Solsken Limited

Solsken Limited

Inspection report

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Date of inspection visit: 14 July 2021 to 23 July 2021
Date of publication: 29/10/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location is inadequate because:

- Immediately following this inspection we took enforcement action and issued a Section 29 warning notice to the provider. This was to tell them that they needed to make significant improvements to the safety and governance of the service. We were concerned that people were at risk of avoidable harm.
- We had concerns about the safety of the service because staff had not undertaken the training required to ensure they could perform their roles safely. There were not always enough staff available and this meant that some staff were working excessive hours, were unable to attend training and could not take annual leave. The service had a high turnover of staff which impacted on the consistency of care delivered to people.
- The service did not keep track of incidents within the service to ensure learning and improvement.
- During our inspection we observed that staff did not always wear personal protective equipment.
- Staff did not receive regular and effective supervision and appraisal.
- Although staff delivering care were kind and compassionate and conscientious in their roles, we could not be assured that all service users received kind and compassionate care. This was because the service did not monitor this. Not all patients and carers were receiving person centred care. Two relatives raised concerns about the treatment received.
- There was mixed feedback from carers and inconsistency in experiences with the service. Some carers told us they found it difficult to contact managers, that they felt communication was poor and they did not know the process to complain.
- The service was not well led. Senior health care assistants were not adequately prepared to undertake their management roles. There was limited oversight of the service as a whole and a lack of governance systems or processes to monitor risks and provide assurance. The service had no risk register or similar process to identify and highlight risks to the service and plan mitigations, for example, relating to staffing recruitment and retention. There were few systems to track actions and monitor progress, for example in relation to safeguarding, and incidents. Where systems were in place these were not effective because actions were not always taken to address concerns.
- There was no process to review key items such as the strategy, values, objectives, plans or the governance framework.

However:

- Some carers gave positive feedback about the core staff who delivered care to their loved ones. They told us that managers were easily contactable, they received feedback regularly and that they were aware of how to raise concerns.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- We reviewed five care and treatment records. Care plans were well written and reflected good practice guidance.

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Summary of findings

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Solsken Limited

Solsken Limited is operated by Solsken Limited.

The service opened in 2018. It is based in Sheffield, South Yorkshire but operates nationally.

The service provides care to individuals with complex care needs in their own homes. At the time of our inspection the service provided care to 13 patients.

Solsken Limited are commissioned by five clinical commissioning groups, two in the Midlands and three in the Yorkshire and Humber region, to provide care under the NHS continuing healthcare budget.

The service has had a registered manager in post since 2018.

This is the first comprehensive inspection of this service.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location including information discussed at provider engagement meetings and monitoring calls.

During the inspection visit, the inspection team:

- visited the registered office in Sheffield;
- undertook three home visits;
- spoke with two patients who were using the service;
- spoke with eight carers or family members of patients;
- spoke with the registered manager;
- spoke with four other senior staff; including operational managers and clinical staff;
- received feedback from 13 staff members, either remotely or face to face;
- reviewed facilities and equipment used to train staff;
- looked at five care and treatment records; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

We gave the service short notice the day before the inspection visit because it supports people across a large area and we needed to be sure that the registered manager would be available.

Areas for improvement

- The service must ensure that there is effective governance and oversight of this service.
- The service must ensure that there are sufficient staff available so that staff receive appropriate rest time between shifts or to accommodate training.
- The service must ensure that staff complete all mandatory training.
- The service must ensure that all staff are trained in safeguarding children.

Summary of this inspection

- The service must ensure that staff training others have the appropriate skills, experience and training to undertake this.
- The service must ensure that staff receive regular management supervision.
- The service must ensure that all staff have an annual appraisal completed.
- The service must ensure that all complaints are recorded and actions taken as per the service policy. Patients and carers must be aware of how to make a complaint.
- The service must ensure that all patients and carers are treated with dignity and respect.
- The service must ensure that feedback about the service is regularly sought and acted upon.
- The service must ensure that managers are available and accessible to staff and to service users and their families to respond to any issues and ensure the safe and high quality delivery of care.
- The service must ensure that all staff follow guidance relating to personal protective equipment and that governance processes are in place to ensure it is appropriately used.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Inadequate

Community health services for adults

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Inadequate

Are Community health services for adults safe?

