Sevacare (UK) Limited

Sevacare - Coventry

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 April 2018. The inspection was announced.

Sevacare-Coventry is registered to provide personal care support to people. At the time of our inspection the agency supported approximately 270 people with personal care and employed approximately 106 care workers. The service is located in Coventry in the West Midlands and provides long and short term care packages.

This service is a domiciliary care agency. It provides personal care to people living in their own homes, including, older people, people living with dementia, physical and learning disabilities and mental health problems.

We last inspected Sevacare-Coventry in April 2017 and gave the home an overall rating of 'Requires Improvement'. This was because we found some risk related to people's planned care had not always been assessed and some people did not receive their care visits at the times they needed. People's capacity to make decisions had not been established in line with the requirements of the Mental Health Act 2005 and the provider's quality monitoring systems were not always effective.

At this inspection on 19 April 2018 we checked to see if improvements had been made and if they were effective. We found the provider had taken some action. However, we also identified areas which remained in need of improvement and areas where standards previously demonstrated compliance with regulations had not been maintained.

This is the third consecutive time the service has been rated as requires improvement.

The service had a registered manager. 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.

Risk associated with the delivery of people's planned care had not always been assessed to ensure care workers had the information needed to keep people and themselves safe.

The provider had not ensured people's medicines were always managed and administered safely and in line with their procedure. Action was being taken to address this.

The provider's systems to check monitor and improve the quality and safety of the service provided were not always effective. Some people and relatives were dissatisfied with the service provided and the way complaints were managed. Action was being taken to address this.

The management team and care workers understood how to protect people from abuse and their responsibilities to raise any concerns. People felt safe with the care workers and there were enough care workers to provide people's planned care visits. The provider's recruitment procedure checked staff were of suitable character to work with people's in their own homes.

The management team had an understanding of, but had not ensured they were consistently working within the requirements of the Mental Capacity Act 2005 and the provider's procedure. Care workers did not have the information they needed to understand which decisions people could make and those they needed support with. Care workers sought people's consent before care was provided.

Care workers completed an induction and on-going training the provider considered essential to meet people's needs safely and effectively. However, people and relatives had mixed opinions about the skills and knowledge of the care worker who supported them.

People's care plans were personalised and contained information about how people preferred their care and support to be provided. However, some care plans contained inaccurate information.

Information about the service was available in a range of different formats to meet people's communication needs. Most people and where appropriate relatives were involved in planning and reviewing their care and support.

There were enough care workers to provide all planned care visits. Some people did not receive their care calls at the times they needed. People told us care workers stayed the agreed length of time at care calls and knew how they liked to receive their care.

Care workers respected people's life style choices, privacy and dignity and supported people to maintain their independence. People and relatives spoke positively about care workers with whom they had developed friendships. Care workers supported people to maintain their nutritional and health care needs where this was part of their planned care.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk associated with people's care were not always assessed and records did not always evidence the actions staff needed to take to manage identified risks. Medicines were not consistently managed safely in line with the provider's procedures. There were enough care workers to provide planned care visits. The management team and care workers understood their responsibilities to safeguard people from abuse. The provider checked staff were of suitable character to work in people's own homes.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's capacity to make decisions and consent to care and support was not always established in line with the requirements and principles of the Mental Capacity Act 2005. Care workers gained people's consent before care was provided. People were supported with their nutritional and health care needs where this was part of their planned care. Care workers were completed an induction and on-going training the provider considered to provide effective care and support.

Is the service caring?

Good

The service was caring.

