Sulem Care Limited

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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

The inspection took place on 9 October 2018 and was announced. This was the first rated inspection for Sulem Care Ltd. The service has been registered for almost 12 months, however has been providing personal care since August 2018.

This service 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 older adults. At the time of our inspection there were seven people receiving support

There is a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 had been appropriately recruited to ensure they were suitable to work with vulnerable adults. There was enough staff employed by the service to help people with their day to day support needs at the times they wanted.

There were systems and processes in place to ensure that people who lived at the scheme were safeguarded from abuse. This included training for staff. Staff we spoke with confirmed they knew how to raise concerns.

There was a process for recording, reporting and analysing incidents, accidents and general near misses to determine what could be improved within the service provision.

Risk assessments and support plans had been completed for everyone who received care to help ensure people's needs were met and to protect people from the risk of harm.

There was personal protective equipment (PPE) available for use, such as gloves and aprons. Staff confirmed they had good supplies of gloves and aprons when supporting people with personal care.

The service supported people with medication. Medication was administered by staff who had the correct training to enable them to do this. Records were kept in line with current guidance.

The service was operating in accordance with the principles of the Mental Capacity Act (MCA) and consent was sought in line with people's best interests.

Staff received training to enable them to support people safely and training records confirmed this. Staff engaged in regular supervision with their manager.

People were treated as individuals, and their choices and preferences were respected by staff.

People's care plans were person centred and contained details about the person, their likes, dislikes, how they want to be supported and what they could do for themselves.

People's dietary needs were managed with reference to individual preferences and choice.

There was a complaints process in place which. There had been no complaints since the service started providing support.

The service had been providing support to people for eight weeks. The quality assurance system was being developed. Checks were being made each week to people who used the service by telephone or in person to ensure the care was safe and was meeting people's needs.

The service worked in partnership with other professionals such as the local authorities, Occupational Therapists and dieticians.

Further information is in the detailed findings below.

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.

There were systems in place to assess and monitor any risks to people's safety.

Staffing numbers were satisfactorily maintained to support people. Staff had been appropriately checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Medicines were administered safely.

Is the service effective?

Good

The service was effective.

Staff were supported through induction, supervision and the service's training programme.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Good

The service was caring.

People said staff were caring and friendly.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

People told us they felt involved in their care.

Is the service responsive?

Good

The service was responsive.

Care plans were completed and were being reviewed when needed so people's care could be monitored.

People's preferences were recorded in respect of personal care routines, getting up and going to bed and likes and dislikes for food and drinks.

A process for managing complaints was in place. People knew how to complain.

Is the service well-led?

Good

The service was well led.

There was a registered manager. There was a clear management structure with lines of accountability and staff responsibility which helped promote good service development.

There were a series of on-going audits and checks to ensure standards were being monitored effectively.

The Care Quality Commission had been notified of any reportable incidents.

Sulem Care Ltd

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 inspection took place on 9 October 2018 and was announced. 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 available for the inspection.

Inspection site visit activity started on 9 October 2018 and ended on 11 October 2018. It included speaking with people who received support, their relatives and speaking with staff over the telephone. We visited the office location on 9 October 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection team consisted of an adult social care inspector.

Before our inspection visit we reviewed the information we held about Sulem Care. This included notifications we had received from the registered provider, about incidents that affect the health, safety and welfare of people who used the service. We also accessed the Provider Information Return (PIR) we received prior to our inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. This provided us with information and numerical data about the operation of the service. We also contacted the local authority commissioning team.

We used this information to populate our planning tool. This is a document which helps us plan how the inspection should be carried out.

We spoke with a person receiving support, two relatives, the registered manager, the care coordinator and two care staff. We looked at care plans for three people and other related records. We checked the recruitment files for four staff. We also looked at other documentation associated to the running of the

service.

Good

Is the service safe?

Our findings

People we spoke said they felt safe when being supported by Sulem Care staff.

Staff we spoke with understood how to recognise abuse and how to report concerns or allegations. There were processes in place to help make sure people were protected from the risk of abuse. Staff had completed safeguarding training. A 'safeguarding vulnerable adults' policy was available to support staff with aspects of abuse and the procedure to report suspected abuse.

Risk assessments and support plans had been completed for everyone who received care to help ensure people's needs were met and to protect people from the risk of harm. We saw risk assessments had been completed for medication, mobility, including using hoisting equipment and falls, nutrition and pressure area care.

There was a process for recording, reporting and analysing incidents, accidents and general near misses to determine what could be improved within the service provision. Any changes to people's health or support needs was reported to the appropriate health care professional for reassessment.

Care staff we spoke with had a good understanding of how to keep people safe in their own home. This included the use of equipment such as hoists to transfer people safely or stand aids to support them to move with some independence.

Assessments were reviewed regularly by the care coordinators to help ensure any change in people's needs was reassessed so they received the appropriate care and support.

