Solution2care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Solution2Care is a domiciliary care agency providing personal and nursing care to people living in their own homes. The service provides support to children and adults with complex healthcare needs, as well as people living with dementia and people with learning disabilities and or autism. At the time of our inspection there were 62 people using the service including 14 children.
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
Right Support
One person was having restrictive interventions used without adequate assessment or training. This left the person at risk of inappropriate restraint. Some incidents and concerns which needed to be communicated to the local safeguarding authority and CQC had not been recognised as safeguarding concerns. Therefore, they had not been communicated to other agencies appropriately and not always fully investigated. Some risk assessments lacked detailed guidance for staff on how to support people with specific care needs. Staff we spoke with were, however, knowledgeable about people's care needs. People were supported by adequate numbers of staff. Where possible care calls were made by the same staff to enable them to develop a detailed knowledge of how the person wanted to be supported.

Right Care
Some people's care records did not contain much information about their cultural needs. However, the staff we spoke with knew people well. Two people told us they did not know they had care plans. One said they would need assistance to read the care plan, and this had not been offered. Staff had received training in safeguarding adults and children and policies and procedures were in place. These were not always followed. This meant the management team could not demonstrate they had done everything they could to ensure people were protected from the risk of abuse and future risk.

Right Culture
Systems to investigate and analyse incidents for learning opportunities were not always effective. Some incidents were not being recorded and analysed. This meant learning to prevent future risk and improve care was limited. Systems to investigate and address complaints had not always done so effectively. Some complaints had not been formally investigated. Formal apologies to people and relatives had not always been made when things had gone wrong. This meant opportunities to learn from complaints could have been lost and the learning culture was not as open as it could be. Staff told us they felt supported by the management team and they felt the induction was helpful in preparing them for their role.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 03 August 2022).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of neglect. This inspection examined those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. At this inspection we found the provider was in breach of regulations.

You can see what action we have asked the provider to take at the end of this full report. The provider has agreed to review policies and procedures to ensure practice is effective and in line with regulatory requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Solution2care Limited on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the systems in place to protect people and ensure safe treatment and care, how complaints were investigated and responded to and the oversight and management of governance systems at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not always well-led.

Details are in our well-led findings below.

Solution2care Services Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was completed by 1 inspector and a Nurse Specialist Advisor.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the registered manager would be in the office to support the inspection.

What we did before the inspection

We reviewed the information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people about their experience and views of the service. We spoke with 5 relatives about their experience of care provided. We spoke with 8 staff including the registered manager and clinical lead, a senior carer and carers. We reviewed a range of records. These included 8 people's care records and 4 medication records. We looked at 2 staff files in relation to recruitment and staff supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
- Monitoring of safety and assessment of risk was not always robust.
- A risk assessment had failed to identify the inappropriate use of restrictive intervention for 1 person. The risk assessment had identified a risk and specified a restrictive intervention which could be used as needed. However, the risk assessment also stated the person should not be subject to any physical restraint. The management team had failed to recognise the restrictive intervention being used was a form of restraint.
- The risk management process had failed to appropriately assess the person for the possible need to use physical intervention.
- An incident monitoring process was in place but was not being used to record episodes of physical intervention. This meant these episodes were not subject to analysis and review which could promote learning for staff and possibly reduce the need for restrictive intervention.
- Guidance and training for staff lacked sufficient detail to help them support the person at times of risk effectively. This left the person at risk of avoidable harm.

Risk assessment and safety monitoring had failed to ensure the adequate assessment of risk and the possible need for restrictive intervention. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A referral to the local authority safeguarding team by the Inspector was made regarding the risk to this person. The registered manager gave assurance they would work with the local authority to review the risk.

Systems and processes to safeguard people from the risk of abuse
- Although systems were in place to monitor and assess risk, they had not always enabled staff to identify and fully act upon possible risks of abuse. Some incidents which required investigation to determine whether abuse had occurred had not been shared with the local authority safeguarding team. These incidents had not resulted in anyone being harmed but risks to people had not always been fully explored or mitigated.
- Staff had received training in how to recognise and report abuse. However, the registered manager was not clear about how to apply this. They had not always identified incidents which required full investigation and referral to the local authority safeguarding team. For example where there had been a near miss and a person had been at risk of harm but not actually harmed, the need to consider this formally as an incident had not been identified.
- Staff told us they knew where the safeguarding policies for children and adults were. The policies correctly outlined how to identify risk of abuse to people. However, in practice this guidance had not always been

followed.

Learning lessons when things go wrong
● Incidents were not always recorded and analysed effectively. For example, a complaint raised about poor manual handling practice was not fully investigated and shared with the local authority safeguarding team.
● The registered manager was not always clear about what defined an incident. This resulted in some concerns being investigated fully whilst others were not.
● Opportunities to learn were missed because the information gathered to feed into the systems was insufficient. For example, a complaint one person had made about staff conduct was not investigated formally. The management team therefore failed to identify a second person had made a very similar complaint, which had been investigated and recorded in the complaints/ safeguarding log. This meant the opportunity to identify a possible trend was missed.

