Sevacare (UK) Limited

Sevacare - Kirklees

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

The inspection of Sevacare Kirklees took place over 14, 20 and 21 March 2017, the first two days of which were unannounced. In addition, telephone calls were made on 16 March 2017 to people using the service to obtain their views of the service. During the previous inspection in October 2016 the service and it was rated inadequate and placed into special measures. We found seven breaches of regulation which related to person-centred care, safe care and treatment, staffing, need for consent, dignity and respect, good governance and requirements relating to registered managers. On this inspection we checked to see if any improvements had been made.

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 169 people using the service during the time we inspected which included people with a learning disability receiving support with personal care.

The service had a registered manager at 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.

People, and their relatives, told us they felt safe receiving support from care workers at Sevacare Kirklees. We looked at safeguarding records and found evidence of appropriate reporting and thorough investigations where concerns had been raised. All staff had recently undergone refresher training in relation to safeguarding and were confident in recognising signs of abuse or neglect, and in taking action.

During the previous inspection we had highlighted significant concerns around the timing, duration and location of calls for care workers to manage. At this inspection we found signs of significant improvement. The service had implemented a system of electronic call monitoring which provided key data for the care co-ordinators and registered manager to analyse. This had only been in place for three weeks at the start of the inspection but we saw evidence of issues being addressed as a result.

We still saw some people were receiving less care than they had been allocated and the registered manager had liaised with the local authority in regards to this. People's views, and staff comments, were much more positive and the general view was rotas were more consistent and tasks were completed as required. People were pleased to receive their rotas in advance so they knew who was coming.

Further work was required on the risk assessments in relation to people who were experiencing some form of memory loss as the impact of this was not always clear. We recommend that the registered manager urgently review all risk assessments to reflect people's level of capacity to assess risk and consent to support, providing guidance for staff on how to best to support where there were concerns. We found some very good examples of person-centred moving and handling assessments and stressed to the registered

manager the importance of following these records.

We had no concerns around the administration of medication during this inspection and felt confident all staff understood their role in relation to this part of the care delivery. We saw all staff had received refresher training in this area and records were being audited in depth. By the end of our inspection the registered manager had secured agreement for further home visits to take place to ensure practice was sound.

All staff had been re-trained in relation to medication, safeguarding, and moving and handling. They had also received training on the Mental Capacity Act (MCA) 2005. Supervisions had been completed, and where due had been scheduled with the staff member.

The service had not progressed since the last inspection with meeting the requirements of the MCA as there was no evidence of any capacity assessments or best interest decisions. People told us their consent was obtained before care tasks were undertaken but some records we read did not indicate everyone had the capacity to make this decision. This meant the service was not meeting the requirements of the MCA.

No issues were raised in relation to nutrition or hydration and people said all care tasks were completed as expected. People were supported to access health and social care agencies as required.

People and relatives were very complimentary about care staff, saying how much they valued their involvement. Evidence was shared of positive relationships with interested and engaged staff who respected people's dignity.

Care records had remained person-centred in their style but not all had been reviewed by the time of the inspection due to the need for the service to focus on other key areas and needed further clarity around people's needs.

Complaints were handled in more depth although the service needed to ensure follow up checks were completed to evidence situations had improved for people.

We found evidence of sound leadership which provided guidance and direction for staff. Audits were thorough and reflected what was required to determine if the service was performing well.

The registered manager was aware not all the planned changes had been fully implemented but had a detailed timetable of action to follow and the service needed to sustain areas where it had made progress.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

We found continued breaches of Regulations 11 and 17 at this inspection. 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 always safe.

People told us they felt safe and the service was reporting concerns appropriately.

Risk was managed better with evidence of person-centred assessments although further work was needed in relation to people with memory loss.

Although there was still some evidence of call times being cut short, the service had improved staffing rotas in relation to continuity and distribution of staff.

No concerns were raised in regards to medication on this inspection.

Is the service effective?

Requires Improvement

The service was not always effective.

All staff had received refresher training and although some were overdue supervisions these were scheduled.

The service was still not compliant with the requirements of the Mental Capacity Act (2005) as there was little evidence of capacity assessments or best interest decision making where people were unable to consent to care.

