Sevacare (UK) Limited

Sevacare - Kirklees

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

The inspection of Sevacare Kirklees took place over four days between 10 and 19 October 2016, three of which were in the registered office. We visited people using the service on 19 October 2016. The inspection was unannounced and has previously been compliant with all regulations.

Sevacare Kirklees is a domiciliary care agency that operates in the Kirklees area including Batley, Dewsbury, Huddersfield and the Valleys. The agency provides personal care support to people in their own home. There were 133 people using the service during the time we inspected. There were a further 30 people with a learning disability receiving support to access the community. The registered manager had informed us these 30 people did not require personal care support and therefore did not come under our regulated activity regulations. However, upon sampling some of the care records of these people we found they were receiving support with personal care.

There was a registered manager in post during the time of the inspection. 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.

We found serious issues with the allocation of care tasks that left people with late and shortened calls, staff had no time to carry out their duties effectively and there was a high risk of the likelihood of errors as staff were tired and under pressure to complete tasks in unrealistic timeframes. The service had no effective monitoring procedures in place to evaluate the provision of the calls and relied on staff or people using the service to report any concerns in relation to missed or late calls. This meant some people who were not in a position to request help were potentially left vulnerable as they had not received appropriate care.

Staffing numbers were inadequate to meet the demands of the service and some staff were working particularly long shifts, with no allocated travel time between calls and in most cases, having to pick up shifts for colleagues who were off sick. Some staff told us, and we saw written evidence, that working hours could not be altered due to pressures in the service.

Not all people receiving the service said they felt safe with the care workers and we reported two serious concerns which were investigated by the local authority. One of these had been partially addressed by the service but the other was not recorded despite the person saying they had reported it. Staff showed they had an understanding of how to report safeguarding concerns.

We found risk assessments did not always reflect individual need which meant staff did not always have effective guidance to follow if a person's needs were more complex.

Medication records were completed in full by care workers at the start of each month with no extra time in place to fulfil this task or ensure these were double checked by another staff member, which increased the

likelihood of error. We observed poor medication practice on one occasion which we reported to the registered manager who agreed to address the concerns promptly.

Staff had received an induction and supervision although only at six monthly intervals. Training records also indicated all staff had up to date training, although this was not reflected in conversations with staff.

People felt they had appropriate access to external support agencies as needed and care workers contacted these as required.

Where people lacked mental capacity to make decisions such as administering medication we found no evidence of capacity assessments or best interest decision-making. The registered manager told us they relied on information from the local authority.

People said most staff were pleasant and caring but there was evidence of a lack of dignity and respect for others. This was mostly attributed to staff rushing their tasks due to a pressured rota and not completing tasks in line with requirements. People's preferences, such as for gender of carer, were not always respected.

Care records were written in a person-centred manner and outlined all key tasks that should be undertaken. However, there were serious issues with the records held in the office where we found conflicting lists of people using the service, paper files and electronic records. We found little assurance the registered manager had a full knowledge, understanding or oversight of the service.

Quality assurance measures were ineffective and did little to identify the concerns we found. There was little evidence of reviews of care provision involving the people using the service; these were limited to basic telephone questions. Although complaints were logged, investigations were not always completed thoroughly and low level concerns were not recorded effectively. There was a lack of effective leadership, scrutiny and ownership of the service which meant people did not always receive the care they were entitled to.

We found breaches in the following regulations; 9, person-centred care, 10 dignity and respect, 11 consent to care, 12 safe care and treatment, 17 good governance and 18 staffing.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is

still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult 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?

Inadequate

The service was not safe.

Some people told us they did not feel safe.

Some risk assessments did not identify how the risks were to be reduced and did not tally with information in people's care records.

Staffing levels were poor: rotas were badly planned and staff did not have allocated travel time. Calls were often late and people told us time was cut short.

We saw examples where medication was administered safely and records were not properly checked.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received six-monthly supervision and training every three years which meant knowledge was limited.

The service did not complete mental capacity assessments or best interest decisions in line with the requirements of the Mental Capacity Act.

People were supported with nutrition but comments from people and relatives said basic cooking skills were poor.

Assistance from external agencies was sought as needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people were happy with their carers and we observed positive interaction between people.

People told us they felt rushed and some people said that staff did not complete all tasks as required.

People's preferences were not always respected and there was a mixed view of how much people were involved in their care planning.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care at their preferred time and call times varied significantly on a day to day basis for some people.

Care records were written in a person-centred style but they were not always complete.

Complaints were logged but not always investigated thoroughly, and some low level concerns were not noted in this manner which meant concerns were overlooked.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager was unclear of their role and this was reflected in contradictory service information.

There was little evidence of robust quality assurance which meant many issues had not been identified.

There was no effective scrutiny of service provision in regards to timing and duration of calls.

Sevacare - Kirklees

Detailed findings

Background to this inspection

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

This inspection took place on 10, 13, 17 and 19 October and was unannounced. The last day was spent visiting people in their own homes.

The inspection team consisted of four adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience made telephone calls to people. Two adult social care inspectors visited on two of the office days and one on the other. Another adult social inspector conducted the home visits.