Medication was administered safely by suitably trained staff and was recorded correctly. Information was recorded in people's care records which included a full list of their current medication and a Medication Administration Record (MAR). Staff we spoke with confirmed they had received training. A competency assessment was yet to be completed by senior staff to ensure people received their medication safely as care staff had not worked for the service for long. The registered manager told us competency checks would be carried out in the very near future. The care records informed us that a medication risk assessment was undertaken if a person needed support with their medication.

Staff were recruited safely as the registered provider had a robust recruitment process. We found copies of application forms and references. Staff had been subject to a Disclosure and Barring Service (DBS) check, to ensure they were entitled to work in the UK and police checks had been carried out. We found they had all received a clear DBS check. This meant that staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults.

There were appropriate numbers of staff employed to meet the needs of people who received a service and to ensure they received the support at a time when they needed it. Everyone said the visits by the care staff were on time and staff always stayed for the full time. Staff we spoke with confirmed this to be the case.

They told us they had enough time to get to their next call so people received the whole time allocated to them. This meant that staff were able to support people with all the care and support they needed. The Care Coordinator and registered manager told us new referrals were not started until staff were available to support people when they needed it. This helped ensure support could be provided to the people who needed it.

We asked people if they had ever experienced staff not arriving to help them when they were expected. People told us that staff always arrived. The Care Coordinator explained to us how the Care Planner system helped to ensure nobody missed a call. Staff were expected to log in and out each time they visited a person's home. This information was transferred to the electronic system. If a staff member had not logged in 15 minutes after the expected time of arrival a message was sent to the Care Coordinator to alert them. This meant that in the event of a staff member not visiting a person the Care Coordinator could arrange for another staff member, or even the care coordinator themselves to go out to the person.

People told us that staff used protective clothing, for example aprons and gloves, when working in their home. We saw evidence that staff were regularly supplied with aprons and gloves. This helped to promote good hygiene and prevent any cross contamination and infection.

Good

Is the service effective?

Our findings

The registered provider used an electronic system called 'Care Planner' to record a person's service, which included their assessed needs and care plans; staff rota and any updates or messages regarding people's health and support. Staff had access to the system information via the application on their mobile telephone. This informed them of people's needs and any changes to their care needs. Staff we spoke with confirmed this and said they found this helpful as the information they required was readily available to them.

Care plans were completed following the initial assessment and commencement of the service; these included, medication, personal care, communication, mobility, diet and fluids.

We found that the staff at Sulem Care were well trained and those we spoke with had a good understanding of people's needs. Staff told us they mainly visited the same people, so they were familiar with their needs. People we spoke with confirmed this to be the case.

Staff completed training when they commenced their employment at Sulem Care as part of their induction to the service. The registered manager used a training matrix to show when staff had completed each training course and when they were due an update. We found that all staff members had completed training in subjects relevant to the needs of people they supported. For example, health and safety, basic life support, moving and handling, infection control, fire safety, food safety and safeguarding vulnerable adults. Some staff had also completed training relevant to the specific health care needs of the people they supported. For example, medication administration, end of life care and stoma care.

Each member of staff had completed a two-day induction which included a number of shadow shifts with an experienced member of staff; a checklist evidenced the activities they had completed. A review was held with the employee after six weeks in their role, to discuss any issues that may have arisen and to discuss their progress. Written records were made of these meetings as evidence to refer to in the future.

Staff received regular supervision from the start of their employment with Sulem care. Records we saw confirmed this. The registered provider's supervision policy stated supervision would be held every three months. However, records showed meetings took place more frequently. Staff we spoke with said they felt well supported by the registered manager and care coordinator.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications must be made to the Court of Protection.

The service was not supporting anyone where an application had been made to the Court of Protection. Staff received training regarding people's mental capacity to consent to care during their induction.

The Mental Capacity Act 2005 is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Staff told us they would always ask a person before carrying out a task to ensure they consented to it taking place. Care records showed that people had signed care plans to consent for the provision of care and support with medication. Staff confirmed they always asked a person's consent before carrying out any support or care.

We saw from care records that people were supported to eat and drink regularly by staff. Their care plans clearly documented what food and drinks should be provided at particular times. People told us they were happy with the meals and snacks staff prepared for them.

Where appropriate, staff supported people to maintain good health. Staff sought the input of health and social care professionals if people's needs changed. For example, we heard that the care coordinator had liaised with social workers on people's behalf when more time was required to meet people's support needs during each visit because their mobility had deteriorated. In another example, care staff had contacted Speech and Language Therapists for advice for a person who required a thickening agent added to their drinks to avoid choking when they had some concerns.

Good

Is the service caring?

Our findings

Everyone we spoke with during our inspection told us that the staff who visited them in their home were caring and kind. A relative told us they were always informed of any changes in their family member's health.

The service had only been providing support to people for eight weeks. We saw that they had received a thank you card from a relative of a person who was supported by Sulem Care. For some people this was their first experience of having care staff in their home. For others they had previously had other service providers. Everyone spoke positively about their experience with Sulem Care managers and care staff.