Inadequate

Mandatory training

Staff had not completed the mandatory training in key skills which meant that they may not deliver care and treatment to an appropriate standard.

The service provided online mandatory training modules. Whilst the provider had recently swapped online training providers, this service had been in place for seven weeks with an expectation that staff would complete all training within eight weeks of the start date.

At the time of inspection, basic life support completion was 70%, care certificate 28%, conflict management 23%, dignity and respect 27%, equality and diversity 82%, fluids and nutrition 38%, food hygiene 84%, health and safety 66%, infection control 71%, medication administration awareness 75%, moving and handling theory 50%, personal protective equipment 27% and positive behaviour support 83%.

Staff completed practical training and competency checks for the tasks required for the individual care package that they were employed for, such as; basic life support, management of choking, specific moving and handling and personal protective equipment needed. The service were not able to provide evidence that all staff had been trained in and were competent to provide all aspects of care. The completed competencies were stored by the service per package rather than for individual staff and records were not kept for this specific training.

Managers and seniors have been booked to attend train the trainer courses in moving and handling and first aid since this inspection, however at the time of this inspection no staff had completed valid training to train others.

Safeguarding

Staff had some training on how to recognise and report abuse and they knew how to apply it. However, most staff had not completed safeguarding children training which was needed in order to safely carry out their roles.

The service had previously only ensured staff had completed safeguarding adults training. Only 17% of staff had completed safeguarding children this at the time of this inspection. We were concerned about this because the service provided care in family homes, and to both adults and children. Safeguarding adults training had been completed by 81% of staff.

Managers completed safeguarding alerts to the local authority when needed.

The service had a safeguarding policy for staff guidance.

Cleanliness, infection control and hygiene

The service controlled infection risk. Most staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff completed infection control training. The service had an infection control policy and a pandemic management policy to guide staff. There were sufficient quantities of personal protective equipment stored at the head office for distribution to staff, including FFP3 masks and gowns for undertaking procedures which were aerosol generating. The clinical lead had been trained to fit test staff for FFP3 masks and completed this with staff who required these.

During the home visits, we visited three patients. At two visits, staff were wearing appropriate personal protective equipment and showed good awareness of infection control principles. At one visit, the member of staff was not wearing protective equipment supplied, but their own face covering, and was not bare below the elbow.

Two carers told us that they were concerned about the service management of covid19, with concerns related to staff not wearing personal protective equipment appropriately and a lack of information and guidance from the service.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

The head office had been altered to allow safe working during the pandemic. Managers were able to work from home or remotely. Staff attended for training and meetings with staff they worked with in individual care packages.

Managers completed environmental risk assessments for each patient's home so that staff knew where key locations were in an emergency, for example, fuse boxes and stopcocks.

Equipment in use in each home was supplied by local NHS or CCG suppliers. Staff were able to practice techniques, for example, using hoists, with equipment stored at the head office, before being trained to use equipment in the patient's own home. Equipment used for training by the service included a non invasive respirator, profile bed, free standing hoist, suction machine, nebuliser and cough assist. These were in good operation and serviced annually.

The provider had a lone working policy and lone working care plans. Support was available for staff via a clinician and manager on call.

Assessing and responding to patient risk

Inadequate

Community health services for adults

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed specific risk assessments, for example, in relation to risks of falls and pressure damage. These were reviewed regularly and contained clear summaries of risk, risk factors and actions to be taken by staff. These were used to inform care plans.

Staffing

The service did not have enough staff and this meant that some staff were working too many hours without a break. Managers regularly reviewed and adjusted staffing levels and skill mix. Records of staff recruitment checks were not fully completed.

Between 15 July 2020 and 15 July 2021 there were 51 staff leavers. Four staff were dismissed. The service did not routinely complete exit interviews, staff leavers were marked 'other' in the data we reviewed. In the same time period there were 43 new starters. Staffing numbers will vary across time depending on the number of staff needed for care packages.

Staff were recruited and employed for each individual care package. Some care packages had staff who had worked with a specific patients for a long time, whilst some care packages had a higher turnover of staff and more use of temporary or ad hoc staff. There was no use of agency staff in the service. At the most recent governance meeting in June 2021, there were vacancies in six separate care packages, amounting to potentially 18 additional staff members required.