Before the inspection we had information of concern about the service and we liaised with the local safeguarding and commissioning teams for further intelligence. We also used notifications from the service along with the Provider Information Return. 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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. Information was also obtained from pre-inspection questionnaires sent to people using the service and health and social care professionals.

We spoke with eight people using the service and two of their relatives. We spoke with 11 staff including six carers, three care co-ordinators, the area manager and the registered manager.

We looked at 23 care records including risk assessments, seven staff records, minutes of staff meetings, complaints, safeguarding records, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe with the care workers. One person we spoke with said "I feel safe with all but one of the carers. I like them and know them. The one I didn't like was very awkward and everyone was frightened of [them]. They knew it all and made me very depressed." Another person told us "One carer who comes is not nice at all. They made others cry and is very 'cocky', a know it all." We asked each person using the service if they had complained and both said they had. We informed the registered manager of our concerns and also notified the local safeguarding body to instigate an investigation. We found evidence that one concern had been logged and addressed but was not perceived as a safeguarding issue by the registered manager. In light of our findings a full investigation was promptly undertaken and the staff member offered further training and guidance around effective communication with ongoing monitoring of their performance.

Other people we spoke with had had a more positive experience. One person said "Yes I do feel safe. They have been alright with me. If I am worried I can talk to my carers and they will help me" and another told us "I trust the staff but would not talk to them if I had a concern. I would speak to the manager."

Staff were able to describe different forms of abuse. One care worker told us "physical, mental, financial or emotional." They told us they had not reported any concerns whilst in this role but knew how to if necessary. Another care worker was aware of the possible vulnerabilities of people using the service and gave the following scenario "they could easily have family members taking their money." A further care worker said "I would make sure they are safe and contact whoever I need to. Signs of abuse could be bruises, no food or no money." The care co-ordinators advised us staff rang into the office and they would refer on concerns as necessary.

The service was notifying us of significant events as required under the Health and Social Care Act registration regulations. Initially we were only given access to north Kirklees information but the other area's information was accessed on subsequent days. The registered manager had reported concerns appropriately and followed up where necessary with local social work teams. All the safeguarding referrals made related to the conduct of family or friends rather than issues with the service provision itself. This showed the care workers had an awareness of when to raise concerns and that they did so in a timely manner.

People said staff continuity and timekeeping was not good. One person said "Staff keep leaving. They aren't always on time. I feel sorry for them. They get unexpected jobs given to them. They do phone and let me know they are going to be late. I have not had any missed calls but during holiday times or sickness they will send different carers." Another person told us "They are usually on time although tea time can be bad. They don't let me know if they are going to be late and I have had missed calls but if I phone the office someone calls eventually. I have two carers usually and they tend to arrive together. Morning I get regular carers but not other times. I would like to have the same ones as it takes them ages to understand what I want." A further person told us "On a weekend it's horrendous – I might get four different carers in a day."

However, other people did say they were informed if staff were running late and most understood that this was usually through having to deal with urgent incidents. A few people also told us that new workers often came to shadow more experienced carers which they felt was a positive move as people got to build a relationship. The registered manager said the service ensured staff remained in the same location and usually had the same rounds. They said they aimed for four full-time staff to share a round if a person needed two carers; one pair would cover mornings and the other the afternoon and evening shifts. However, they also said the complexity of care delivery was also considered and its impact on staff. They said staff retention was stable but recruitment was proving increasingly difficult. They said they never used bank or agency staff, and only three staff had left in the past three months. However, this was not reflective of the situation in south Kirklees where at least five had left recently and sickness levels were higher.

We asked people if they received their care at the expected time. One person initially said "My visits aren't shorter, I get my time" but when we asked where the travelling time came from (as they knew staff were not allocated this) they said "I don't mind if they go five minutes early if they're finished." This person told us "They can't get the staff. I don't think they have enough." We also looked at length of call times. In one record we noted one person was allocated 30 minutes for a night call but on three occasions in a ten day period their call had only been 20 minutes.

We were told by people that they felt there were not enough staff as holidays and sickness posed particular difficulties for cover. One relative said "They do not have enough staff as even the office girls have had to come out to do some caring when carers are off sick." One care worker said they were having to cover a lot of extra calls due to high levels of sickness and said "I feel pressured to get everything done."

One care worker told us they had indicated their preferred working hours when they began working for Sevacare but this had not been adhered to. They wanted to work either mornings or evenings and were actually doing both. They were rostered for the next nine days from early morning until 8 or 9pm. They had been allowed a 1.5 hour break which they told us was used to catch up due to the lack of travel time. We looked at this individual's rota and saw this was correct. Staffing rotas themselves did not allow for travel time between visits and were calls were spread over large distances especially in the south of Kirklees. This care worker told us "I can work a 13 hour shift but only get paid for 7 or 8 hours because of all the travelling times between calls." They had also been asked to cover on their weekend off as "They just keep saying we haven't got enough staff. You feel like you shouldn't say no." A further two staff commented on the pressured working environment.