People and relatives had developed positive relationships with care workers who they found to be caring and friendly. People were able to make everyday choices which were respected by care workers. Care workers prompted people's privacy and dignity and encouraged people to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive visits from care workers at the times they needed. Care plans were personalised and informed

care workers how people wanted their care and support to be provided. However, some care plans contained inaccurate information. Most people and where appropriate relatives were involved in planning and reviewing care needs. Information about the service was available in varied formats to meet people's communication needs. Complaints were not always managed in line with the provider's policy and procedure.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

People and relatives had mixed opinions about the way the service was managed and the quality of the service provided. People and relatives were given opportunities to share their views about the service. The provider's quality monitoring checks and systems were not always effective. Care workers felt supported by the management team and received the support and guidance they needed to carry out their roles.

Sevacare - Coventry

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 site visit took place on 19 April 2018. The inspection was announced. The provider was given 48 hours' notice because the service provides a domiciliary care service and we needed to be sure staff and the registered manager would be available to speak with us about the service.

The inspection team consisted of two 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.

Before our inspection visit we reviewed the information we held about the service. We looked at statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

We also spoke with local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. They told us they had no feedback they needed to share with us about the service.

We reviewed information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. During our visit we found the PIR was not always an accurate assessment of how the service operated.

We conducted telephone interviews with 13 people and six relatives of people to obtain their views of the service they received.

During our office visit we spoke with the registered manager, the branch manager, two team leaders, a senior care worker and three care workers.

We looked at four people's care records and other records related to people's care, including medicines and daily logs. This was to see how people were cared for and supported and to assess whether people's care delivery matched their records.

We reviewed four staff files to check staff were recruited safely and were trained to deliver the care and support people required. We looked at records of the checks the provider and registered manager made to assure themselves people received a good quality service, including complaints and medicines records.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection 'safe' was rated Requires Improvement. This was because some known risks associated with people's care had not been assessed and risk assessments which had been completed did not always provide staff with the information they needed to keep people safe.

Prior to this visit the provider informed us in their PIR that all risks were assessed and risk assessments had been updated to minimise risk and keep people safe. However, during this inspection we found this was not an accurate reflection of the way the service managed risk. The rating remains Requires Improvement.

For example, we saw one person's 'Assessment of need' showed they were known, at times, to display aggressive behaviour, included physical aggression towards staff. This behaviour was related to the person's diagnosis of dementia. However, this risk was not reflected in the person's risk management plan. This meant staff did not have the information they needed to keep the person and themselves safe, so that this was managed in a consistent way. We discussed this with a care team leader who took immediate action to update the risk assessment.

Another person's care plan stated they were at risk of choking. Whilst the care plan recorded the person understood their own risks and how to manage them, it also instructed care workers to ensure the person's food was cut into small pieces, and remind the person what steps to take to reduce the choking risk. However, the care plan did not include any information about how the risk had been determined, there was no guidance from relevant health professionals, and did not inform care workers on what actions they should take if the person did begin to choke.

A third person required specialist equipment to enable them to move around their bed safely. We saw a moving and handling risk assessment had been completed in March 2018 but this did not included details of the need for care workers to use specialist equipment, or the type of equipment assessed as needed. We discussed this with the branch manager who told us they would ensure the assessment was updated.

We also saw the branch manager had agreed and signed off this person's 'Assessment of Needs' which contained inaccurate and incomplete information and did not include information about known risk. This meant care workers did not have the information they needed to the person were supported safely.

Other risk assessments we reviewed were up to date and provided staff with the information needed to manage and reduce each risk. For example, one person needed assistance to transfer from their bed to a chair. The assessment detailed the equipment needed and the number of care workers required to support the person safely.

Despite the omissions in risk assessments, discussions with care workers demonstrated they knew about the risks associated with people's care and how these were to be managed. One said, "You have to know how to do things right to keep them [people] safe. It's all written down so we know what to do." A team leader told us risks associated with people's care and the environment were assessed when the service

started so information could be shared with care workers before they visited the person. However, this conflicted with some of our findings during the inspection.

At our last inspection visit we found medicines were managed and administered safely. However, during this visit we identified some areas where the service had previously performed well, now required improvement.