No concerns were raised in relation to food preparation on this inspection, and people were supported to access other services as needed.

Is the service caring?

Good

The service was caring.

People and relatives spoke highly of all the care staff and shared some very positive comments.

People felt their dignity was respected at all times and they were involved in their care delivery.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records had remained person-centred but there were still some which required further analysis to reflect people's needs.

Complaints were handled in a timely and detailed manner but follow up actions were not always completed.

Is the service well-led?

Requires Improvement

The service was not always well led.

People were happy with the service and their views had been obtained.

The new registered manager had made significant progress in terms of direction, guidance and oversight of the service.

There were still further improvements to be made and sustained in relation to care records, mental capacity assessments and allocation of visits.

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 checked 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 14, 20 and 21 March 2017 and was unannounced on the first two days. The inspection team consisted of two adult social care inspectors on the first day and one adult social care inspector for the other two days. There was also an expert by experience who made telephone calls to people and relatives using the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not request a 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. We used intelligence received from local commissioners, the local authority safeguarding team and notifications to the Care Quality Commission to determine the focus of the inspection.

We spoke with eight people who used the service and three of their relatives. We spoke with nine staff including four care workers, two care co-ordinators the office manager, the auditor and the registered manager.

We looked at thirteen care records including risk assessments, sixteen staff records, minutes of staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in October 2016 we found there were issues with call times and duration, whether tasks were completed and staff highly stressed due to the volume and geographical spread of the calls. We found some improvements had been made.

People told us "Most of the time they are on time. If they are going to be late, it will be only a quarter of an hour and they will call me if they are late," "Yes, they are on time unless there is an emergency at the last call. The care worker will ring me or the office will ring me to inform me if they are late," and "The care workers do come on time. I do not have issues with this." We also asked people if support was offered as per their care plans. One person said "They turn up on time and all tasks are completed." Another person told us "All jobs are completed when they are here." This showed the service had better allocation of call times and duration.

We spoke with staff and asked their views on the rotas. One care worker said, "The shifts are realistic. My hours have been cut down and all my people are in the same area, and the rounds tend to be the same." They continued "I may get the occasional request to cover an extra shift but it is not that often and I'm happy to pick these up." Another care worker told us "The rounds have been changed and involve less travel. It has got better." A further care worker said "I have no issues at all. If I have too many calls on my round I tell them and they are taken off me. They always listen to me." Staffing rotas reflected these views and although some calls were still allocated consecutively, the registered provider had made some significant improvements in terms of managing capacity and location of calls.

The registered provider had implemented electronic call monitoring for all people receiving the service in the south of Kirklees since 20 February 2017. Consent had been obtained and where this was refused, care workers were logging their call times with the office on a weekly basis to ensure monitoring could take place.

The registered manager told us the system had identified evidence of good practice but also areas of concern, similar to what we had found on the previous inspection. One of the main issues had been staff altering the care rotas to suit people's preferences and reduce travelling times. However, this had not always factored in the necessity of specific call times for medication and so each person's call allocations were being considered on an individual basis to ensure their needs were being met appropriately.

We still found evidence of some call times being cut short or care workers arriving outside of the planned time by more than thirty minutes. One person we discussed with the registered manager had already been identified as a concern and was under review. Another person had as much as 50% of their allocated call time cut according to the data we were given. Where it became obvious allocated call times were too long as all tasks had been completed, reviews were being requested with the local authority. As the system showed planned and actual call times it enabled data to be collected for any late or missed call times, and allowed prompt action to take place where needed, and also evidenced two care workers had visited where specified.

Due to the complexity of implementing this system for south Kirklees the monitoring of call times in north Kirklees was still being managed by a mixture of spot checks, audits and telephone monitoring. We saw evidence of these checks which meant there was greater scrutiny than we had observed during the previous inspection. Any anomalies were noted and followed up by the registered manager on a one-to-one basis with the staff member. The registered manager had also implemented a monitoring system for missed or late calls including the reason and actions taken. They explained these would be reported to the local authority safeguarding team as necessary.

