Solace Community Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Solace Community Care Limited on 05 March 2018. This was an announced inspection. We gave the service 48 hours' notice of the inspection visit because the manager was often out of the office supporting staff. We needed to be sure that they would be in.

At our previous inspection on 4 August 2017 we found the provider was meeting regulations in relation to the outcomes we inspected.

At the last inspection, the service was rated Requires Improvement.

At this inspection, the service was rated Good.

Solace Community Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to mainly older adults. It was providing a service to 32 people at the time of this inspection. Not everyone using Solace Community Care Limited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

A director of the provider organisation told us they intended to apply for registration, the service had been without a registered manger since June 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us that they were happy with the service. They said they felt safe when care workers supported them with personal care. They reported that they were treated with kindness and compassion and care workers respected their privacy and dignity.

Appropriate support was provided if people needed assistance with medicines.

People said that care workers attended on time and if they were running late or had to be replaced, they were kept informed. The provider employed enough care workers to meet people's needs and had thorough recruitment checks in place.

Care workers received induction when they first started in their roles and thereafter received refresher training on a yearly basis. Their competency was tested through assessments that were carried out after each training module. Records showed that care workers were up to date with training.
Staff had received training in the Mental Capacity Act 2005 (MCA) and understood the importance of asking people for their consent before supporting them with personal care. Where people were not able to consent

to their care, the provider worked with relatives and health professionals in people's best interests to ensure they received appropriate support.

A care co-ordinator completed an assessment of people's needs, including any risks and the support they required before people began to use the service. Care plans were developed in line with these assessments. Peoples risk and care packages were reviewed regularly.

People told us they were confident if they raised any concerns these would be acted upon.

Although people told us they felt satisfied with the service in general, the lack of a registered manager and continual change in the office based staff meant that some quality assurance checks were not being carried out.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service had improved to Good.

Risk assessments were carried out before people began to use the service which helped the provider to manage risk.

People told us that they felt safe and care workers were aware of procedures to follow to safeguard people from abuse.

The provider had robust recruitment checks in place and carried out appropriate checks to ensure suitable staff were employed.

Care workers supported people to take their medicines.

Is the service effective?

Good

The service had improved to Good.

Care workers received induction training when they began their employment and thereafter received refresher training and ongoing supervision.

The provider obtained people's consent to the care and support they received.

People were supported with regards to their health and well-being.

Is the service caring?

Good

The service was caring.

People told us that care workers were kind and friendly and that they were treated with respect.

Care workers understood the importance of respecting people's privacy and dignity.

People were supported to express their views and were involved in making decisions about their care and support and treatment.

Is the service responsive?

Good

The service had improved to Good.

People using the service received care and support that was responsive to their needs. Care plans were developed in collaboration with people, and where appropriate with their relatives and health and social care professionals.

People using the service and their relatives felt able to raise any concerns or complaints.

Is the service well-led?

Requires Improvement

The service remained as Requires Improvement.

A registered manager was not in post at the time of our inspection.

Some aspects of the quality assurance checks were not being carried out.

Solace Community Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We gave the service 48 hours' notice of the inspection visit because the manager was often out of the office supporting staff. We needed to be sure that they would be in.

We inspected the service on 5 March 2018. The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a domiciliary care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths. An expert by experience spoke with four people who used the service and five relatives to gather their views about the service provided. We also spoke with five care workers, the manager and the care coordinator.

We reviewed a range of documents and records including; four care records for people who used the service, five staff records, as well as a sample of complaints and compliments records and policies and procedures kept by the service.

Good

Is the service safe?

Our findings

People using the service told us they felt safe in the presence of the care workers who supported them. They said, "Yes I feel safe. No problem with that. If I have a problem, I call the agency" and "I feel safe because when I'm not well, they make every effort to look after me." Relatives also told us they had no concerns about leaving their family members with the care workers who visited them at home. They told us, "Yes, [family member] is safe; has one really good carer, and there's always a family member with them" and "Yes, the carer's good and my [family member] is happy."