Medicine administration records (MARs) had omissions. For example, one person's MAR had not been signed by care workers on 14 separate occasions during February 2018. At the time of our visit the person's communication record (completed at each visit to show the support provided) was not available which meant we could not check if the person had been supported to take their prescribed medicines. Another person was prescribed Paracetamol to be taken twice a day but their MAR had not been signed to show if the person had taken, or refused their medicine. However, we saw care workers had recorded the person had taken their medicine on the communication record.

We also saw some MARs did not include the name of the medicine, the number of tablets to be administered and the prescribing instructions. For example, a handwritten entry on one MAR read 'eye drop'. The name of the eye drops or the prescribing instructions had not been documented.
Another person's MAR read 'Fish tablets'. The entry had been added by hand but gave no further details.

These omissions meant we could not be sure people had received their medicines safely or as prescribed. We discussed our concerns with the registered manager who said, "There is no excuse for this. It should have been picked up." We have asked the provider to improve the monitoring of medication records so they can be assured people receive their medicines as prescribed. The registered manager gave assurance this would be addressed.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Other MARs showed medicines had been administered and signed for at the specified time.

Most people managed their own medicine or had a relative who assisted them with this. People who required support told us they received there medicines at the times they needed. One person commented, "[Care worker] gives me my tablets to take and always records that she has done it in the book. I keep a note of this myself too."

People told us they felt safe when being supported by care workers. One person explained they felt safe because their care workers always made sure the door to their home was locked at the end of the care call. A relative told us they were confident their family member was 'absolutely safe'. They added, "If there were any concerns about safety we would speak with the office."

The provider protected people from the risk of abuse and safeguarded people from harm. Staff had received training in how to protect people from abuse. Care workers were able to give us examples of what might be cause for concern, what signs they would look out for and what action they would take. One care worker explained, "People might be withdrawn, quiet, just not themselves." Staff knew who to contact if they felt their concerns were not taken seriously and people might still be at risk.

Discussion with the registered manager confirmed they were clear about their responsibilities to inform the local authority safeguarding team and the Care Quality Commission [CQC] if there were any concerns about people's safety. Records showed the provider managed safeguarding concerns in accordance with their

policies and procedures which helped to keep people safe.

The provider's recruitment policy and procedures minimised risks to people's safety. The provider ensured, as far as possible, only staff of suitable character were employed. Prior to staff starting work at the service, the provider checked their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Records confirmed staff were not able to start working at the service until all pre-employment checks had been received by the provider.

There were enough care workers available to ensure people received all their planned care visits. One person told us they had been receiving support from Sevacare-Coventry for over 12 months and had never had a missed call. They added, "Once my regular girl [care worker] didn't come and they sent someone else." The branch manager and team leader told us there was sufficient staff to cover all the calls people required.

Accidents and incidents were logged and appropriate action taken at the time to support people safely and to check for trends or patterns in incidents which took place. The registered manager told us, accident and incidents from all the provider's services were reviewed by head office. They explained any themes identified by the head office analysis were shared at managers meetings so any learning or action needed could be discussed and agreed.

The provider had emergency contingency plan in place in the event of them not being able to provide a service, for example in the event of widespread staff sickness or extreme weather conditions. Care workers demonstrated they had an understanding of the emergency procedure and the actions they needed to take in the event of an emergency.

Our discussions with care workers assured us they understood their responsibilities in relation to infection control. We saw care workers had access to disposable gloves and had completed infection control training.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated 'effective' as Requires Improvement. This was because the provider had not always ensured people's capacity to make decisions was assessed and some people's consent to care had not been obtained in line with the principles of the Mental Capacity Act 2005.

During this inspection we found the required improvements had not been made. The rating remains Requires Improvement.

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. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way possible.

During this inspection records showed some people's consent had not been recorded in line with legislation. For example, one person's care file contained a consent to care form which had been signed by the person's relative. However, there was no information to show the relative had the legal authority to make decisions on the person's behalf or that the relative had signed the consent form following a 'best interest' decision being made.