Continuity of staff was noted as a concern during the previous inspection. However, this time feedback was more positive and included comments such as "Yes I have the same care worker," "I have the same team of four care workers," and "I have a team of five care workers. I get a letter from the company in advance to let me know who is coming on the rota." One person did say, "At the beginning we used to have the same carer, now we have different care workers but I know the team now." Another person mentioned the difficulties of working with new staff as they didn't know their routines, "I get the same care workers but now and then the odd one is different. It is those that I may have a problem with," but another person said "The care workers are usually the same, but I am also fine with the new ones." Again, the registered manager explained this was a work in progress where all rotas were being readjusted to allow for greater continuity of care staff.

We checked the rotas for eleven people receiving a range from one call to four or five per day, and found over a four week period most people had the same teams of staff up to six care workers, and for the larger and more complex care packages the most we found was sixteen. Although this was very high the person was seeing the same care staff over a day which meant some continuity of care for them as far as the service could allow.

One relative we spoke with was very complimentary, "We do have very good care workers - the company sends a rota to tell us who is coming. My relative finds this very useful as they want to know in advance who is coming." However, another struggled to communicate due to their limited English skills. They told us "We do get different care workers. I have a problem as I do not speak good English but they do send care workers who can communicate with me a little" which showed the service was trying to meet people's needs as best as possible.

We looked at staffing numbers and the registered manager advised us of the ongoing recruitment campaign. We also looked at staff recruitment records and found the service was ensuring staff were subject to the appropriate scrutiny. References were obtained and Disclosure and Barring Service (DBS) Checks completed. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

At our previous inspection in October 2016 we found risk assessments did not reflect individual need. We found some improvement had been made. We asked the registered manager how the service managed risk. They told us it depended on the situation but, if pertinent to a person receiving the service, necessary assessments would take place. For example if a person smoked, they would ensure fire reduction measures were implemented through guidance of the fire service and we saw this reflected in people's care records. They told us about one person who had refused the use of a hoist to transfer and wished only to use a stand aid as they were fearful of losing their independence. A risk assessment had been completed in conjunction with the local authority who agreed the person could make their own decisions and the use of the stand aid was agreed as a safe piece of equipment to use.

We looked at risk assessments and found mixed evidence. One person's risk assessment said they had no cognitive impairment when referring to their ability to assess fire risk but in the section on mental health

said they could be confused and forgetful. In another risk assessment it was recorded the person had regular seizures, often without warning and yet the guidance for staff was limited to simple first aid instructions. A further risk assessment stated a person had a diagnosis of Alzheimers and 'can be forgetful' to the extent of putting microwave meals under the grill and yet their awareness of danger was rated as 'low'. We recommend that the registered manager urgently review all risk assessments to reflect people's level of capacity to assess risk and consent to support, providing guidance for staff on how to best to support where there were concerns.

Moving and handling records had been amended to contain more detail about specific transfer methods. All those we saw had reference to the type and serial number of sling and hoist including the position of loops, and the method of transfer such as log roll.

We checked the accidents and incidents log and found no concerns. Where people using the service had been involved their views had been obtained and they had signed the records to acknowledge they were accurate. All were recorded appropriately with any necessary action taken to remove future risks and spot checks of staff carried out where poor practice had been a possible factor.

At our previous inspection in October 2016 we had concerns with the administration of medication, completion and auditing of records and a lack of competency checks for staff. One of the concerns was with lack of allocated time for the writing of the monthly medication charts (MAR). We spoke with the registered manager who said staff had been told they could have extra time to do this if this was needed, but they said no concerns had been raised recently. The registered manager said they were considering pre-populating as much information as possible to save care workers' time on the actual call. When we asked staff about this one said "I have to write up all the medication at home as there is no time during the care call. I am not given extra time to write up the MAR. It can take me between 30 and 45 minutes to do it." However, this was only one care worker who commented on this.

We found evidence of staff's medication competences which were assessed by passing a written test and through observation. Where staff were supporting people with more complex needs such as percutaneous endoscopic gastronomic (PEG) feeding, they had received specialist training. No one was receiving covert medication. Time-critical medication was logged on the electronic system, enabling calls to be identified easily and to be spaced evenly so as to minimise the risk of over-medication. Body maps were in people's medication risk assessments to assist care staff in where to apply cream or other topical medication.