The provider arranged training in safeguarding and understanding the different types of abuse that people could be at risk of for both new and experienced care workers. They were given information about how to protect people from abuse and who they could raise their concerns with. Staff files and the training matrix confirmed this training had been delivered within the past year. Staff confirmed they had completed safeguarding training and said they would approach the manager if they had any concerns. One care worker said, "We have to look out for any changes or unexplained marks, if there are any then we have to report it to [the manager]." Another said, "Safeguarding is making sure people are safe."

There were thorough recruitment processes in place for new staff which helped to ensure people were protected from the risk of receiving care from unsuitable staff. Staff files were arranged clearly with evidence of the checks had been carried out before staff started to work for the service. These included application forms, written references, proof of identity and address, and a Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. Staff files also contained details of care workers induction training and certificates of their refresher training.

People confirmed that they were happy with the staffing arrangements as provided by the service. Comments included, "They call if they're running late; they've always turned up", "There has been a few times when carer has not turned up, but the agency sorted it out", "I've always been informed if they're not turning up in advance. I'm in tune with my carers and really happy that I've got the right carers in place. Other agencies have been awful, but I'm lucky with the person I have now, and I'm very happy" and "Always turn up."

The care co-ordinator carried out a 'needs and risk assessment' when they received a referral. This included assessing people's level of independence and support needs in relation to a number of areas including communication, medication, personal hygiene, dietary needs and maintaining the home environment. Any potential risks/hazards in relation to each of the assessed areas and how they could be mitigated by care workers were included. Risk assessments were reviewed regularly to ensure people continued to be safe and staff were able to meet their needs.

The service managed the control and prevention of infection. Staff received training in infection control. Access to personal protective equipment was explained during their induction and new care workers signed to confirm that they had read and understood the Infection Prevention and Control policy/procedure.

People and their relatives confirmed they were happy with the support they received with regards to their medicines. They said, "Carer supports me with meds and I'm very happy", "They prompt me to take my meds and I'm happy with what they do", "In terms of meds, I can take my own, but I need prompting. My memory is not as good as it used to be, so I find that helpful - in fact, it's a necessity", "The carer informs me if medicines are running out and I then re-order", "I don't live with my [family member], but he/she's never complained and would say if they were unhappy."

The manager said they supported people with medicines, at the time of the inspection six people were being prompted to take their medicines but care workers were not administering medicines. The manager said a list of medicines and their times were printed off every week and given to the care workers with their timesheets. We reviewed medicine records for people and care workers were completing every time they prompted people to take their medicines. A care worker said, "I just have to remind [person] to take medicines."

There had been no incidents and accidents since the previous inspection. The provider had an incident monitoring form in place and all care workers were aware of reporting procedures if an incident occurred whilst delivering personal care. Any CQC reportable incidents were covered during care workers supervision meetings.

Good

Is the service effective?

Our findings

Staff were given regular mandatory training which enabled them to carry out their duties effectively. This training was in line with the requirements of the Care Certificate. The Care Certificate is an identified set of 15 standards that health and social care workers adhere to in their daily working life. The training was delivered via DVD's but one of the management team were always available to answer questions. Care staff then answered questions to test their competency on the relevant topics. These were filed with their certificates in their staff files. Care workers told us, "I had an induction, we did moving and handling and health and safety and other topics" and "The training is very helpful."

Staff told us they felt supported and had an opportunity to discuss any concerns or feedback in relation to their work. One care worker said, "I'm happy working here. The training is good and it suits me." Staff files contained evidence of regular supervision with care workers. Topics for discussion included general wellbeing, action from the previous supervision, client's needs, work performance, training needs and actions for next supervision.

A schedule of appraisals was maintained with details of when staff had their last appraisal and when the next one was due.

A care co-ordinator assessed people's support needs when a referral for a new person wishing to use the service was received. The care co-ordinator explained the process for new referrals. This was completed in people's homes and involved a risk assessment and development of a support plan based on the person's needs. They said that relatives were invited to the assessment and always when there were concerns about people's capacity. If the referral came from a local authority, the assessment was carried out in line with the care and support plan received from the social worker. Records of these were kept in people's care files.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who use the service and 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. We checked whether the service was working within the principles of the MCA.

