who used the service, activities, holidays, relatives, team work, confidentiality, safeguarding, timekeeping and concerns. This meant staff were supported to carry out their role effectively.

Staff supported people with food shopping and meal preparations. Records and people who used the service confirmed this. One person told us they were able to choose the food they ate and stated, "I've cut down so I can lose weight. I can do exercises." Another person said, "I do choose my food. I'm having pizza tonight. Cheese and tomato is my favourite." Staff were knowledgeable about people's dietary requirements. At the time of this inspection there was nobody using the service who needed support with cultural or religious diets.

People's weights were monitored on a monthly basis. Records confirmed that one person's weight had increased and staff encouraged the person to eat healthy food. This person was also supported by staff to lower their cholesterol levels. The above meant people had a choice of nutritional food to eat.

Records confirmed that people were able to access healthcare whenever they needed to. The outcomes of healthcare appointments were documented. These included dental treatment, optician, psychiatry, psychology, medicines review and flu vaccination with the GP, neurophysiology and chiroprody. People had a hospital passport which they could take with them if they were admitted to hospital. The hospital passport gave key information about support needs and health needs and a list of professionals involved in the person's life. This meant people were supported to maintain good physical and mental health.

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.

Staff were aware that they needed to obtain consent before delivering care. One staff member told us, "We get consent all of the time. They have to have their choice." Another staff member said, "Yes, we always do that [get consent]. First and foremost I always take permission from [people who used the service]."

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 are using services in the community, the Court of Protection has to agree to any restrictions on people's liberty. We checked whether the service was working within the principles of the MCA.

At the time of this inspection there was nobody using the service who had their liberty deprived by the Court of Protection. However, the registered manager told us one person who used the service always had staff with them when they accessed the community. This was because the person required a level of care and supervision to keep them safe and was therefore a restriction on their liberty. We discussed this with the registered manager and they told us they were planning to discuss this with the funding local authority.

We recommend the provider seeks guidance and advice from a reputable source about their responsibilities under the Mental Capacity Act (2005).

Is the service caring?

Our findings

People told us staff were caring. One relative told us, "The staff we have now are caring." This relative explained staff previously in employment were not always caring.

Staff were knowledgeable about developing caring relationships with people. One staff member told us, "I always communicate with [people who used the service] and talk to them. I listen to what they say and what they want." Another staff member said, "I have to read their care file and talk with the person. I need to find out if there is anything they are dissatisfied with."

The registered manager told us, "[People who used the service] have weekly keyworker sessions." A "keyworker" is a staff member who is responsible for overseeing the care a person received and liaising with other professionals or representatives involved in a person's life. Care records showed the key worker wrote a monthly report and documented the views of the person. This meant people were involved in the care they received.

A relative told us they maintained regular contact with the service and "They would tell me if there's something important I should know." We asked the registered manager how they involved relatives in the care provided. The registered manager told us, "I meet with the parents, sometimes they visit [family member] and I have one to one discussions. I share the review reports with relatives and call them once a month." The above showed the provider included people and their relatives in decisions about care.

Staff described how they promoted people's privacy and dignity. One staff member told us, "I make sure I close the windows and blinds so that people cannot see in. I make sure the door is shut." Another staff member said, "I have to make sure they have privacy and not expose them in front of other people. I close the door and curtains." This showed people's privacy and dignity were promoted.

The provider had an equality and diversity policy. The registered manager told us they discussed equality and diversity in staff meetings and supervisions. Records showed this was the case. Care records showed that where a person needed support to attend a place of worship they were supported to do so.

The provider also had a relationships policy. We asked the registered manager and staff how a person who identified themselves as lesbian, gay, bisexual or transgender [LGBT] would be supported. The registered manager told us, "I think it's just being aware of their sexuality and the care plan would have those details. During my assessment, I find out about their sexuality and how comfortable they are with their sexuality. I need to discuss with my staff. My staff don't discriminate."

Staff were knowledgeable about supporting people with their relationship needs. One staff member told us, "It's their life and they need to have their privacy. There can't be any discrimination." Another staff member said, "In my work, we must not discriminate. I don't discriminate. I have to accept people and make them feel comfortable." The above showed staff were aware of people's relationship and equality and diversity needs.

Staff described how they assisted people to maintain their independence. One staff member told us, "I try to encourage them to do things themselves. If they can wash themselves in the bath I prompt them to do this." Another staff member said, "I have to empower them. Let them have their choice and let them do things themselves when they can." This showed people were supported to maintain their independence.

Is the service responsive?

Our findings

Staff were knowledgeable about providing personalised care. One staff member told us, "It's got to do with care that is adapted to the [person using the service]. It's the [people who used the service] who say what they want and what they need." Another staff member said, "It is care in the way the particular [person] wants and how they want to be assisted."