We looked at staffing rotas and found one care worker had worked two consecutive days completing 29 visits on one day and a further 26 on the second. On the third day they had completed a further 10 visits. They told us they were exhausted and couldn't remember the last day off they had had. Another staffing rota showed the care worker had worked eleven shifts in a row, working over ten hours per day which meant working for a period of over 110 hours in eleven days. This meant people were not receiving a consistent or timely service and could be at risk of missing essential support when they most needed it.

This evidence is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staffing numbers were not adequate to provide safe care.

Some people told us they had had missed calls but there was usually a positive response from the office once they had alerted them. The service deemed anything over 30 minutes late was a missed call. We asked the registered manager how missed calls were logged and assessed and they told us they were not recorded for the service overall. They relied on staff and people using the service to alert them on a day to day basis where there were issues. The service did not have electronic call monitoring although this had been

discussed with the local commissioners. However, we saw missed calls were noted on each person's electronic record and remedial action taken in each instance. This meant there was no overall analysis of service delivery and checks were not in place to ensure people were actually receiving support when required and any deficiencies could not be identified easily.

We checked staff files and found that all necessary recruitment checks were in place. Identity checks had taken place and references obtained for people. These were verified with the person giving the reference and Disclosure and Barring Service (DBS) Checks were carried out for all staff. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

In people's care records we found evidence of risk assessments. In one file it was noted a heightened risk of fire as the person was a heavy smoker. This had been addressed through a full fire risk assessment and appropriate risk reduction methods were in place. Moving and handling assessments considered a person's weight and height and any particular difficulties such as poor balance, muscle wastage or communication difficulties. Each specific task was considered, such as moving from chair to bed, toilet support to sitting to standing and methods or equipment needed recorded. Service details of equipment were not always recorded despite there being space for this. There were also generic risk assessments which considered environmental risks such as uneven pathways or unlit locations. We found evidence of risk assessments in place for people who used bed rails which were completed in conjunction with the district nursing service.

Each assessment concluded with a risk management plan where the risk was described and actions recorded to minimise the likelihood of these. Most of the risk management plans we saw contained the same detail in reference to the key tasks and some only related the risks to staff rather than people using the service.

In one record we found inconsistencies with the information in the assessment of needs compared with their risk assessment. It was noted that the person was independently mobile with the support of a zimmer frame throughout their assessment but the risk assessment indicated they were hoisted for all transfers. We queried this with the registered manager who advised the assessment information was correct and they would amend the risk assessment. In the same record it was recorded the person had no mental health issues as they did not have a diagnosis of dementia. However, we pointed out to them their needs assessment did indicate another significant mental health condition which had not been linked and could have posed a significant risk for both the person and care staff supporting them.

In a further moving and handling assessment details of two different slings were noted for use with an electrical hoist. However, it was not clear from the information which sling was to be used for which transfer which meant staff did not have accurate information to follow. Neither were differing transfer methods recorded which meant staff did not have access to the correct guidance. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risk assessments did not provide staff with all the necessary guidance to support a person safely and reduce the likelihood of harm.

Accidents and incidents were logged in a file for north Kirklees with details of the event, who was involved and subsequent action taken to minimise the likelihood of re-occurrence. However, the file was empty for south Kirklees. It was not known if this was due to poor recording or there were no incidents to record.

We asked people if they received their medication in a timely manner. One person said "The carers check the medication with me and help sort it out. They have got the pharmacy to sort them in proper boxes." Another person said "The staff do this for me. They know what it is for and I get it more or less on time." Medication

records included an overview assessment as to the level of support a person required and where there were issues who to contact such as the GP or other health services. Each person who required assistance with their medication, even if just a prompt, had a Medication Administration Record (MAR) on which staff recorded the medication being given, time and dosage.

Information about how tablets were obtained and stored was also noted. However, where medication was boxed no stock checks were taken so care workers had no means of checking if the medication tallied. For medicines which were prescribed PRN (as required) we saw protocols in place identifying when they should be given such as creams to be applied when sore areas of skin were evident. However, not all MAR sheets evidenced that people had been asked if they needed their PRN medication nor were there body maps for all topical medication applications guiding care workers as to where the creams should be applied.

One care worker we spoke with told us "I look at the chart and check it is the right medication, how it is to be given and then double check. I always offer someone some water. If I have any concerns I always ring the office." However, the registered manager advised us care staff were responsible for recording any changes and notifying the office when this happened, and so there was a possibility that office records did not tally with those of the person. A care worker also told us "Carers have to fill out the MAR at the beginning of each month which if the worker is off sick, is a nightmare as it eats into our care time." This showed the service had not developed an appropriate system for ensuring medication records were up to date, and staff were not supported with this task by the allocation of extra time. This task was also completed by the individual carer and no checks against the prescription were made, increasing the likelihood of error as staff were under pressure to complete this task.

We observed people being given medication but care workers did not always check people had taken them. Tablets were removed from a dosette box and placed into an egg cup but the care worker did not observe the person actually taking the medication. We asked the care worker how they knew the person had taken their tablets and they told us "We leave them and check the egg cup is empty later in the day." The care worker marked the medication administration record (MAR) as having given the medication and the people having taken it which was not what we had observed. We also observed topical medication being applied but the actual medication was from their partner's jar rather than their own. The MAR stated that the cream was to be applied at night only but this was done during the morning call. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving their medicines safely.