We reviewed staffing data from 1 May 2021 – 11 July 2021. For the most part, care packages were staffed with core groups of staff who worked shifts to fill the requirements of the package, including short visits and respite up to full 24 hour care. The service told us that shifts were not left unfilled if there was short term absence but there were instances in the staffing data where some staff had worked longer to cover and in one case a day shift had been covered by a family member. In care records we saw arrangements where escalation arrangements for staff who became aware that the next shift was not covered were to try to contact other core team members, then on call managers, then the commissioner. In practice, we saw records where staff had stayed but this caused stress and anxiety for them in terms of their own circumstances.

The provider was aware of these shortages and told us they had continued to recruit staff but there had been difficulties during the recent pandemic, including staff being recruited who had been unable to continue to work due to school closures or unexpected caring responsibilities.

On one occasion in May a member of staff had worked overnight for over 13 hours before returning less than 11 hours later for the next night shift. In June 2021 one member of staff had worked for over 16 hours and another for 20 hours in a 24 hour period. On three occasions, staff were rostered onto training between shifts which meant they worked for too long. In May 2021 one staff member had worked a 14 hour waking night shift with a two hour break before three hours of training. Another member of staff in June 2021 had worked a 12 hour night shift, was booked for 6 hours training, then returned to the patients home for a further 5 hours, equalling 23 hours worked with a one hour break. In July 2021, a new starter had worked a 13 hour night shift, then attended training for 8 hours, then after a three hour break had completed a further 13 hour night shift.

Inadequate

Community health services for adults

We checked seven recruitment and personnel records. Checks were in place including references and disclosure and barring service checks. In four records, there was no interview record or notes.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had one full time nurse clinical lead and another nurse had recently started. Nursing responsibilities were to assess care packages, complete risk assessments and care plans, train staff in aspects of the care packages, assess competencies on site and to oversee medicines management, including training and audit. They were also on call out of office hours.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The service used an electronic records system. At each individual home, staff were able to access the system using computer tablets. Records could be updated throughout the day as care was delivered. A back up paper file of care plans and important documents was also stored on site and kept up to date in case of difficulties.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Medicines were prescribed by the patients GP. Medicines administration records were incorporated into the records system. These could be reviewed remotely by managers and the clinical lead audited these regularly for any issues/ errors.

The clinical lead liaised with GP's for any medicines changes.

Staff completed medicines competency training online and as part of training for specific packages.

During home visits, we saw that medicines were stored securely.

Incidents

The provider did not have an incident reporting procedure and processes for staff which enabled the incidents to be monitored across all the services. They did not review and learn from incidents.

Incidents were recorded within the electronic records system for the individual patient concerned. Incidents were noted in some of the team meeting minutes that we reviewed. These were reviewed within specific teams where the incident had occurred. It was not clear how learning from an incident in one part of the service was shared with other teams.

Inadequate

Community health services for adults

The service did not have data relating to incidents in the last twelve months and did not have an incident reporting policy or guidance for staff.

Following inspection, the service notified us of an incident relating to specific practical training which should have been delivered as part of a care package several months ago and which had just come to light. There had been no impact to the patient involved, however there was a significant risk of avoidable harm. The service had investigated and instigated a disciplinary process within one week however there was no evidence which could be provided to us which evidenced that the incident was investigated, and lessons learned noted. The investigation report and findings were requested from the provider but not received. This meant that there was a lack of learning from serious incidents to reduce the risk of this issue recurring in the future.

Safety Performance

The service was not routinely collecting or publishing data relating to safety performance.

Are Community health services for adults effective?

Requires Improvement

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

We reviewed five care and treatment records. Care plans were well written and reflected good practice guidance. Care plans also included up to date plans from other professionals involved in care, including tissue viability nurses, speech and language therapists, dieticians and respiratory specialists.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They used special feeding and hydration techniques when necessary. They worked with other agencies to support patients who could not cook or feed themselves.

The service had a nutritional and hydration needs policy, which referenced the National Institute for Health and Care Excellence guidance for nutrition support in adults. Patients nutritional needs were clearly documented in care plans. Care plans were devised with community dieticians or speech and language therapists where needed.

We reviewed care plans for patients receiving feeds via percutaneous endoscopic gastrostomy. Care plans were detailed in terms of how staff should ensure cleanliness of the site and how feeds should be delivered.