The consent to care form on a second person's file had also been signed by the person's relatives. We saw one of the relatives had power of attorney over finances, and the provider had proof of this on file. However, having power of attorney over finances does not enable relatives to make decisions about people's health and social care support.

Elsewhere in the person's care plan, it stated the person had capacity to make their own decisions about their care and support. We raised this with the registered manager, who told us the person did have capacity but had given permission for their relatives to sign the form on their behalf. The registered manager acknowledged this had not been documented and assured us they would visit the person to discuss consent with them again, and ensure this was properly documented.

People told us care workers sought consent before providing any care or support. One person said, "They [care workers] do ask but my regular ones just carry on because they know what they are doing." The person told us they were happy with this approach. Care workers demonstrated they understood the importance of gaining people's consent from people before they supported them. One said, "You have to ask and if a client [person] refused repeatedly you inform the office."

At our previous inspection visit we found mental capacity assessments were not always completed when people could not make decisions for themselves and the services dementia assessments did not conclude whether people did or did not have capacity to make decisions.

During this visit we continued to find some people's capacity had not been assessed in line with the requirements of the MCA and consent had not been obtained in line with the principles of the Act. Information care workers needed to understand the type and level of support people needed to make decisions was not always available.

For example, one person's local authority support plan detailed the person had a confirmed diagnosis of Dementia and was in the advanced stages of the disease. This information had been recorded in the person's care file but a capacity assessment had not been completed and there was no information about what decisions the person could make or who could make decisions in the person's best interests.

A second person was known to be living with Alzheimer's disease which their support plan described as 'severe'. There was no information to show the person's capacity to make decisions had been assessed and the completed 'dementia assessment' did not conclude if the person had capacity to make decisions or not.

We were concerned care workers did not have clear information about people's capacity to make decisions, or if decisions needed to be made in their 'best interest' and by whom. We discussed our findings with the registered manager they said, "If there are doubts about capacity then I expect this (Assessment of Mental Capacity/Consent To Care') to be completed and they should be in the care plans." The registered manager acknowledge these assessment had not been completed and told us they would ensure this was addressed.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Need for consent.

Care workers had received training in the MCA and had a basic understanding of the Act. One commented, "It is about choices and whether or not people have capacity to make their own decisions. You sometimes have to keep it simple and give people options." Our discussions with care workers demonstrated they knew what action to take if someone lacked capacity and put themselves at risk. One explained, "I would contact the office if I thought that was happening."

People's needs were assessed and documented before they started using the service. Records showed staff collected a range of information about people's life histories, their likes and dislikes, cultural and religious motivations. One relative told us their family member had a male care worker because this was their preference. Another explained their family member was supported by care workers who spoke Urdu because they did not speak English.

The registered manager told us the service provided support to people from a wide range of different cultural and ethnic backgrounds so they targeted staff recruitment from the local community to ensure people's needs could be met. They added, "At the moment we have staff who can speak many different languages, including African, Urdu, Punjabi, English and Polish. We have male and female staff and staff who understand and respect different cultures, this is very important."

People and relatives had mixed views about whether care workers had the skills and knowledge needed to support them effectively. One relative told us they were confident about care workers skills because they were 'observant' and described how staff alerted them to the fact their family member's hand was swelling because their watch was too tight. Another relative told us, "They [care workers] do seem to lack basic training… some of the carers don't really know what they are doing."

Care workers told us they had an induction when they started working for the service which included

working alongside an experienced care worker. One care worker told us, "I did three days training initially, it was good. I was well supported." Care workers confirmed their induction was linked to the Care Certificate, and records showed staff had completed this. The Care Certificate assesses staff against an agreed set of standards during which they have to demonstrate they have the knowledge, skills and behaviours expected of specific job roles in social care sectors. This demonstrated the provider was acting in accordance with nationally recognised guidance for effective induction procedures to ensure people received good care.