One relative said "The staff are supposed to give my relation their tablets. The previous carers used to make sure they took them but this new carer puts them into an eggcup with a drink of water but doesn't check my relation has taken them." We spoke with a care co-ordinator about time specific medication, for example needing to be taken 30 minutes before food. They replied "We'd say give the medication as soon as you get into the client." This did not ensure they would receive their medication at the correct time as most call times were below 30 minutes in duration.

The registered manager advised us "We do a regular medication audit every two months. This is to check the paperwork matches, there are no gaps and the details are completed properly. If there are issues we issue a letter to staff." This audit was completed by an internal auditor who checked MAR sheets that had been returned to the office which were often over six weeks old which meant any errors were identified some time after the mistake and problems could have continued in the interim. The registered manager said no controlled drugs or insulin was given by care workers as district nurses supported with this. The registered manager also informed us all staff had their competency with medication checked every six months as part of their spot check. New staff would be checked immediately after their induction using a dummy dosette

box, then after their first two weeks, followed by a further check after nine weeks. If any particular issues were noted these would be followed through.

One care worker told us "We always have plenty of PPE (personal protective equipment) and are encouraged to use it."

Requires Improvement

Is the service effective?

Our findings

One person said "I am quite satisfied that the staff I have know what is needed but I will tell them if they ask." Another person said "To be fair some are well trained but others are not as good as they could be but improve as time goes on. I tell them how and what things I want done."

A further person told us "Most of them seem to know what they are doing except when it comes to meals. Some don't know how to do basic cooking such as cheese on toast. I have to tell them how to do it, so some basic cookery skills would be helpful." This was also identified by a relative who said "In some things I think their training is OK but there are little things like the new carer doesn't cut up my relation's toast into manageable pieces. It's left whole which my relation finds hard to handle. It's the common sense things they don't always do. Cooking skills are very poor."

One care worker told us "I went for an induction. It took a week. We did health and safety, policies and procedures, medication training. Quite a lot really. I also did some shadowing for a week." Another care worker told us "The training when I started was useful and supportive." The registered manager told us that new staff had a meeting two to four weeks after completion of their induction and then at the end of their probation. Staff were allocated up to 20 hours of shadowing time with an experienced member of staff as part of their probation period. The registered manager said specialist training was available if staff had to use a particular piece of equipment and this would be through the local authority.

Staff only received supervision at six-monthly intervals in line with Sevacare's supervision policy. One record we looked at showed poor practice had been identified and raised with the worker, with clear explanations given as to why the conduct was unacceptable. One care worker told us "I see the managers regularly and can talk things through with them. At my check I am asked if I'm happy, have I any issues and is everything OK?" However, we did see that their practice was monitored in the community. One care worker said "I had a competency check just before my appraisal which looked at everything including medication." We looked at this competency check which had observed a care worker's performance in relation to moving and handling, personal hygiene support, medication, communication and record keeping among other areas. It was a tick list to indicate whether the care worker was competent. There was no detail as to how they had actually performed the task which meant the service was not assessing the quality of service delivery in detail by evidencing how the care worker had performed such support.

We saw evidence for north Kirklees which showed 84% of staff had received supervision and a further 78% an appraisal. 96% of staff practice had been spot checked. There was no equivalent data for south Kirklees. We looked at one appraisal record from February 2016 which showed a care worker had requested a 'day off' for their organisational objectives. The response to this by the registered manager was recorded as "I spoke to [name] about putting two rounds together so then we can look at giving a day off." In another record we saw a care worker had asked about changing their working pattern but it was recorded "Not able to change for six months but then we would put in a timetable." A further care worker told us they had asked to change their hours but was advised "I needed to work there longer." This demonstrated the service was struggling to support staff in their preferred working pattern.

Staff's view of training was mixed. One care worker told us "I have not had any safeguarding training but do moving and handling every year. We don't get paid for training." The registered manager however, told us all staff had received safeguarding training. Another care worker said "I have started to do my NVQ but just don't have time to do it as I'm always out doing care."

The registered manager told us all core training was completed at induction and this included moving and handling, infection control, medication, communication, confidentiality, record keeping, catheter care, mental capacity and safeguarding. Induction training was classroom-based but any renewal training was through the completion of workbooks which were verified by the registered manager. Training records showed when training was due for renewal (mostly after three years) and the registered manager informed us that staff did get paid for refresher training. However, we noted on staff's attendance certificates the induction dates and the refresher dates were the same which meant staff did not receive any further training for three years unless specific issues were raised.

People told us their consent was obtained before any tasks were undertaken. One person said "Yes, but I've had them for so long they know what is needed and I will tell them if they ask" and another person told us "They always ask me what and how I would like things done." A further person agreed and said "They encourage me to be as independent as possible."