People's consent, or that of their relatives if they were unable to consent to their care was taken and they were given a copy of the support plans and time to make a decision about whether to proceed with the provider or not.

Training records showed that care workers had received training in understanding their responsibilities under the MCA. Staff said they were always careful to ask people for their consent before delivering personal care. They said if people refused they would respect their decision. Where people lacked capacity to make some decisions, the provider worked in their best interests and consulted with their relatives about their care plans.

People said that care workers looked after their general health and corresponded with health professionals if required. They said, "Because of my illness, I can't be exposed to flu viruses; the carers make sure they do not attend when they've got the flu or the start of a cold, and they send somebody else", "If I need to go to GP, they go with me; they're flexible." Relatives said they were kept informed about their family member's health and wellbeing, "Yes, they keep us informed" and "They will say if she's not herself."

Care plans contained an information sheet with details of people's GP and their current medical conditions and history in case health professionals needed to be contacted. A list of current medicines were also included, in case the services required this information.

People and their relatives told us they were happy with the support they received in relation to their dietary needs. They said, "They support me with meals, and I'm very happy with their support", "The support me with meals and I'm happy", "We put food in fridge and the carer warms it up and gives to [my family member], I'm happy with this help" and "The morning carer helps out with breakfast/washing. I'm happy with the service."

Care workers told us, "[Person] only eats vegetarian food, the family does the shopping and I prepare it", "[Person] tells me what they would like and I make it" and "I prepare lunch for [person], whatever is in the fridge or the cupboards."

Care plans included details of any support people needed with their nutrition and hydration and care workers completed daily care records where they recorded the support provided in this regard. Care plans also included details of people's religious or cultural dietary needs, for example if a person required a particular diet.

Good

Is the service caring?

Our findings

People using the service told us they were treated with kindness and were positive about the caring attitude of the care workers. Comments included, "They're always willing to listen and help me if I need it", "The current carer is very good and I think very highly of them" and "I love the fact that they pay attention to detail; they're attentive. They come into my home and they do their due diligence. Just by asking how I'm doing, it really lifts me up. They respect me by making feel happy and taking care of me."

Relatives also confirmed they were happy with the care provided, "I can't complain. The main carer spends a lot of time with my [family member]", "[My family member] is quite attached to the carer and she's very good" and "They look after [family member] well."

Care plans included a 'client profile' which included their likes and dislikes and also their family background. Care workers demonstrated that they understood people's preferences in relation to their personal care needs and told us they respected their choices. A person using the service said, "In the beginning I was shy, now I'm coming out of my shell because of the carer; the carer respects my wishes and ensures I'm taken care of in accordance with my care package. I've got a good carer and I trust her and she trusts me."

People were supported to express their views and were involved in making decisions about their care and support and treatment. People and if appropriate, their relatives were involved during the initial assessment and also consulted during care plan reviews. People said their wishes and choices as to how they liked their personal care and other support tasks delivered were recorded and considered by staff.

Care workers understood the importance of respecting people's privacy and dignity. Dignity and respect training was delivered during induction of new staff and principles of person centred care was delivered as mandatory training. A care worker said, "[Person] has her own room so privacy is not an issue, all personal care is delivered in her bathroom."

One person said, "I'm Catholic and I say prayers several times a day; my carer is Muslim and she respects my religion; they abide by my privacy by closing door when I'm getting dressed; they give me my freedom and so far, have never denied me anything." Relatives said, "The carer is female anyway, so it's all fine and [female family member] is happy" and "They cover her up when washing; she's never complained and she's one who will complain if something is wrong."

People's independence was promoted by staff. Care plans included details of people's visit times and the duties that care workers were required to carry out at each visit. Where appropriate, these included people's objectives such as developing their social skills or to remain independent so that care workers could promote and encourage their independence. One relative said, "They make [family member] breakfast, but they feed themselves." A care worker said, "We try and encourage her to be as independent as possible, asking them to put their shoes on."

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs.