Care workers received on going training to enable them to keep their knowledge and skills up to date. This included training in supporting people to move safely, medicine administration, safeguarding vulnerable adults, and health and safety. Records confirmed training was up to date.

Care workers told us if they supported people with specific health needs, they received training to support them to deliver care effectively. One care worker told us they had just completed a qualification in supporting people living with dementia. Another said, "Recently we had training from district nurses who came to the office to explain about the PEG feed." They added, "The training is very helpful." A PEG (Percutaneous endoscopic gastrostomy) is a means of providing nutrition via a tube inserted into the stomach.

People's nutritional and specific dietary needs were met by care workers if this was part of their planned care. One person told us they were diabetic and described how care workers always checked if the person was able to eat certain foods. They added, "They make sure that I do not eat anything that I shouldn't. " Other people said they could choose which meal the carer workers prepared for them. One person commented, "They [care workers] make me plenty of drinks."

People told us care workers supported them to manage their day to day healthcare. One person explained care workers had telephoned the doctor on their behalf because they had a swollen leg.
They added, "The morning carer packed my bag ready to go to the hospital…" A relative described how care workers checked their family member's feet because they were prone to their skin becoming sore. They added, "They always alert me and advise I contact the doctor if there is a problem."

Records showed the service worked in partnership with other health and social care professionals to support people. One person told us, "The carers work together with the district nurses – they liaise and ask each other's opinion."

Good

Is the service caring?

Our findings

At our last inspection we rated caring as 'Good'. At this inspection we found people continued to receive care and support from care worker they described as caring and friendly and who understood people's individual needs. The rating continues to be 'Good'.

People and relatives spoke positively about the care workers who supported them. Comments made included, "They are helpful and gentle…professional but warm with it." "The carers are fantastic.", "They are all very friendly, both men and women.", and "They have a sense of humour. [Person] calls them her darlings – her angels."

We asked care workers what being 'caring' meant for them. One told us, "Providing good quality care is being patient and gentle with people." They added to be caring they had to ensure people were treated with kindness and respect. Another explained how being a care worker had changed their life. They said, "To look after someone and do your best teaches you a lot. We learn all the time from the people we support."

People told us their regular care workers knew about their care needs and supported them in the way they preferred. One person told us, "They know I like coffee not tea and not instant. They know I like the sachets." Another person told us, "They [care workers] know exactly what to do and how I like things done." They added, "It's up to me. It's my choice."

Care workers had a good understanding of people's care and support needs and had built positive relationships with people. One relative described how care workers had used singing to develop a relationship with their family member. They said, "[Person] used to refuse a shower all the time. Now [care worker] sings when they are in the shower room and things have really improved. A care worker told us, "I get on with people, I communicate well. You form a bond. It is nice when you go into people and they smile. It's great." Other care workers felt they were able to build relationships because they regularly visited the same people.

People were supported and encouraged to maintain their independence where possible. One person told us their care workers 'encouraged' them to do things for themselves but were always there if they needed assistance. A relative described how care worker supported their family member to complete some household tasks which assisted the person to remain living in their own home. Care workers understood the importance of enabling people to remain independent. One explained, "We are there to help clients stay in their own homes so It's important to help them keep doing things."

People told us their privacy and dignity was respected by care workers. Care worker described how they closed doors and curtains to ensure people privacy and dignity was upheld. One said, "If relatives are about we politely ask them to leave the room before we do any personal care. We don't want the clients [People] to feel embarrassed." Another care worker said, "Clients are asked if they prefer male or female staff. Their choice is respected."

People and relatives told us care workers had sufficient time to carry out their calls without having to rush. One person said, "They are never rushed and stay as long as it takes." Another person told us their care workers had time to sit and chat, which the person enjoyed. A care worker commented, "It's really important to take time to chat. Talking is all part of our job. We could be the only person they see all day."