We asked people if they felt safe when receiving support from care workers at Sevacare Kirklees and we were told "Yes, I do feel safe," "Oh yes indeed I do," and "Absolutely." This view was echoed by people's relatives who said, "There is no issue about not feeling safe," "My relative feels safe - no abuse or harm," and "My relative is extremely happy; they look forward to when the care worker comes."

We looked at safeguarding records and found they had been completed appropriately. Where allegations of staff misconduct were made there was a swift and proper response with a full investigation and necessary disciplinary action taken. People's views were sought at the outset of the process to ensure they understood the actions that needed to be taken and to agree an acceptable outcome. Where there was the potential for other people using the service to have been affected, telephone monitoring calls were carried out to obtain feedback and ensure people's safety. This showed the service took people's safety seriously and was confident taking action where it was deemed necessary.

Requires Improvement

Is the service effective?

Our findings

We asked people if they felt confident receiving care from care workers at Sevacare Kirklees. One person said "I do have different care workers but they do know what they are doing" and another told us "Yes, they are very good." A further person said, "I cannot fault them." The view from relatives was mixed. One relative said, "Oh yes, they are good with my relative" and another told us "My relative is really happy with the carers. They are very good with my relative."

However, one person's relative raised some historic concerns regarding the care of their relation which we spoke with the registered manager about. This included allegations care workers were not washing their relative properly, however the person's relative said they reported it and this was resolved. When we asked how the care delivery was now, they said "My relative has not had their hair washed for over five months. Staff keep saying that I should speak to the office but I can't communicate with them fully" as the person's relative's first language was not English. The registered manager agreed to conduct an urgent review into this situation.

Staff completed an intensive three day classroom-based training session covering policy and procedure, safeguarding, health and safety and emergency situations, medication, moving and handling and mental capacity. This was followed by a period of shadowing more experienced colleagues. New care workers were not assigned any people until their competency had been assessed and verified. However, we found evidence of these checks was sparse. When we questioned the care co-ordinators they explained staff currently undergoing this would have their booklets with them, but this did not explain the lack of records for more established staff. In one care worker's file we saw all competences had been signed as completed despite not all having been observed. However, we did see evidence of discussion of these unobserved competences in supervision around these topics to show the care worker had some knowledge of these areas.

In two other staff members' files all evidence of induction, shadowing, competency checks and completion of the Care Certificate was evident. All senior staff were aware of the requirements of the probationary period which was two care worker assessments, two spot checks and one face to face supervision. This showed the service understood the requirements to ensure all staff were appropriately trained but needed to ensure this covered all their staff and reflected what was actually observed and completed.

Staff told us they had been subject to spot checks. One care worker said "Someone came out about six weeks ago to observe me while I was giving care. I got feedback and was told I was doing everything fine." Care worker assessments, or competency checks, were detailed outlining the staff member's performance in relation to key care tasks such as moving and handling, personal care delivery, communication, record keeping and attitude. The assessments were summarised at the end and praised staff where this good practice had been observed. We saw comments such as "ensured [name] was cared for with dignity and care," and "gave excellent support and attention to [name's] safety."

All staff had completed refresher training in relation to medication, moving and handling, mental capacity

and safeguarding since the last inspection. Each course had a test at the end to check staff's understanding and, combined with an ongoing programme of competency checks, meant the registered manager was more confident in staff's abilities. Staff confirmed they had attended and one told us, "Yes, it's a good idea as all refreshers are useful. I picked up some good tips." Another said, "We covered all routes of administration for medication and completed a written test including checking the medication is for the right person and the right dose."

We found training was current for all staff and where it was due to expire staff had been assigned courses to complete. When looking at training records we were concerned no specific training was available for staff who worked with people with learning disabilities. This is important due to the complexities of behavioural needs that staff may be presented with which would need more specialist intervention. We found one care worker with no previous care experience had completed their induction and refresher training but had no training for their role as a community support worker for people with learning disabilities despite supporting a person with complex health needs. Although we found details of one spot check and care worker's competency assessment in their file for 2016, there was no evidence of any shadowing having been undertaken or supervision for that period.