We asked people if their choices were respected. There was a mixed response. One person said "They always respect my choices and call me by my first name which is my preference" and another said "They always ask me before they do anything." However, another person said "No, they do the same thing every day and never ask about anything. I tell them if I'm not happy and they will act on what I say at the time."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The registered manager advised us "We do not do our own capacity assessments. If a service user does not have capacity we request one at the time of the assessment from the local social work team." We asked them how many people they felt lacked capacity to agree to receiving care and they told us about 25% of current people receiving support. In one record we saw that a person was deemed to be confused in relation to their medication but there was no best interest decision recorded in regards to how staff were to support them safely with this aspect of care. This meant the service was not operating in line with the requirements of the Mental Capacity Act 2005.

We found service user agreement forms in some care records which indicated whether the person had received a guide to the service, the complaints procedure, a copy of their needs assessment, medication information and details of any risk assessments in place. These were signed where the person was able to agree to this. However, where people lacked the capacity to make these decisions, we could not find any evidence of mental capacity assessments or best interest decision making, nor were there any checks where family members had signed to say they had the authority to do so as required by the Mental Capacity Act 2005. One care worker we spoke with told us "I've never heard of power of attorney for health and welfare decisions. It's the social worker who assesses capacity. I wouldn't have a clue how to do an assessment. I wouldn't know where to start." This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 as the service was not operating within the requirements of the Mental Capacity Act 2005 by obtaining the appropriate consent.

We asked people how supported they felt with their nutrition and hydration. One person said "They tell me what is in the fridge but I generally know what I have got. Once they understand what I want they do it. They always leave me with a cup of tea or coffee and some water." Another person said "They always ask me what I want and give me plenty to drink. They leave me with a flask of coffee during the day and night as I am up a lot." We observed one person being asked their choice of lunch and this was duly prepared.

We asked staff how they encouraged people who were unable to make their own choices. One care worker told us "My policy is to put down food in front of people even if they say they don't want it. Most of the time they eat it anyway." This was in line with the person's preferences and tastes. Another care worker told us of people who were on nutritional supplement drinks, and they understood the importance of recording what was actually given. A further care worker told us "I always ask people if they want a hot meal or a sandwich, offering them the choice. One person I visit often refuses food so I complete a food and nutrition chart." It was unclear what happened with this monitoring as we did not find any evidence of these in the care records.

People were confident if they needed to access urgent medical help then staff would organise this if they were unable to. During one of the home visits one person slipped down the last two stairs in their home but was able to get up unaided. The staff member assessed the person for any injuries, rang the office and the person's next of kin, and also recorded the incident in the person's care records. They checked with the person before leaving that they were not in any pain. They advised us if they had any concerns they would always contact the district nurse.

Another care worker told us "I visited a service user who was confused so I reported it and wrote it down. Another one I visited felt dizzy so I left them in bed until family were able to come and support. I wouldn't leave them on their own."

One care worker told us they were aware to look for signs of pressure damage to a person's skin, "We keep an eye on them. We use Cavillon and I look at their feet." They continued "I've got the same clients most of the time which is what I asked for. This means I can tell if their health is changed." Another care worker said "I make sure they're clean properly, use the creams and make sure they change their position." The registered manager said all staff were encouraged to monitor skin integrity regularly and any concerns were to be noted on a body map. They said they would contact the district nursing service who would provide pressure care advice.

Requires Improvement

Is the service caring?

Our findings

One person told us "The majority of staff are excellent but they work very long hours." Another person said "The staff on the whole are very cheerful and respectful towards me. We have a bit of a laugh and a joke." A further person said "They are very kind to me and know me so well as they have been coming a long time." One relative said "They do talk to me when necessary but they always talk to my relative (who is having the care) and have a laugh and a joke with them." We observed care workers being bright and cheery with people and that people responded well to them.

In terms of people's preferences we asked them if they felt they had been respected. There was a mixed feedback with most people saying they had been asked if they preferred male or female carers but on occasion these choices had not been met, for example people had received a male carer despite them saying they preferred a female. One care worker told us they had not received any training in regards to supporting people with different cultural needs.

One relative we spoke with told us about an incident when a new member of staff was supposed to be shadowing a more experienced carer. When the relative arrived they found the newer staff member sitting downstairs while the regular carer was assisting their relative upstairs which meant they were not receiving an effective induction as they were not observing how care support was provided for that person. This newer member of staff has now taken over the care and the relative has found care has not been given as directed in the care plan. Instead of their relation having a full body wash, the staff member has only washed their hands and feet, and not supported the person to change their clothes. They also said "The previous girls used to chat to [them] as they filled in their notes but [their] current carer writes them up in a different room. They also do not goodbye when they are leaving so my relation doesn't know if they have left."

Another relative told us "Sometimes care is rushed in the evenings and lunchtimes. My relation now only gets a shower twice a week, other times they just rush washing their face, hands and feet. They are incontinent and will leave dirty pads around instead of putting them in the disposal bin when they were rushing. I have to tell them about it. They apologise but it happens a lot." One person receiving support also said "Just lately they don't seem to have as much time as they used to but will sometimes find it if I need something." One care worker we spoke with also said "I sometimes don't have long enough with each person so I have to catch up. I can rush sometimes. I always think if this were a member of my family how would I feel?" This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's dignity was not always respected.