Care records which we reviewed showed notes of food and fluid intake, including details of amount of food and fluid and type.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff followed care plans outlining conditions which may cause pain, pain relief prescribed regularly and on an as needed basis and also alternative strategies which may alleviate pain, for example, in terms of alternative positioning.

Patient outcomes

There were no outcome measures used in the service. However, care was regularly reviewed and care plans and risk assessments updated as a result. Regular reviews and updates took place with patient's care co-ordinators to review care packages and make changes if needed.

Competent staff

Managers did not appraise staff's work performance and did not hold regular supervision meetings with them to provide support and development.

Supervision was not taking place regularly. The organisation supervision policy did not stipulate a frequency for supervision and centred around more clinical and case based supervision. There was reference to supervision being distinct from managerial processes not being used to assess performance or competence and that this should be dealt with separately using the disciplinary mechanism.

Managers told us staff initial supervision session was at six weeks and then every 12 weeks. In five files which we reviewed, two had no supervision records at all, one had records from 2019, one had two supervision records nine months apart and one had two records from 2021.

A weekly report was compiled from the people planner system showing when supervision was due, care certificate completion dates, probation dates and spot visits done. The most recent July report showed half the staff were overdue for supervision. There were 14 spot visits overdue, which meant these staff had not seen a manager for over three months.

Appraisals were not taking place for staff. In the five records reviewed, two had an appraisal completed within the last 12 months, one had been started, one was completed over 12 months ago and one file did not contain an appraisal.

The provider has made changes since inspection, including plans to appraise staff more regularly moving forward and reschedule where sessions have been adjourned. Spot checks will be completed by managers. The supervision policy will be updated.

Staff met regularly in teams to discuss patient care. The service also used an electronic system to keep up to date with staff, send news and encourage communication for staff.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Inadequate

Community health services for adults

Records showed there was good communication with other agencies involved in care, including other health professionals, GP's and specialist services. Regular feedback and communication took place with commissioners and care co-ordinators.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported people to make informed decisions about their care and treatment. They knew how to support people who lacked capacity to make their own decisions or were experiencing mental ill health.

Care records showed that staff offered patients choices wherever possible, assisted them to make choices and respected patients' rights to refuse interventions or to change plans. It was clear that staff understood capacity and consent principles.

The service had a policy outlining both the Mental Capacity Act and associated legislation, and covering principles of consent.

Following inspection, the provider sent updated figures showing 88% of staff had completed this training.

Are Community health services for adults caring?

Requires Improvement

Compassionate care

Not all staff delivering care to patients, treated them with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We undertook three home visits. One carer fed back about some staff ignoring some of their relative's requests and some staff not listening. Another carer fed back that some staff told their relative off and spoke at them rather than to them.

There were few methods of service users and their families being able to offer feedback to the service about their care. The provider sent feedback forms to patients and families every six months. We saw that these were completed and action plans developed by the service.

Staff were able to give thorough and detailed explanations of the care planned and showed good understanding of patient's individual needs.

Care plans were person centred and individualised, showing good awareness of patient's wishes and preferences.

Understanding and involvement of patients and those close to them

The engagement and communication with carers could be improved.

Inadequate

Community health services for adults

We spoke to eight carers at home visits and over the phone following inspection. All carers gave positive feedback about the core staff who delivered care to their loved ones.

Some carers gave specific examples of good care provided, including staff who had accompanied them on holidays and staff who had arranged shifts around activities and events to ensure patients could be involved.

Carers gave mixed feedback about their involvement in recruitment of staff, with some feeling fully involved in recruitment and interviews, others being involved but their feedback not acted on and some not involved at all.

Some carers mentioned that there was a lot of change with new staff starting, who were not always well prepared. The provider told us they arranged for new starters to shadow and observe to begin with. Managers said staff did not work independently unless they were fully clinically competent. Some carers said staff rotas changed at short notice so carers and patients did not know who was coming for shifts.

Some carers told us that managers were easily contactable, they received feedback regularly and that they were aware of how to raise concerns. However some carers told us they found it difficult to contact managers, that they felt communication was poor and they did not know the process to complain.

Are Community health services for adults responsive?

Requires Improvement

Planning and delivering services which meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service planned care packages along with patients and commissioners to meet individual needs. Staff, including clinical nurses, developed links with specialist services in the areas that patients lived in, to ensure access to equipment or training needed.