The care co-ordinator for this part of the service had sought some training opportunities for staff but the expectation was for staff to complete these in their own time. The registered manager advised us this was not acceptable and before the end of our inspection they had shown us a planned timetable for training about understanding specific conditions and managing behaviour which challenges to be completed within normal working hours for implementation from April 2017.

The registered manager advised us all staff should receive four supervisions a year which included two face to face meetings with the registered manager or care co-ordinator (one of which was an appraisal), and two on-site observations as a minimum. If there were concerns regarding specific staff the frequency would be increased. Spot checks would also be conducted twice a year. The registered manager advised us supervisions had fallen behind a little due to the focus on all staff receiving refresher training in key areas which had all been completed by the time our inspection concluded. However, we did see supervision notes in staff files which indicated discussions had been two way and had checked how staff were feeling which was an improvement on the previous inspection.

The registered manager showed the actual and planned dates for supervision of all staff which included spot check visits. This ensured all staff were seen by a member of the management team at regular intervals. We saw out of 63 staff in north Kirklees and the community support service, nine required supervision and for south Kirklees this was only three staff. This meant the majority of staff had received supervision as per Sevacare's policy and those who required it had it booked in.

At the previous inspection in October 2016 we found no evidence of the completion of mental capacity assessments for people unable to consent to receiving care. At this inspection we found no improvement had been made.

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 told us no one currently receiving support lacked the capacity to make decisions regarding their care needs. We found one person who was not able to make decisions about their care according to their records. This person did have a mental capacity assessment which was extremely detailed with a corresponding best interests' decision. However this was the only capacity assessment we saw despite other records indicating people were unable to consent to receiving care.

The registered manager advised us all care plans now had a 'consent to care' form which was signed by the person receiving support, however we did not always see evidence of these. We looked in people's care records and in one where it was noted "[Name] is not able to recall if they have taken their medication" there was no corresponding mental capacity assessment or best interest decision to say care workers had permission to assist this person with their medication. In another file it was noted "[Name] does not have the mental capacity to make decisions re medication" but there was no capacity assessment to prove this, nor any evidence of best interest decision making. This was reflected in two other assessments we looked at. However, where people were able to make their own decisions they had signed the care records to evidence their agreement to staff supporting them with medication due to physical difficulties.

The registered manager was not aware anyone had a lasting power of attorney (LPA) for health and welfare which would give the appointed person the power to make decisions on behalf of the other person. However, they were aware of people with LPAs for finance. We found some care records had been signed by people's relatives whose authority to do so had not been established which meant the service was not complying with the requirements of the MCA. The registered manager accepted this part of the service needed further work along with the reviewing of the care plans. This is a continuing breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the previous inspection, we asked the registered manager how they had addressed concerns raised by people about the lack of cooking skills some staff had displayed. They agreed they had noted this concern but still needed to develop training around this. They told us it had been stressed to all staff in their recent mental capacity training about the importance of offering choice at all times and not just considering the easiest options dependent on the time allowed for each call.

We saw evidence in people's care notes other health and social health care agencies input was requested as needed.

Good

Is the service caring?

Our findings

At the previous inspection in October 2016 we found people's dignity was not always respected as calls were rushed leaving tasks unfinished and people' s preferences ignored. People's view of the care workers was much more positive than during this inspection. Views included "The care worker is very, very good, very caring and very compassionate," "Excellent care. Staff are caring and thoughtful, always checking that I do not need anything else doing. I cannot fault them at all," and "All lovely people and very respectful. They have beautiful smiles that do me good. They sit with me and talk to me. It really makes me feel so much better."

People spoke with us about their high levels of satisfaction as "I am very, very fortunate to have these care workers," and "I am so happy with my care workers." One person said "Very happy with the carers. They are a friendly bunch." No one voiced any concerns regarding a lack of respect for privacy and dignity which showed the service had emphasised the importance of these values. As people felt their care needs were now being met, the issue of care workers rushing tasks was no longer an issue.

Relatives were equally positive. One relation said "Oh yes, they are lovely and friendly. They always talks to my relative while they do the tasks," and another told us "The care workers are good." A further relation told us "My relative loves every minute when the care workers come. They wait for them and they are so nice. They love them and (my relative) is very fond of all the care workers who come."