One person said "I was not involved with my care plan, it just evolved but I don't complain. I do feel rushed in the morning and at tea time though." However others had a different experience. One person said "I was involved in my care plan and they did listen to me about what I wanted and needed. They meet my needs and I have a good rapport with them." One relative said "We, as a family, were involved in their care plan and we got what we asked for."

We asked people if they felt comfortable receiving care. One person said "Staff always cover my bottom half

when doing my top half, and they call me by my preferred name" and another told us "Yes I do as they check my curtains are pulled and doors shut when doing my personal care, and they always make sure I am covered when washing me in a chair." The registered manager said this area of care was monitored during spot checks visits which were unannounced. Findings were recorded on a detailed assessment of the care worker's performance which included their appearance, timekeeping and general performance.

Staff told us how they promoted a person's privacy. One told us "I'm careful of my conversations and what is said and I try and deliver care how the person wants to receive it." Another care worker said "Most people are able to say how they want to receive support and I always ask them." A further care worker said "I always make sure the person is happy to receive support, respect their privacy by covering them if needed and explain what I am doing. I am here to help them."

Inadequate

Is the service responsive?

Our findings

People told us they had little choice over call times. One person said "No, I don't have much choice especially time wise. I have them as and when they get here." Another person told us "No I don't - it has just evolved over the years." A relative said "We were not given any choice regarding times and there appears to be no set times. Sometimes they can arrive to my relative before 8am and another time it is after 9.20am or later. This is not good when they put them to bed early evening." Three further people also said they had no choice, one even said "It seems to be as and when it suits the carers." One person said "We talk about all sorts of things whilst they are here but they don't have a lot of time so can't talk too much" and another told us "They come as a rule before 10am. It depends when they see the people before us. They come when they can fit us in."

In one care record we noted preferred call times for the morning call to be 08:15, lunch 13:15, tea 17:20 and bed 20:30. Most of the calls for this person over an eight day period were 07:45, 11:20, 15:15 and 17:40. This meant the service was not adhering to the person's preferences and also that calls were condensed during the day meaning the person did not have night-time support at an appropriate time. In another record, for one week in August 2016 morning call times varied between 8:12 and 9:40 which meant the person receiving the call had no certainty that care workers would visit. One relative told us "I wouldn't call the plan person-centred. My relation and I were involved in discussing the plan but didn't think to specify a set time for the carers to arrive. They have a carer four times a day and the timing has now become when it suits the company, not when it suits my relation." This demonstrated the service was not delivering consistent call times in line with people's requirements and preferences, and potentially leaving some people vulnerable and without timely care intervention. This is evidence of a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 person-centred care as the service was not always meeting people's needs and reflecting their preferences.

One care worker said "I've probably only read the care plans once or twice because the office lets us know if anything changes. This could be if the medication changes, they're in hospital or not well." However, they also said that communication could be improved as these messages did not always get through, "Sometimes you get a rota and you go and they're not there. I think there's a lot of time wasting going on." Another care worker said "I wouldn't say for sure that everyone has a care plan. Some are very out of date. This is because team leaders go out to cover calls, so how are they supposed to update care plans? They're always fighting fire all the time."

We observed one person being asked to sign the record to confirm the care worker had been to visit. There were also smart folders with people's records in them containing key contact information and polices including moving and handling, safeguarding, advocacy, medication and confidentiality.

We asked people if they had been involved in a review of their care needs. There was a mixed response. One person said "No I have not had my care reviewed but if I wanted anything extra I am sure if I contacted them it would be provided" and another told us "Someone comes regularly and asks but there is always an annual review." However, other people said "I have not had a review in three years" and "I don't think we've

had a review."

We saw in some care records people had been contacted by telephone for their feedback. In one record the person had commenced the service in February 2016 and been contacted twice since then, once in March (about two weeks after commencement of the service) and then in April. Each time they had spoken positively of the service they received. A different person had told staff on their telephone review "I'm very happy with the service. Staff are lovely and get on well. I'm very happy with all the care and staff do the tasks they're supposed to." A care co-ordinator said "Reviews are every six months, either a visit or by phone. If needs change in-between we change the whole of the care plan. We rely on the carers to feed the information back."

We looked at care records. Initially we were only provided with paper records but later obtained access to records on the electronic systems which provided additional information. Care records were person-centred referring to a person's specific situation and their preferred title. There was also a summary overview of their needs which was a helpful tool for staff to obtain key information quickly. Tasks that needed completing were noted alongside the preferred location of these such as people preferring to be washed in their living room as this allowed more space. The assessment referenced needs for medication, personal care, communication, meals and mobility.

Individual outcomes were recorded for each person but these tended to be generalised such as 'maintain a good level of personal hygiene', or 'good skin integrity through daily inspections'. These specific outcomes were broken down into tasks for staff to complete on each visit and were very detailed. In one record it was noted "Care staff to encourage [name] to allow them to make something to eat – can be a slice of toast." This was for a person who had little appetite first thing. Each call was equally detailed and prescriptive ensuring staff had clear guidelines to follow to meet all this person's needs. There were also regular prompts for staff to record and report any concerns promptly. Daily notes followed the task required list outlining major support offered, what a person had eaten and drunk and if there were any concerns. We saw concerns were followed up as required. In one record we saw noted "Apologised for being late but had call from call centre to say a carer had rung in sick and I had to cover" and in another how a person had been supported to use their inhaler as they were short of breath.