People's records held in the office which contained personal information were secured and kept confidential. Discussion with care workers demonstrated they understood the importance of maintaining people's confidentiality.

Since our last inspection the provider had introduced a new initiative called the 'care awards.' The provider asked people using the service to 'nominate' care workers they felt were doing a particularly good job. For example, in relation to helping people to stay independent. Successful staff were awarded a certificate of achievement. Care workers we spoke with were positive about the scheme. One told us, "It encourages us to do our best and do good things."

Requires Improvement

Is the service responsive?

Our findings

Previously, 'responsive' was rated as Requires Improvement. This was because some people and relatives told us care workers regularly arrived late to provide their care call which caused them concern. During this inspection we found some people and relatives continued to have concerns about the consistency of their call times. The rating remains Requires Improvement.

Some people and relatives told us the timing of their care calls were not consistent. One person said, "They [care workers] do have some set times but they have to be flexible if the office asks them to do something else. The carer comes anytime between 7.00 and 10.30." Three people told us the time of their care call had been changed because their care worker had been allocated additional care visits. People told us this meant their care call was either too late or too early. A relative told us they had been informed their family members call times would be 10am and 7pm. They said, "It's rarely the case. They are often up to an hour earlier or later."

Care workers told us they were able to make most care call at the agreed time because they had a set rota. One said, "With regular clients, the calls are at the same time." Another told us call times could be changed if people requested this. However, care workers explained rotas could also be changed if they were allocated additional 'short term' calls. Care workers told us 'short term' calls were provided to assist people whilst they recuperated following discharge from hospital.

We discussed people's concerns about call times with the registered manager. They told us they were surprised at people's comments. The registered manager explained this was because when the service started if they took on a package of care, they would be honest and tell people they could not accommodate their preferred times initially, but would work towards it. When we asked the registered manager if taking on short term packages could affect other people's call times they said this would not happen because additional work was only allocated to care worker who had availability. However, this conflicted with what people, relatives and care workers told us.

We looked at the call schedules for seven people who used the service over a three week period. These showed people had received all planned care visits and that staff had arrived and stayed the agreed amount of time. However, it was not possible to confirm if visits had been undertaken at the times agreed because this information was not clearly recorded in people's care records and some daily records completed by care workers after each visit were not available, in the office, at the time of our inspection.

People told us they received their care calls from regular care workers who they knew. Comments included, "It's very rare that we have anyone different.", "I have a regular carer now but it has been a battle.", and "We have the same person." Care workers told us they had a small group of people they saw regularly, and that they thought people had consistent support. One commented, "Most of the time we see the same people. I can say to my regular 'clients' 'I'll see you tomorrow'."

Most people told us they were involved in agreeing and reviewing their planned care. One person said, "I was

involved in it. I said what I wanted them to do." A relative told us they attended a meeting when the service first started to discuss their family member's needs. People's care files contained 'Service Monitoring and Review forms' which showed the provider contacted people regularly to establish their views on their care.

We saw people's care plans included some personalised and detailed information which supported staff to provide personalised care. For example, one person's care plan included very clear guidance for care workers to follow when supporting the person to stand including, "Ask [name] how they are feeling before attempting to support them."

However, we saw another person's care plan informed care workers the person needed assistance with continence management. Through discussion we identified this information related to another person and had been included in error. We raised this with a team leader who told us they had not completed the care plan and were not sure how this had happened. However, the registered manager acknowledged this was an error and rectified it immediately.

Care workers spoke positively about care plans and the information these gave them. One told us, "Care plans give us a lot of information, medication, health problems. It is quite helpful to read through the plan at the first call." They added, "We are able to do that within the time we have allocated." Care workers explained there were procedures in place should they feel a care plan needed updating. One commented, "We contact the office if a care plan needs changing, to let them know and they make sure it is changed."