Meeting the needs of people in vulnerable circumstances

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Each package was planned in terms of staff needed who were then recruited according to those needs. This could also include, for example, recruiting staff who spoke particular languages. Once staff were recruited, training was arranged which included specific conditions and needs of the patient and practical skills training which was bespoke for each care package.

Access to the right care at the right time

People could access the service when they needed it and received the right care in a timely way.

Inadequate

Community health services for adults

The service told us they had never had shifts unfilled as a result of staff sickness or absence. Carers told us of two instances where this had been the case. We could see from rotas reviewed at the service that staff covered for each other or when there was short term absence.

Learning from complaints and concerns

The service did not always follow its own complaint process in terms of using its formal process where needed.

The service had a policy for how complaints would be managed. We reviewed one recent complaint, noting that the policy was not followed in terms of actions being taken by phone and that a written outcome was not provided. The registered manager noted that complaints were generally informal and dealt with as they were raised, however these were not recorded.

Feedback from carers was mixed, with some carers saying any concerns they had could be raised with staff or managers, but some saying their complaints were not acknowledged.

The service used compliment data and feedback on their website, with permission obtained to use these. However the current information on the website includes two employee testimonials who are not current members of staff and one previous patient's feedback and it is unclear how long ago this feedback was given.

Are Community health services for adults well-led?

Inadequate

We issued the provider with a warning notice. This means that the rating for this key question is limited to inadequate.

The service operates as separate teams and care packages, with oversight from managers. There was limited oversight of the service as a whole and a lack of systems or processes to monitor risks and provide assurance.

Leadership

Some senior leaders had the skills and abilities to run the service although this did not include the senior health care assistants who needed more development to carry out their role.

The registered manager had managed similar services previously. They were supported by two operational managers who managed a number of care packages and staff. They were responsible for day to day staffing and supervision and along with clinical managers they were responsible for ensuring care packages were delivered.

Whilst we saw that care staff could progress to become senior health care assistants we had concerns that these senior care staff were expected to take on responsibilities that they were not suitably trained or experienced for. This included delivery of supervision, management and training of other care staff.

Inadequate

Community health services for adults

The job description for senior health care assistants included maintaining all documentation, stock checks, devising staffing rotas, quarterly spot checks, regular supervision of health care assistants, new starter shadowing/training/induction, completing audits, arranging appointments and liaising with professionals, arranging team meetings and completing necessary risk assessments. There was no evidence that training or support was in place for all these additional responsibilities.

Managers were not always visible and approachable in the service for patients and staff. There was mixed feedback from carers and staff about the visibility and approachability of managers. We acknowledge the pandemic has posed a unique set of challenges and circumstances to providers, meaning that the traditional ways of monitoring the service, such as spot checks could not always be carried out. However, we found that the governance and monitoring systems in place were not effective.

Vision and Strategy

The service had a vision to provide high quality complex care for patients. Some staff referred to the vision and values within their feedback. The registered manager told us they had no current expansion plans and were keen to consolidate their current care services and packages.

Culture

We asked all staff for feedback during this inspection and 10 staff submitted feedback via email or webform.

Most staff gave positive feedback about the care they provided, the support from managers and being proud of the care they provided.

The service also collected feedback from staff, which was then incorporated into a report for the care package that staff worked within, with actions added by managers or clinical staff. This did not always capture or address all issues raised, particularly where individual issues were raised.

The most recent feedback forms had been collated to give statistics across the service. Across ten questions most questions were answered positively by staff. Over half the staff surveyed suggested they found their role stressful and the service planned to potentially address this in one to one discussions or appraisals. However, these were not regularly taking place. Narrative responses to this question in forms suggested there were specific systemic issues around staffing which were not being addressed by leaders.

Themes within staff feedback were related to staffing issues, including being unable to take leave, working excessive hours, lack of contingency or additional staff and stress related to staff cover and rotas. Where staff identified their role as stressful, this was often linked to concerns about rotas and working hours. Some staff also highlighted communication themes, including seeing more of managers, regular meetings and more regular visits.

We noted several previous feedback forms with individual issues raised where staff had subsequently left the service. The provider told us that since inspection, feedback is now actioned on an individual basis and a written response is provided to all feedback received.

Governance

Leaders did not operate effective governance processes.