The records were stored in relation to geographical areas and we found that many assessments were missing from the paper files for the south Kirklees. We were told that communication records (daily notes) and MAR sheets for the previous month were returned to the office on the second Monday of the following month. However, we found there were no records for some people from June 2016. Of the records returned we did see that some had been audited but these related to basic information and readability rather than any rigorous assessment of whether the care being delivered was in line with the care package.

People who received care out of office hours could access an 'on call' system which was located in the head office in Birmingham. Staff could access all the relevant care records and speak to a local senior member of staff if needed in an emergency.

People told us they knew how to complain and were happy to do so if needed. People had access to the complaints policy in their care records. One person said "When I made a complaint it was dealt with to my satisfaction." Another person told us "I have in the past raised issues that were more or less resolved but what they think of satisfactory and what I think is a different matter." One relative also said they had raised various issues but "no improvements have been made relating to call timings, cooking skills or the issues about the staff member I discussed."

The registered manager told us there had only been two complaints received. This was in reference to the north Kirklees area. They told us most issues are treated initially as concerns and they prefer to contact people early on to try and seek a swift solution. However, this meant these concerns were not being logged in accordance with their policy which stated "Any expression of dissatisfaction whether or not identified as a complaint by the person expressing dissatisfaction." We looked at the complaints log and found that one referred to call times not being adhered to and that this was partially upheld. An investigation had been conducted and staff spoken with regarding the call time requirements. It was not always evident that follow up calls to people had happened to check they were happy with the outcome.

On the second day of the inspection we were given access to the complaints folder for south Kirklees where we found a further three complaints. All related to late call times and inconsistent staff providing care. One investigation said spot checks of staff practice would be conducted over the subsequent four weeks but we did not see any evidence of this. There was no evidence of any analysis of the care records. The complaint had been signed off by the registered manager saying that the concerns were not related to the service provision but it was unclear now this conclusion had been reached as this was not evidenced in the investigation which had not been completed in full.

The service had a record of compliments. We noted four had been received between April 2016 and July 2016 for the north Kirklees area thanking the service for their care.

Inadequate

Is the service well-led?

Our findings

We asked people how they found the service. One person said "Overall it's good. I am encouraged to do things for myself". Another person said "To be honest the service is quite good. I cope with the odd times they are late as they always manage to send somebody." However, one relative said "I am slightly less confident with the service this company is providing in comparison with the previous company. I am hoping things might improve."

We asked people if their views had been requested regarding the quality of the service. One person said "In all the years I have been with the service no one has asked for my opinion on the service I receive. I have nothing but praise for the majority of carers I have." However, another person told us "Occasionally someone calls and asks if the carers are OK." This was reiterated by a relative who said "The office girls have contacted me if they had a query about my relative or want to check up on things. Any important decisions they do contact me." No one we spoke with receiving the service was able to identify the manager of the service.

We saw there was an annual survey but again not everyone had completed this. One person actually said "About a month ago I was sent a questionnaire which the lunchtime carer helped me fill in. I haven't heard anything back, probably as I said nothing was really wrong." This meant the information was not completed impartially. A relative said they had been receiving the service for six years but had never been asked their opinion. The registered manager shared a copy of the annual service user satisfaction survey from June 2016 which showed the views of 24 people using the service. Most people felt staff were caring and were competent. However, nearly 30% of responses indicated people were receiving unknown care staff and 33% felt staff were in a hurry. There was no completed action plan following this survey to tackle the identified issues which showed the registered manager had not followed up concerns or considered how to address them.

One care worker told us "I like my round and I love my clients. I do enjoy my job." Another said "I do really enjoy my job. I enjoy what I do. A lot of the staff are really nice people and they work hard." A further care worker told us "I am here to help people stay in their own home and remain independent."

We queried whether staff felt supported. One care worker told us "If I need anything I do ring up and get it sorted. I don't have any problems with the managers when I see them. They're nice." Another care worker told us "I am very well supported. I have no issues and it doesn't matter how silly the question is. Everyone is very professional and there's always someone available to talk to." However, a further worker said "I don't think it's well managed. I don't think they know what they are doing. Everything seems to be mix and match" which they related to how calls were organised. A further care worker said "It's whatever's cost effective, isn't it?"

We were given copies of staff meetings which were infrequent. One set of notes from February 2016 was an exact copy of notes from a meeting held in September 2016 which meant staff may not have had access to latest guidance or policy changes. However, another set of notes from August did refer to the recent merger

of the branches.