Staff we spoke with demonstrated a genuine positive regard for the people they supported. They told us they provided care to a number of the same people on a regular basis which meant they had the opportunity to develop good relationships with the people they supported.

Staff told us the information recorded in the care records also helped them understand what support people required. They had access to this information from the Call Planner phone application. They were informed of any change in people's needs or circumstances by a text message. This information was updated through consultation with people or their relatives and there was evidence that people were involved in discussions about their care. Care staff also used the application to update records when they found a change in a person's health or care needs.

Personal information recorded relating to people who received support and staff was stored confidentiality on the Care Planner system; staff had an individual log in password to ensure access was restricted. Paper records kept in the office were stored in locked cupboards.

People told us that staff supported them in a respectful and dignified manner and their privacy was maintained when being supported with personal care. People said they did not feel rushed when being helped to wash or dress. When asked, staff were able to give examples of how they maintained a person's dignity when supporting them and offered them privacy. For example, covering people with a towel before carrying out any personal care.

Some people supported by Sulem care had communication needs. We found details to support and communicate with people were clearly recorded in care plans. Details of any communication aids used were recorded. Staff we spoke with were familiar with these needs and the support used to aid effective and direct contact. This meant that people could communicate directly with staff to express their needs and wishes.

Good

Is the service responsive?

Our findings

People we spoke with told us they received care when they wanted it and staff did what was required of them. A relative told us they had requested a different time for staff to arrive, as they were arriving too late. They said, "I only had to ask and it was changed to a more suitable time."

Care records we looked at showed people's needs were assessed by the Care Coordinator before receiving a service. Care plans had been developed where possible with each person and their family, identifying the support they required. We found evidence of people and their relatives being involved in their care plan and providing information about people's preferences and daily routines; their likes and dislikes and some had completed social histories. This gave staff some personal information about the person so they could be supported in their usual and preferred way.

A range of care plans were completed to identify people's needs and the support required during each visit. For example, care plans were completed for health, medication and personal care. Particular attention was made by staff, ensuring people who required them had their hearing aids and glasses on or to hand. Information regarding people's communication needs were clearly recorded. For example, having a conversation by writing and using people's communication books or photographs. This meant that staff were able to effectively communicate with people they supported.

Staff recorded in people's daily notes what support had been provided and any health issues or other information that needed to be shared with other staff also supporting the person. Staff would also send text messages of any changes to a person's health or circumstances, which was recorded directly on the Call Planner system. This served as an accurate record for any referrals to, for example a dietician or social worker.

We found people's preferences had been recorded in respect of personal care routines, getting up and going to bed and likes and dislikes for food and drinks. Allergies and other medical information was also recorded.

The service had a complaints procedure, which was made available to people in the service user and staff handbook. We spoke to people who received a service and relatives and they said they knew how to make a complaint if they were unhappy. They told us they would feel comfortable raising a concern or complaint should it become necessary and would speak to the registered manager or Care Coordinator. No complaints had been received since the service began. Everyone we spoke with told us they had no complaints about the service.

Good

Is the service well-led?

Our findings

There was a registered manager employed at Sulem Care Ltd. 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.

The day to day running of the service was managed by the registered manager and Care Coordinator; we found them to be dedicated to providing a quality and personalised service. Staff spoke positively about them. The registered manager was supported by three Care Coordinators who were monitoring the quality of the service and updated people's care records.

The Care Coordinator carried out the initial assessment and information gathering to establish if a service could be started and to ensure the person was supported correctly. The service did not begin support packages until they had the care staff available to support them. This way existing packages of care were not compromised or rushed.

People we spoke with who received a service told us that they did not feel staff were rushed or hurried when providing their support in order to get to another person. Calls were arranged in two geographical areas and therefore staff did not have to spend a lot of time travelling from one
person to another.

The service provided an out of hours on-call service for people and staff in case of an emergency.

We found that the registered manager and Care Coordinator communicated well with the staff so they were kept up-to-date about any changes. Staff rotas were available to staff electronically on the Care Planner system.

Meetings were held to keep staff updated. All staff received regular supervision.

There were systems in place to monitor the quality of the service provided. Due to the service being in the early stages of operation, the system was not fully operational. However, safety and quality audits were being completed for medication administration and accident reporting.

The organisation had systems in place to gather the views and opinions about the service from the people who received the service or their relatives.The service had only been providing support to people for eight weeks; people were visited in their own home on a weekly basis by the care coordinator and relatives were telephoned regularly to ensure they were satisfied with the service provided and to ensure the care package was meeting the person's needs. Unannounced spot check visits were carried out to check whether care staff were working according to the person's care plan and in a safe and professional manner. We saw examples of both home visits records and spot checks in people's care records.

Policies and procedures were in place and provided guidance to staff regarding expectations and performance. These included policies regarding people's diversity, safeguarding vulnerable adults, infection control, staff supervision and medication management.

The registered manager was aware of incidents that required the Care Quality Commission to be notified of. Notifications had been received to meet this requirement.