Care plans were developed in collaboration with people, and where appropriate with their relatives and health and social care professionals. Before they started to provide support to people, the care co-ordinator visited them to complete an assessment of their needs and their views about the support they required. A care plan was then written based on their identified needs. People and their relatives said, "I do have a plan and I was involved in the planning", "I have a copy of the care plan; I was involved in catering for my needs", "[My family member] has the plan and was involved in the planning", "Social Services put plan together" and "I do have copy of care plan; I was involved via emails and phone calls."

The care coordinator worked with people and to schedule visits according to their needs. Care workers said they were given information about people's care and support needs before they visited them for the first time.

People and their relatives also confirmed that their care plans were reviewed as and when required. Social Worker does this all for me and it's done about once a year. One person said, "It's reviewed as and when needed, only if things need to be changed; otherwise it stays the same." Comments from other people indicated their care plans were reviewed once a year.

Care plans reflected people's physical, mental, emotional and social needs. They included people's personal history, individual preferences and interests. There was a section called 'communication and senses' which identified and documented people's communication needs including if they had any sensory impairment and effective ways in which staff could communicate with them. Other areas included support needs and preferences in relation to personal care, medicines and home care.

Daily care records were completed by care workers staff at the end of each visit. These included details of the support tasks carried out, including any personal care, food and medicines support given.

Technology was used when providing the service. There was an automated signing in and signing out system which care workers used when carrying out visits. This enabled the provider to have an accurate picture of whether care workers attended and stayed for the allocated time.

People and their relatives were given details of how to make a complaint through the service user guide that was issued to them when they first started to use the service. There had been no formal complaints received since the last inspection.

People told us the provider was receptive to and responded to them when they raised any concerns. They said, "Never had to make a complaint", "Yes I have made a complaint. Problem with the carer not coming on time and not turning up; they changed the carer and the one who comes in now comes in on time and is good", "I've never had to complain, but I know that the door is open for me", "Never needed to make a

complaint", "Yes we have made a complaint and it was concluded to our satisfaction", "We had a carer that was not turning up or turning up late, and not completing her allocated time; we complained to the Agency and they sorted it all out - the carer was removed from the job and they gave her a warning."

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us the service was well led. Comments included, "I'm quite happy and there's nothing I can think of to improve; they're always there for me", "I couldn't fault it; it's quite good", "I've been with them for 5 years; I will continue to use the service", "The carer they have provided is quite good. They provide a good service."

Some people made comments relating to the office staff and that they did not always know who they were dealing with. They said "Management has changed over last few years so things change", "I've never seen the managers face-to-face, only spoken over the phone" and "The person who is in charge, I've spoken to her on the phone, but I don't know what she looks like."

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

A registered manager was not in post at the time of our inspection. The director told us she was in the process of applying to become registered. Although care workers told us they felt valued and supported by the manager and other staff, there had been instability within the management and office team structure for a number of years, with a succession of managers some of whom had become registered and care co-ordinators. We spoke with the director about this instability and she told us she would be applying to become registered.

This instability had resulted in some aspects of the quality assurance checks not being completed in a timely manner. There was a lack of spot checks carried out. The manager said spot checks had not been completed since the last inspection due to a staff shortage in the office based team. They said they were looking to recruit an administrator to undertake some tasks and take some burden of the care co-ordinator and to free them up to start resuming the spot checks.

The care co-ordinator checked the clocking in system for random sampling to identify instances of late visits.

A quality assurance survey was sent out to people with 21 people responding. 70% of people or their relatives gave positive answers in response to a series of questions based around the CQC standards and relating to staff, privacy, medicines, complaints and other areas. These surveys were sent out by post but also carried out over the phone. Where people had raised any concerns, these were followed up by the manager directly with people or if they responded anonymously then as an action point.

Team meetings were held regularly with good attendance. These were minuted and involved formal discussions but also role play scenarios in various topics to supplement the mandatory training that people received. The manager also gave out rewards to care workers who showed initiative and demonstrated a

caring attitude on top of the usual expected standards.

The service worked with external stakeholders and agencies to support the care provided to people. We saw evidence of the provider corresponding with health and social care professionals to help ensure joined-up care, for example with social services.