The Accessible Information Standard (AIS) is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We spoke to the registered manager about how they ensured information was accessible for all people using the service. They told us information about the service was available in a range of different formats, including audio, large print and braille.

People and relatives told us they knew who to contact if they needed to make a complaint. One person said, "I would ring the office. They would do something to sort it." However, other people and relatives were not satisfied with the way their complaints were managed. One person explained this was because they felt their complaint had been 'trivialised and not been taken seriously'.

Care workers told us they understood how to support people if they wanted to complain, including their responsibility to share information with the management team. However, this conflicted with our inspection findings. For example, we saw one complaint a person had made to a care worker had been recorded in the person's file but had not been logged as a complaint. There was no evidence of any actions taken as a result. We raised this with the registered manager who agreed this should have been logged as a complaint. They assured they would do so and would investigate.

The provider kept a record of complaints received. Where these complaints were recorded, records showed they were investigated and actions were taken in line with the provider's policy and procedure . However, the number of complaints documented was not consistent with what some people and relatives had told us. For example, one relative we spoke with said they had formally complained about 'numerous aspects' of the service in February 2018. There was no record of this complaint being made. This meant we could not be assured complaints were being consistently managed in line with the provider's procedure to ensure complaint raised were investigated and addressed.

The provider kept a record of compliments they received. One from a person's relative read, "The care and compassion they [care staff] showed and gave [name] was outstanding. They were gentle and

understanding of [name's] needs at all times."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in April 2017 we rated this key question as 'Requires Improvement'. This was because the provider's quality monitoring systems and checks were not always effective.

During this inspection visit we found the required improvements had not been made. We also found areas where the service had previously performed well, now required improvement. The rating remains Requires Improvement.

The home had a registered manager. 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.'

The management team's oversight of the service did not assure us that people were always cared for safely, and that the quality and safety of the service provided was effectively monitored, maintained and improved.

Audits and checks to assess and monitor the quality of the service had not always been completed in line with the provider's procedures. For example, the registered manager described how office staff completed monthly checks of MARs and communication records and then submitted a management report to confirm these checks had been completed. We saw both types of records had been filed without being checked, some of which contained omissions. This meant poor practice had not been identified and addressed. We discussed this with the registered manager who said, "The processes are clear cut. Staff know what they should do and I accept we [registered manager and branch manager] didn't check." They gave assurance this would be addressed.

Audits which had been completed were not always effective. For example, weekly and monthly audits of medicines had not identified the range of medicine management issues we found. This meant the provider had not assured themselves medicines were being safely managed in line with their procedures.

Some quality auditing processes were not sufficiently detailed to enable them to be effective. For example, we saw the audit tool used by the provider to check different aspects of the service asked whether or not care files included certain documents such as needs assessments. However, the audit did not ask how accurate, clear and up to date these assessments were. We discussed this with the registered manager who acknowledged audits were not always effective, and that they would discuss this with the provider.

The Provider's medicine procedure stated only trained staff administered medicines and their practice was regularly observed to ensure they remained competent. Records confirmed this. However, some competency checks did not show action had been taken when required. For example, one observation record dated February 2018 asked, "Was it evident the care worker checked the medication against the MAR and care plan?" In response the observer had ticked, "No." However, in the 'outcome' section of the form, the assessor had recorded, "No concerns." We raised this with the registered manager who acknowledged

action should have been taken and recorded, and assured us they would look into the matter.

The provider had not ensured improvements made to the service were maintained. For example, the provider had developed an action plan following our last inspection. This showed all risk associated with people's care had been assessed, risk assessments had been updated and care files had been reviewed to ensure people's capacity to make decisions, including 'best interests' decisions were clearly recorded. These actions were signed as completed in July 2017. However, we found where needed some people's capacity had not been assessed and information about people's capacity to make decisions was not always recorded.