Inadequate

Community health services for adults

The company structure consisted of the registered manager and company director, managing two operational managers, clinical/nursing staff, a head of business development and a compliance officer. We asked the service to provide job descriptions for the leadership team but did not receive these for operational managers or the compliance officer. Both operational managers had originally worked as healthcare assistants and been promoted and there was no job description or interview notes in their personnel files. There were not clear lines of responsibility for managers and senior staff.

Leaders held governance meetings, however these did not take place regularly. We reviewed the last four governance meeting minutes. These had taken place over the last 12 months, in July 2020, January 2021, March 2021 and June 2021. The meeting in July 2020 was structured by the registered manager with actions for managers to complete in relation to team meetings, auditing, policies and safeguarding. It was not clear how these would be monitored and there was then a six month gap before the management team met formally again. At each meeting actions from the last meeting were not reviewed and new actions were decided. The meeting minutes from March 2021 include reference to a more regular targeted meeting being set up but this does not appear to have been addressed. In the meeting minutes we reviewed, we noted that when the registered manager made decisions these were not always followed up and decision changed between meetings. For example the registered manager had discussed an organisational process to escalate concerns from carers to prevent them coming directly to the registered manager. This had not taken place.

Staff meetings took place within each care package and centred on the care of the patient and any issues with this. There were no discussions about the wider service or company, or information from other packages in the form of learning, incidents etc. There was no service wide staff meeting. Staff used an internet based system to communicate rather than emails and the registered manager told us this would be used to communicate news across the company.

In recruitment files, there were not always records of interviews. Recruitment processes did not provide assurance that candidates were fit, competent and skilled for the roles employed. Disclosure and barring checks took place on initial appointment, but there was no system to update these.

Staff had raised concerns in routine feedback forms about pay and conditions, contingency staff, shift preferences, inability to take leave or leave being cancelled. These were not addressed. Similarly, exit interviews were not completed when staff left. This meant that the service were unable to improve staff retention.

Staff were rostered to shifts which were sometimes extended to cover for absence. The number of shifts where this happened was not collected or reported. The service told us that shifts were not left unfilled if there was short term absence but there were instances in the staffing data where some staff had worked longer to cover and in one case a day shift had been covered by a family member. We saw occasions where staff were working excessive hours without breaks. Sometimes this was because staff were expected to attend training following their shift. Sickness and absence were not monitored and effective contingencies were not in place.

When a new training system started, the service set an eight week period for staff to complete new training and update previous training. We inspected seven weeks after this period started and training figures, particularly for new modules, were low. This was not being managed.

Carer feedback suggested that some families and carers experienced a different service than others, with poor communication and difficulties contacting the service, and it was not clear why this was the case. Similarly, some staff had feedback that they did not feel supported sufficiently and suggested improvements, which were not always addressed.

Inadequate

Community health services for adults

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify or escalate relevant risks and issues and did not identify actions to reduce their impact.

The service had no risk register or similar to identify and highlight risks to the service and plan mitigations, for example, relating to staffing recruitment and retention.

There were few systems to track actions and monitor progress, for example in relation to safeguarding cases. A weekly report was compiled from the people planner system showing when supervision was due, care certificate completion dates, probation dates and spot visits done. The most recent July report showed half the staff were overdue for supervision. There were 14 spot visits overdue, which meant these staff had not seen a manager for over three months. The report did alert managers when staff were approaching overdue, but this was not acted on in the reports we reviewed.

Information was often collected at the level of each care package, for example, staff clinical competencies. There was no system to be able to check quickly which staff were competent in a particular area of care.

Information Management

Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service predominantly used two electronic systems, a clinical system and a staffing system. Data could be gathered from these systems to assist in overseeing the service, but this was not routinely completed with the exception of medicines audits. Some systems were not being used efficiently to provide data, for example, information collected relating to staff leavers in the last year showed 48 staff leavers reasons for leaving as “other” despite categories built into the system and the ability to add information.

Performance data was not incorporated or discussed within the senior management team meetings. The governance meetings appeared to be led by the registered manager with issues identified and discussed on the day rather that planned in advance with contributions/concerns invited.

Data or notifications were consistently submitted to external organisations as required.

The service sent weekly clinical updates to commissioners. Statutory notifications were sent to CQC as required.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance