RockSolid 247 Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
RockSolid247 Limited is a domiciliary care service providing personal care to children in their own homes. At the time of the inspection two children received personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The assessment and management of risk was inadequate. Whilst staff told us they knew how to keep the children they cared for safe, assessments of children's needs were not completed before they started using the service. Risks relating to the safety, health and welfare of children had not been assessed by the provider. Therefore, guidance and instructions to help staff manage risks was not in place at the time of the inspection. The director and staff relied solely on the information provided to them by the local authority to manage and mitigate risks. The director could not assure themselves the service provided was safe.

Risks associated with COVID-19 had not been assessed. National infection prevention and control guidance was not followed which placed both children and staff at risk. Staff had not completed infection prevention and control or basic first aid training to help them provide safe care. Staff had received training to help them protect children from the risk of abuse. The director understood their role in protecting children and knew how to escalate any concerns to ensure they were investigated.

Staff were recruited safely. Enough staff were employed to meet children's needs and relatives told us they had confidence in the ability of staff. However, the organisations staff induction did not reflect nationally recognised induction standards.

Leadership at the service needed to be strengthened and improved. The registered manager had not been at work since May 2021 and the director had taken over the responsibility for running the service in their absence. The director was open and honest about the challenges the registered managers absence had caused and how their absence had impacted on the service.

Whilst the director spoke passionately about providing a caring service, the individual characteristics of children including their emotional needs had not been assessed. Furthermore, children and their families had not been involved in planning and making decisions about the care provided by RockSolid 247.

Relatives felt staff were kind and respectful. Whilst staff knew the children they cared for well care records were not in place to help them provide personalised and responsive care. Staff understood how children preferred to communicate. However, we found children's communication needs had not been assessed and consideration had not been given to make information available in a format that met children's and their

families communication needs. Whilst staff felt supported and spoke positively about the director more needed to be done to improve communication and engage with children and their families to promote an inclusive and empowering culture.

The director was responsible for running the service but lacked understanding of regulatory requirements. They had failed to operate systems or processes to assess, monitor and improve the quality and safety of the service provided. Audits and checks did not take place and the system used to gather feedback about the service from children and their families was ineffective.

The lack of robust governance had resulted in the failure to identify the issues that we found. A relative told us they did not know how to make a complaint about the service because the providers complaints policy had not been shared with them. That meant opportunities to learn lessons and drive forward improvement could have been missed.

The director welcomed our inspection and they were responsive to our feedback. During and following our visit they took a variety of immediate actions to address the shortfalls we had identified. We acknowledged the director's commitment to making improvements to benefit children.

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

Rating at last inspection
This service was registered with us on 20/08/2019 and this is the first inspection.

Why we inspected
This was a planned inspection of this newly registered service.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, person centred care, staffing and good governance.

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 continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led Details are in our well-led findings below.	**Inadequate**

RockSolid 247 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 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

Inspection team
The inspection was carried out by three inspectors.

Service and service type
RockSolid 247 Limited is a domiciliary care agency. It provides personal care to children living in their own homes. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager who was also the nominated individual had not been at work since May 2021. In their absence the director was solely responsible for running and managing the service.

Notice of inspection
This inspection was announced. We gave the director short notice of the inspection. This was because it is a small service and we needed to be sure that the director would be in the office to support the inspection. Inspection activity started on 08 September 2021 and ended on 14 September 2021. We visited the office location on 13 September 2021.

What we did before the inspection
We reviewed the information we had received about the service since registration. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also gathered feedback from the local authority who fund the care provided. We used all of this information to plan our inspection.

During the inspection
We spoke via telephone with one child's relatives and five staff members to gather their experiences of the service provided. We spoke with the director during our site visit and we reviewed a range of records including staff training data and a selection of the providers policies and procedures. We reviewed the recruitment records of two staff to check they had been recruited safely.

After the inspection
We received information via email and continued to seek clarification from the director to validate evidence found. We shared our inspection findings with local authority commissioners.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant children were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- A COVID-19 staff testing programme in line with the Department of Health and Social Care guidance was not in place. One staff member said, "I test myself, but no, I don't think there is a schedule of testing." The director was unable to explain why a testing programme was not in place. This placed children at risk of harm as regular testing of staff helps to prevent and control the spread of coronavirus.
- Staff had not completed infection prevention and control training to help them provide safe care and protect themselves and others from the risk of infection.
- Two staff members told us they were not always provided with and did not always use personal protective equipment (PPE) when they provided personal care. This was unsafe and placed children at risk. The director told us, "I used to provide it (PPE), we have stocks of it but some [staff] buy their own."
- The director was unaware of the guidance that needed to be followed to manage risks associated with COVID-19. The individual characteristics of staff including staff from Black, Asian and Ethnic Minority groups (BAME) had not been assessed to ensure staff were kept as safe as possible at work during the Coronavirus pandemic.

We found no evidence that children had been harmed however they were at risk because the provider did not follow or meet national guidance in relation to infection control. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our visit, information we received from the director confirmed the immediate actions taken in response to our inspection feedback. Those actions had significantly improved the prevention and control of infection. This included the implementation of a COVID-19 staff testing programme and the completion of infection prevention and control training.
- Despite our findings a relative told us staff wore PPE when they visited their home to provide care to their family member.

Assessing risk, safety monitoring and management

- Risks relating to the safety, health and welfare of children had not been assessed and risk management plans were not in place. Staff and the director told us they relied on the information provided to them by the local authority to manage risks. This was a significant concern to us as children displayed behaviours that could cause harm to themselves or others. This shortfall had been identified by local authority commissioners in May 2021. Remedial action to improve safety had not been taken.
- A contingency plan was not in place. That meant the director was unprepared and was unable demonstrate what they would do in the event of an emergency or an unforeseen event such as, adverse weather.

We found no evidence that children had been harmed however staff did not have the information they needed to provide safe care. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In the days following our visit we received information which confirmed immediate actions had been taken in response to our feedback. This action included the completion of risk assessments that were shared with staff and a contingency plan was put into place to improve safety.

Systems and processes to safeguard people from the risk of abuse
● Staff had completed training to protect children from the risk of abuse. Staff understood the different types of abuse that children could experience. One staff member said, "Physical, financial, neglect. I would report anything that indicated harm straight away to (Director) they would inform the relevant authorities."
● The director understood their role in protecting children and knew how to escalate any concerns to the appropriate authorities to ensure concerns were correctly investigated.
● A relative felt their family member was safe with staff. They commented, "No, worries about safety." However, information had not been provided to children and their relatives to tell them how to report concerns about harm or abuse. Immediate action was taken by the director to address this shortfall.

Learning lessons when things go wrong
● The lack of managerial oversight meant areas needing improvement had not been identified. Furthermore, some areas requiring improvement had been identified by local authority commissioners' in May 2021. We found sufficient action had not been taken which meant opportunities to drive forward improvement had been missed.
● Staff told us they would report accidents or incidents. Whilst the director told us no accidents or incidents had occurred a system was not in place to monitor, manage and reflect on incidents to prevent reoccurrence.

Staffing and recruitment
● Staff were recruited safely, and enough staff were employed to meet children's needs.
● A relative told us staff arrived when they were expected and stayed for the correct duration of the scheduled call.

Using medicines safely
● At the time of our visit staff did not support any children to take their medicines.
● The director understood their staff would need to complete training in safe medicines management before they could administer any medicines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not received all of the training they needed to be effective in their roles. This included training in communication, basic first aid and infection prevention and control. Discussion with the director confirmed the provider relied upon some training provided by their staff members previous employers.
- Mandatory training the provider considered essential, for staff, had not been defined and we received mixed feedback when we asked staff about their training. One staff member said, "Well, I get sent information and the manager sent me a booklet about autism and learning disabilities. I read it, and they told me that was training." In contrast another told us their training helped them do their job well.
- Observations or checks of staff practice did not take place. Therefore, the director could not assure themselves staff were competent and worked in line with their expectations to ensure good outcomes for children were achieved.
- The staff induction did not reflect nationally recognised induction standards and staff told us their induction had consisted of a discussion with the director. Two staff members told us they had not had opportunities to shadow more experienced staff before they had supported children unsupervised. One staff member commented, "I did feel a bit unprepared, but it wasn't a problem. I soon settled into it."
- The director did not have oversight of the training staff had completed. Training records we viewed were not up to date. For example, one staff member who had started work in July 2021 was not listed on the training matrix during our visit two months later.

We found no evidence that children had been harmed however they were at risk because staff were not always suitably trained to carry out their roles. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite our findings a relative told us they had confidence in the ability of staff. They said, "They (staff) must be trained; they know what to do. We are very grateful for their help."
- Staff told us they received guidance through monthly individual meetings with the director.
- Following our visit, the director sent us information which demonstrated the actions they had taken in response to our findings. Actions included observations of staff practice taking place and the completion of basic first aid training.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care

- Whist the director provided examples of how they worked closely with other agencies including social

workers to ensure children received the care and support they needed assessments of children's needs were not completed by the provider before the service started.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the 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.

● At the time of our inspection care and support was only provided to children. As the Mental Capacity Act 2005 (MCA) applies to people aged 16 and over the legislation was not applicable during this inspection.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support;
● Staff told us they knew what children liked to eat and drink and encouraged them to eat a nutritionally balanced diet to maintain their health. However, risks associated with eating and drinking had not been assessed and were not documented. The director took immediate action to address this shortfall.
● Staff understood their responsibility to obtain further advice or support if they noticed any signs of illness in children.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- The individual characteristics of children including their emotional needs had not been considered or assessed. The importance of ensuring staff had the skills and knowledge they needed to provide compassionate and safe support was not fully understood.
- Whilst staff told us they offered children daily choices such as, what they wanted to eat children and their families had not been involved in planning and making decisions about the care provided to them by RockSolid247. Following our visit, the director did visit children and their families to start to involve them in care planning.
- The director provided examples of how they aimed to meet their responsibilities under the requirements of The Equality Act 2010. However, more needed to be done to ensure staff embraced and encouraged equality and diversity. Action was being taken to drive forward improvement in this area.
- Relatives spoke positively about the staff. One said, "We have two regular carers. Both know [name] well. Very good with them, know how to work with them."

Respecting and promoting people's privacy, dignity and independence

- Relatives confirmed staff were respectful. One relative said, "They (staff) are kind and polite. They have very nice behaviour."
- Staff told us how they promoted independence and supported child development. One staff member explained how the support they had provided had resulted in one child being able to walk which was a big achievement. The staff member said, "One child wasn't walking when we started, and we have helped them to learn to walk."
- Staff described how they maintained children's dignity. This included supporting children with their personal care in private rooms with the door shut.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs

- Care records were not in place to help staff provide person-centred care in line with children's needs and wishes. A relative told us they had not seen a care plan and went on to say, "Everything is done through social services, they sort it all out, they are our only point of contact."
- We asked the director why care records were not in place. They explained they didn't think they needed to be in place because they used the information provided to them by social services. That meant the provider had failed to ensure the care they provided met children's needs and reflected their preferences.
- When discussing the importance of having care records in place the director said, "I understand, I know what you mean now. We need to use our own paperwork."

We found no evidence that children had been harmed however the provider had failed to ensure children received appropriate person-centred care that met their needs. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care plans were completed by the director and were shared with staff, children and their relatives shortly after our visit.
- Relatives told us care was provided by regular care staff. Staff rotas we viewed confirmed this. One relative said, "Needs are met, they (staff) know how to calm [name] down. They take [name] to the park and to indoor play centres. Carers are quite flexible in their approach and will take [name]them wherever they want to go, usually the park on the swings."
- Records of the care they provided were completed by staff. Those records were reviewed by the director and were also shared with social workers to demonstrate what care had been provided.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The director was not aware of the AIS at the time of our inspection and consideration had not been given to making information accessible in different formats, such as pictures or easy read print. The director took immediate action following our visit to make improvements in this area.
- Children's communication needs had not been assessed by the provider. This was of signifignat concern to us as one child did not use speech to communicate. However, staff told us they knew how children preferred to communicate and what their behaviours and gestures meant. One staff member said, "If you see [name] hitting their head with their hands you know they are tired. I am familiar with [names]

expressions so I understand, some communication training would be beneficial though."

Improving care quality in response to complaints or concerns

● A relative told us they did not have a telephone number for RockSolid247 and that meant they did not know how to complain directly to the service. They said, "I would go through social services." Whilst the director told us no complaints had been received since registering with CQC in 2019 copies of the providers complaints policy had not been provided to children or their families. This shortfall was addressed immediately after our visit.

● We reviewed the providers complaints policy and it included information about how to make a complaint and what people could expect to happen if they raised a concern.

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.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements ; Continuous learning and improving 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

- The registered manager was also the nominated individual for the service. However, they had not been at work since May 2021. In their absence the director was responsible for the day to day running and management of the service.
- The director was honest about the challenges they had faced and how the registered managers absence had impacted on the service provided. Following our visit, they told us of their plans to strengthen leadership which included obtaining support and guidance from people they knew who worked in the health and social care sector and employing an administrative assistant. They commented, "Its only me doing everything at the moment, I have done my best but haven't been able to do it all."
- Risk management was inadequate. Care records were not in place and the risks associated with children's care were not assessed which meant staff did not have the information they needed to provide safe and person-centred care.
- The lack of managerial oversight meant staff had not been provided with the training they needed to carry out their roles effectively.
- COVID-19 national guidance had not been followed to keep children and staff as safe as possible during the Coronavirus pandemic. The director was not familiar with the national guidance they needed to follow.
- The providers infection prevention and control policy was not fit for purpose and had not been reviewed since 2017.
- Audits and checks to monitor the quality and safety of the service did not take place. For example, the provider did not complete any competency checks of their staff practices to assure themselves staff provided safe, quality care in line with their expectations. Also, a system was not in place to monitor, manage and reflect on incidents to prevent reoccurrence.
- The providers system to gather feedback about the service from children and their relatives was ineffective. Feedback forms were not used until care packages had ended. Therefore, opportunities to drive forward improvement could have been missed.
- In May 2021 local authority commissioners had made some recommendations to the director to improve outcomes for children in line with best practice. In response an action plan had been submitted to the commissioners. During our visit some actions remained outstanding. The director told us this was because they had not had time to complete the actions. For example, risk assessments had not been put into place. This demonstrated lessons had not been learnt.

The provider had failed to operate systems or processes to assess, monitor and improve the quality and safety of the services provided. Accurate, complete and contemporaneous records in respect of each service user were not maintained. Feedback was not actively encouraged. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The location had moved to a new address in July 2021, but the director had not applied to CQC to make the necessary change to their registration until August 2021. That demonstrated a lack of understanding in relation to CQC registration requirements.
● During and following our visit the director took immediate reactive actions to address the shortfalls we had identified during our inspection. We acknowledged the director's commitment to making improvements to improve outcomes for children and their staff. However, more time is needed to demonstrate the actions taken have been effective to make and sustain necessary improvements.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Whilst relatives spoke positively about the care and support provided by RockSolid 247 Limited more needed to be done to improve communication and promote an inclusive and empowering culture. Following our visit, the director provided information about the service and also visited children and their families to improve communication.
● Staff felt supported through regular one to one discussion and spoke positively about the director. One staff member said, "Anytime day or night (director) is available on the phone. She is really good; I can't fault her. She works tirelessly for the company." Staff team meetings were implemented following our visit.

Working in partnership with others
● The service had developed good links and worked in close partnership with the local authority in an attempt to achieve positive outcomes for children. However, the director could not demonstrate how this resulted in safe, effective and person-centred care being provided. This placed children at risk of receiving unsafe care that did not meet their needs.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure children received appropriate person-centred care that met their needs. Regulation 9(1)(a)(b)(c)

The enforcement action we took:

Non- routine conditions imposed on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonable to mitigate risks to ensure care and treatment was provided in a safe way. The risks relating to the safety, health and welfare of children had not been assessed and risk management plans were not in place. The provider had failed to assess the risk or take action to prevent or control the spread of infections. Regulation 12(1)(2)(a)(b)(h).

The enforcement action we took:

Non- routine conditions imposed on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate systems or processes to assess, monitor and improve the quality and safety of the services provided. Accurate, complete and contemporaneous records in respect of each service user were not maintained. Feedback was not actively

	encouraged. Regulation 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:

Non- routine conditions imposed on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to operate systems or processes to assess, monitor and improve the quality and safety of the services provided. Accurate, complete and contemporaneous records in respect of each service user were not maintained. Feedback was not actively encouraged. Regulation 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:

Non- routine conditions imposed on the providers registration.