Previously we found concerns and complaints were managed in line with the provider's procedure and the PIR for this inspection stated, 'We ensure that service users are listened to and responded to in a way that recognises and respects them by way of review, complaints and compliments, feedback from care staff…'

However, we found this was not an accurate reflection of how the service operated. For example, one relative's complaint recorded during a service review meeting in February 2018 had not been acknowledgment or investigated. We raised this with the registered manager and branch manager who confirmed they were not aware of the complaint. The registered manager immediately made arrangements to visit the complainant.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

Previously, when we asked people if they were satisfied with the service received and the way the service was managed we received mixed responses.

During this inspection we found people and relatives continued to have different experiences and opinions. Comments included, "I'm very pleased with the service.", "The standard of care is low. The organisation seems to operate on the fly. They have not got good procedures.", The office is not very well organised… things are not well managed.", and "Communication is not good. If something is wrong they push my call back but don't let me know." However, another person told us they felt communication had recently improved because the branch manager had telephoned to introduce himself.

Since our last inspection the previous registered manager had left the service. The provider had appointed a new registered manager who was also registered to manage another service within the provider group. They told us they spent two or three days a week at Sevacare-Coventry to oversee the service provision and provide support to the branch manager. The branch manager told us they had submitted the required application for registration with CQC.

The registered manager also explained additional office staff had been recruited to strengthen the management team. This now included a deputy manager, a care manager, two care co-ordinators, three team leaders and three senior care workers. They added, "This has really helped to ensure support is there for staff and to check people are happy with the service."

Care workers told us there had been improvements to how well the service was managed under the new management team. One commented, "The positive thing now is that they listen to us and try to help. They are very flexible and give good advice and support."

People and relatives were invited to provide feedback through annual questionnaires. One person told us,

"A survey came just the other day. I get one now and then." The registered manager explained the latest survey had been issued in March 2018 by head office and they were waiting for the results. They added, "Once these are received we will be able to see if we need to take any action."

Staff told us they felt supported by the management team because they had regular individual and team meetings. One care worker commented, "They [managers] go through everything, they feedback good things to us, as well as any concerns they have. We are kept up to date." Another commented, "Even when the office is closed you can get advice by ringing the on-call team." Records confirmed regular meetings were held.

The registered manager kept their knowledge of current social care issues updated. They told us this was achieved through information provided through their membership with the UK Home Care Association who provided links to legislative changes, distance learning and regular updates from the provider. The registered manager also attended meetings with other providers arranged by the local authority. They told us, "These are really interesting you can learn from others experiences and share things that have worked well. " They added, "Any relevant information is shared in team meetings to keep staff informed."

The service worked in partnership with other health and social care professionals to support people. The registered manager told us they had developed 'good relationships' with a wide range of agencies including commissioners and health and social care professional. We saw the service had received feedback from commissioners praising the provider for taking on care packages to facilitate discharges from local hospitals.

The registered manager understood their regulatory responsibilities. For example, they had ensured the most recent CQC rating of the service was displayed in the office reception and had sent notifications to us about important events and incidents that occurred. The registered manager also shared information with local authorities and other regulators when required, and kept us informed of the progress and the outcomes of any investigations.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11 11 (1) HSCA RA Regulations 2014. Need for consent. The provider had not ensured people's capacity to make decisions was established in line with their responsibilities and the requirements of the MCA 2005. The provider had not ensured consent to care and support was obtained and recorded in line with the principles of the MCA 2005

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) HSCA RA Regulations 2014. Safe care and treatment The provider had not ensured care and treatment was always provided in a safe way. The provider had not ensured all risks associated with people's care and support needs were assessed, monitored and reviewed. The provider had not ensured where risk had been assessed that records provided staff with the up to date and accurate detail they needed to manage and reduce risk. The provider had not ensured the proper and safe management and administration of medicines.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 17 (1) (2) (a) (c) (f) HSCA RA Regulations 2014. Good governance. The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured some risk associated with people's care was assessed, monitored and risk management plans developed to mitigate risk.