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

● We found the service was working within the principles of the MCA.
● Documentation about people's ability to make decisions for themselves was not always very clear. However, staff knew about people's capacity to make decisions through verbal and non-verbal means.
● Staff told us about how they respected people's right to refuse treatment. They also told us they had received training in the MCA and how to apply it to support people's decision making.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely. Some people told us carers had been running out of gloves. One person told us they had been giving carers gloves from their own supply. We discussed this with the registered manager who told us they would look into the issue.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was supporting people to minimise the spread of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment
● People were supported by sufficient numbers of staff. The management team endeavoured to provide consistent carers for people to enable better knowledge of their needs. People and relatives told us in practice the staff did change but when the staff team was regular this was their preference. One person told us; "I usually know 1 of my carers."
● Staff recruitment processes were robust, and checks were made to ensure candidates were suitable for the caring role. This included the use of Disclosure and Barring Service (DBS) checks. These provide information including details about convictions and cautions held on the Police National Computer. The

information helps employers make safer recruitment decisions. It also included checking visas where applicable for staff recruited from overseas.
● Staff induction promoted safety. Inductions were tailored to the needs of the people staff were designated to support. Staff told us they felt the induction process was effective and helped prepare them for the role. One staff member told us, "Induction was very good."

Using medicines safely
● People were supported to take their medicines safely.
● An electronic medicines management system was being introduced. The clinical lead explained this allowed better oversight of medicines administration.
● Staff received training to ensure they could support people to take their medicines safely. Their competency in this was assessed as part of spot checks of carers.
● Guidance for staff was clear for the use of 'as needed' PRN medicines.
● Guidance for staff on the use of creams was clear and records showed these were applied as needed.
● People's care plans gave details about how they wanted to be supported to take their medicines.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- Systems to investigate and act on complaints were not robust. Some complaints people told us about had not been recorded in the complaints/safeguarding log. This meant they were not included in the analysis to help identify patterns and trends.
- A relative told us the management team had not responded to complaints they had raised. They also said they had not received a written outcome of an internal investigation into their complaint. A person receiving care told us they had raised complaints about a carer's conduct and nothing had changed as a result.
- A complaints policy and procedure was in place, but was not being followed in practice by the management team. Some people's complaints were not responded to in a way which explained what steps the service had taken to investigate the concerns or how they could be mitigated in the future.
- Formal apologies had not always been provided to people and relatives when things had gone wrong.

Systems to investigate and act upon complaints were not robust. This meant complaints were not always fully investigated and people did not always receive clear outcomes to their concerns. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Systems were in place to share lessons learned when things had gone wrong. For example, there were regular staff meetings. However, failure to recognise some incidents and safeguarding concerns or investigate them fully meant some learning opportunities were lost.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager and provider had failed in their legal duty to notify CQC of some notifiable incidents.
- A review of policies and procedures had failed to identify the main definition of restrictive intervention in the associated policy was not fully accurate. Restrictive intervention was referred to as physical intervention and was defined as 'the use of force to restrict or restraint movement or mobility.' However, restriction is not defined in the 2015 Mental Health Act code of practice as always requiring force. The registered manager was unable to demonstrate a full understanding of what can be defined as restrictive practice. This had contributed to confusion in the guidance for staff on restrictive practice and left a person at risk of inappropriate restraint.
- Systems to monitor the quality of risk assessments and care records had not enabled the registered

manager and provider to identify all potential incidents of abuse and neglect and identify gaps in guidance for staff in some key areas. For example, 1 person's file lacked guidance for staff on how to support a person's mobility needs. Another file lacked guidance on percutaneous endoscopic gastrostomy (PEG) care. When we spoke with staff they had a good knowledge of these areas. However, the safety of relying on staff knowledge creates potential risk in situations such as extreme weather conditions which can result in the need for unfamiliar staff.

Systems to ensure the quality of performance and compliance with regulatory requirements had not consistently enabled the registered manager and provider to identify failings in safety and risk management and mitigation. This was a breach of regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they would review the restrictive intervention policy. They also advised they were working on updating care records to provide more detailed guidance for staff in areas such as mobility needs.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The culture of the service was not always open. Information was not always shared appropriately with other agencies to ensure robust investigation and provide effective learning opportunities.

● Staff told us they felt able to raise concerns with the management team. They described the management team as approachable. However, there was a failure to recognise and respond appropriately in some cases to complaints. This meant people and their relatives concerns were not always able to contribute effectively to service improvement plans and lessons learned.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Some people's care records contained limited information about how the needs defined by their equality characteristics could be met. For example, in some files there was limited or no information about people's religious or spiritual needs.

● Two people told us they did not know they had a care plan. One person commented due to a disability, they would need help to read the care plan, but this help had not been offered. We spoke with the registered manager about this. They stated everyone receiving care does have a care plan. They also said the person could be helped by staff to read their care plan.

● We saw satisfaction surveys which had been designed to seek feedback from people receiving care. Information from people's responses had been summarised for analysis.

● We saw staff satisfaction surveys which also contained summarised information for analysis.

Working in partnership with others

● Liaison with the local authority safeguarding team had not always been initiated when it was necessary.

● We saw evidence of the service working with other health professionals and agencies to provide care people needed. These included GP surgeries, Occupational health and district nurses.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems to investigate and act upon complaints were not robust. This meant complaints were not always fully investigated and people did not always receive clear outcomes to their concerns.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessment and safety monitoring had failed to ensure the adequate assessment of risk and the possible need for physical restraint.

The enforcement action we took:

We served a warning notice explaining why the provider was failing to meet this regulation. We requested a response from the provider to evidence how they could ensure the regulation would be met.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure the quality of performance and compliance with regulatory requirements had not enabled staff to identify failings in safety and risk management and mitigation.

The enforcement action we took:

We served a warning notice explaining why the provider was failing to meet this regulation. We requested a response from the provider to evidence how they could ensure the regulation would be met.