We spoke with the registered manager each day of the inspection. The first day identified some concern around the scope of the service as they told us "I am the registered manager for the North Kirklees area of the service. We also support people with learning disabilities across the whole of Kirklees. Not everyone has personal care support." They continued "We also have Sevacare Huddersfield and there are plans to merge this service but there is a separate manager for this." This was echoed by the care co-ordinator who said "No staff from Huddersfield use this building." This information did not match our understanding of the service which was registered for the whole of the Kirklees area and the Huddersfield branch was no longer in existence. During their interview they also only spoke about staff managing the north Kirklees area who were two care co-ordinators. One of these managed all the domiciliary care and took the lead in preparing staff rotas and conducting staff supervisions and the team leader supporting them undertook all areas of quality assurance such as assessments including those for risk, spot checks and annual reviews.

By the second day the registered manager informed us they had got "confused" and they were fully aware they managed the whole of the Kirklees area. They told us "I completely misunderstood. I am fully clear the services are merged and from the end of October all records will be on one system." They also said they had conducted a staff meeting in Huddersfield in August 2016 but knew the service in Huddersfield had de-registered as of the end of August 2016. They told us the service had a care co-ordinator for the south of Kirklees who had to assist in providing care due to a shortage of staff. This person was responsible for all staffing rotas and had no support from a team leader as they were not at work. We saw from the staffing rotas this care co-ordinator was providing care on an almost daily basis. The registered manager told us that one of the other team leaders would be supporting from the following week.

We were given a list of people using the service in both north and south Kirklees including those people with learning disabilities who were receiving community support. These lists did not all correspond with the paper records in the office. The electronic records showed some as 'temporarily inactive' and equally there were paper records in the office but the person was not on the service user lists given to the team. When we asked one of the care co-ordinators about this they replied "they are probably inactive but the files haven't been removed. It may be the person has passed away or moved to a nursing home." This lack of clarity reinforced the view the service did not have an accurate record of the people currently using the service as records did not tally and we could not be confident they knew who was receiving a service.

We found 19 paper files in the north Kirklees area but these people's names were not on the list, in south Kirklees there were a further 12 extra files. In some paper files there were communication records and medication administration sheets but not for every month, and no other records. In one file we found communication records for November and December 2015, none for January 2016 and then February to May 2016 and then none until August 2016. In south Kirklees seven people were listed as receiving a service but there were no paper records for them. On the initial day of inspection we were given a list of people receiving a service in north Kirklees and those receiving support in the community. It was marked as to which people did not receive assistance with personal care but when we looked at the files for this part of the service we found this was not the case. At least three of the files we sampled contained information to show care workers were assisting with personal care tasks. This reinforced our view the service did not have clear oversight who was receiving a service or what type of help they were receiving.

This is evidence of a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was little evidence of leadership and understanding about the issues within the service, and records were not analysed effectively to monitor and improve performance. Systems to analyse quality assurance were ineffective and meant the concerns posed by a lack of staff had not been identified

leaving people at risk of no or late care support.

One care worker told us "Even though the service is merged, it is still separate. Issues are dealt with according to the location." They told us not all staff had received supervision in south Kirklees but the process had been started "although fitting them in would be difficult given the demands on the service".

The registered manager told us there had been no significant changes to the service over the past twelve months despite it merging with another agency and they were able to pick up work at a steady rate and had a good working relationship with most of the staff. However, some care workers felt under considerable pressure and received little support as "There are now less staff than before and this is hard." This demonstrated a lack of understanding about the extent of the service issues and no overall scrutiny of key areas of concern.

We asked the registered manager what they felt the key challenges were to the service and they told us recruitment but this was not unique to their agency. As a contrast they felt they had achieved a great deal including allowing people to remain at home, provided a flexible service and felt they were managing it well based on feedback they had received from other people. They felt they received sufficient support from senior managers who visited at least monthly and provided direction and guidance where needed. We saw limited input from senior managers with evidence of the most recent formal visit in July 2016. This had resulted in an action plan which mostly referenced changes to care records. The registered manager shared two further action plans which focused mostly on checking paperwork and ensuring records matched. There was no analysis as to the effectiveness of the service or any integration within it of the client survey findings.

There was limited evidence of effective quality assurance measures. Some care file notes were audited with limited feedback. In one instance this referred to a care worker writing on the back of the book rather than requesting a new one. We noted a memo had been sent to the care worker. There was a similar approach with any issues with medication sheets where a standard memo was issued to staff whatever the issue was. Although this memo was comprehensive in setting out clear guidelines for the correct procedure it did not help individual staff members identify issues with their own practice or promote understanding as to what they had done incorrectly.

The registered manager felt confident good practice was being followed as they said feedback, their observations and staff meetings all supported this. One care worker said "I know I'm doing well as no one has complained." Another care worker told us "When I come out of their house, leaving them with a smile on their face and they are happy." However, we did not feel this was evidenced in relation to people's experience, staff's feedback and the lack of effective quality assurance systems ensuring service delivery was in line with expectations and contractual obligations.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service was not always meeting people's needs and reflecting their preferences.

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 17 HSCA RA Regulations 2014 Good governance There was little evidence of leadership and understanding about the issues within the service, and records were not analysed effectively to monitor and improve performance. Systems to analyse quality assurance were ineffective and meant the concerns posed by a lack of staff had not been identified leaving people at risk of no or late care support.

The enforcement action we took:

NoP