Care records were personalised and documented people's preferences and dislikes. For example, one person's care record preferences included jokes, going to church to meet new people and being praised. This person's dislikes included, "I don't like when people talk down to me, I don't like to be ignored and I don't like people to invade my personal space." The above showed the provider was knowledgeable about providing care in line with people's preferences.

Care plans included the person's communication needs. One person's care record stated, "I find it hard to understand and express myself using long sentences. I would like people to simplify words to me and ask me in short sentences. I understand when people talk to me slowly and tell me one thing at a time. What I don't understand I ask them to repeat it to me again."

People had support needs and goals detailed in the care records. For example, one person was being supported to draw up a budget plan in order to learn how to save money. The keyworker for this person stated in the care record, "[Person] is getting involved in household activities more; she always offers to help staff and other [people using the service] with anything especially washing plates and folding clothes." This showed people were supported to reach for goals of their choosing.

One person told us they liked going to the charity shop to add to their collection of teddy bears. This person told us they were going out to buy one that day before going to college. Another person told us they enjoyed swimming, going to the cinema, bowling and shopping. A relative told us staff assisted their family member to go to college and swimming. However, this relative said, "Not enough walking. [Family member] likes to go for walks."

Care records showed that activities people were supported to participate in the community included the gym, an art project, a drama group and pub trips. People participated in household tasks, pamper sessions and board games at home. This meant people were supported to access their preferred activities at home and in the community.

People and relatives told us they had not needed to complain since the last inspection. A relative told us if they were not happy with the service, "I would go to the manager and I assume she would sort it out."

The provider had a complaints policy which gave guidance to staff on how to deal with complaints. Staff were knowledgeable about the procedure to follow if a person using the service or their representative wanted to make a complaint. The registered manager told us there had been no complaints since the last inspection. However, the registered manager told us about a situation they dealt with before it became a formal

complaint. The issue was in relation to one person visiting their relatives. Records showed this was handled appropriately and everyone was satisfied with the resolution.

At the time of this inspection there was nobody receiving end of life care. People using the service were young adults who were healthy. The registered manager told us they intended to discuss this topic at each person's next review meeting. The registered manager explained in the meantime if a person was assessed by medical professionals as needing end of life care, a meeting would be held with the person, relevant professionals and relatives where appropriate to discuss the person's end of life wishes.

Is the service well-led?

Our findings

At the last inspection in November 2016 we found the provider did not consistently record all quality checks of medicine administration record (MAR) charts. During this inspection, we found improvements had been made. We reviewed the MAR charts and found these were audited on 31 January 2018 with no identified issues.

There was a registered manager at the service. Two people told us, "[Registered manager] is alright." One person told us, "[Registered manager] is nice."

Staff told us they felt supported by the registered manager and that they were a good leader. One staff member told us, "Yes I feel supported. [Registered manager] is a good leader." Another staff member said, "Yes we are supported. Our manager's a good leader."

A relative told us the registered manager had phoned them a few weeks previously to get feedback. The provider sent out eight feedback surveys in December 2017 to relatives and social workers. Records showed that six completed surveys were returned and everyone indicated they were satisfied with all aspects of the service.

The registered manager explained that as some surveys indicated a lower score of being satisfied they now called each relative monthly to check satisfaction levels. Records confirmed the registered manager phoned relatives each month to obtain feedback. The registered manager explained the purpose of the calls was to identify any issues and actions to resolve the issues. We reviewed the records of these calls and saw comments included, "Staff do a wonderful job with [person]", "No concerns at all. [Person] is happy and no incidents so far" and "[Relative] said things are going very well as [person] likes the home and the staff."

The provider held monthly meetings with people who used the service. We reviewed the minutes of the meeting held on 7 January 2017. Topics discussed included activities, holidays, respecting each other, eating a healthy diet and cleaning. The above showed the provider had a system to obtain people's views in order to improve the service.

Staff confirmed they had monthly meetings and found these useful. Topics discussed at the most recent meeting held on 31 January 2018 included annual leave, weekly shopping, training, record keeping, house cleaning and people's activities.

Staff were required to complete a handover sheet whereby the staff handing over and staff being handed over to both had to sign each task. This included keys, medicines, petty cash, house cleaning and the movement book indicating where each person was or needed to be. This meant the provider had a system in place for staff to audit their work themselves and quickly rectify any issues identified.

The registered manager carried out regular unannounced spot checks of staff. Records showed the spot checks were weekly for new staff and monthly for experienced staff. The spot checks included reading the

handover book, communication book, checking medicines, the daily log books and activity records. The registered manager told us the outcome of spot checks was used to improve the quality of the service provided. Records confirmed issues and comments documented on the spot check sheets were discussed with staff afterwards. The above demonstrated the provider had systems in place to check the quality of the service and take action on identified issues.