The majority of people we spoke with during the telephone interviews confirmed care workers did involve them in the care plan.

During our time in the office many people using the community support part of the service came in to have a drink or chat. Office staff were very aware of each person and their particular needs, engaging in positive conversations with people and discussing what they had been up to. It was a very open atmosphere and people were put at their ease.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in October 2016 we found care delivery was not consistent, some people did not have any care records and service delivery was poor. At this inspection we found some improvement had been made as all people we checked had records in place, even if not all were up to date. People's experience of care delivery was better as they were informed who would be attending and call times matched the preferred visit time for most people.

We looked at care records and found they continued to be person-centred. Directions for staff included specific details for each person about their preferences of food and drink, or how personal care was to be provided. However, some care records still contained discrepancies. In one care record we saw it noted the person needed help with bathing and skin care. The assessment lacked detail as it referred to the person having pressure sores yet did not indicate where these were or how staff were to support with these. Other care records showed evidence of being updated from old records and meant information sometimes contradicted itself such as referring to four care visits when only one was provided.

We spoke with the registered manager about one record which referred to different people; they agreed to look at this as a matter of urgency. We were shown a timetable of care plan reviews which had just commenced prior to our inspection and so were confident these issues would be addressed.

We continued to find care records for people categorized as having community support who were actually receiving assistance with personal care or more complex health issues such as seizures. We asked the registered manager how this decision was made and they explained it was how the initial referral was received as to which part of the service it was provided by. They stressed all staff received the same induction so had received a basic level of training to manage these needs but as mentioned earlier in the report there was no specific training on offer to support these more complex needs. Feedback from people and their relatives was positive and we had no concerns about poor care delivery but felt staff should be given appropriate support.

Care plan audits had commenced with those in south Kirklees being completed first. An electronic copy was kept in the system with a signed copy in people's files. Amendments had been made to more accurately reflect people's disabilities and health concerns. We found evidence in care records of telephone monitoring to check people's views of care delivery including punctuality, attitude, knowledge and satisfaction.

At the previous inspection in October 2016 we were concerned not all complaints had been addressed fully. At this inspection we found some improvement but not all agreed actions had been completed. We found all complaints were acknowledged and responded to advising people an investigation would be completed. In one instance a relative had complained care workers were often late and then not informing their relatives they would be so. We saw notes had been placed on the rotas and care records to ensure care workers kept to their scheduled time as far as possible. A meeting had been held with the relative who complained to agree a resolution. This was an improvement from the previous inspection.

We found a serious complaint had been logged from October 2016, just after the last inspection, which had identified staff were not engaging with a person with advanced dementia which left the person not being supported with personal care or receiving the correct skin care. This was looked at in depth and various measures implemented to improve the situation. However, despite the outcome of the investigation saying four spot checks were to be completed, we found evidence of only one and this was based on the person's own opinion which given their cognitive difficulties, proved difficult to assess the validity of the comments. The registered manager agreed to remind all care co-ordinators of the importance of ensuring investigations and follow ups were completed in full.

We saw evidence of one compliment sent in from a local community group which stated "Appreciate the excellent service you are providing to our members. Staff are friendly, polite and showed a sincere willingness to help them. Staff are approachable and have the necessary knowledge and skill to help with their concerns."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we had serious concerns about the management of the service as the then registered manager was unaware of the service's remit, displayed a lack of awareness of the issues affecting the service and could not evidence any quality assurance measures. At this inspection we found, due to changes in management, there had been significant improvement since January 2017 but the initial response from the registered provider for the period between the last inspection and January had been slow. Some of the issues we found on this inspection had been tackled only recently, some had not been addressed and others had to be highlighted by us. This is a continuing breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had not taken sufficient action to remedy some of the serious concerns we had found at the previous inspection.

People were asked their views of the overall service. One person told us "I am very happy with the company. They send rotas and keep in touch with us," and another said "I certainly can recommend the company to others." Other comments included, "They are very friendly, they are good and approachable," "The head office does call. We are extremely happy with them," and "I could not fault them." One person said "I have not met the office or had anything to do with them." We saw in people's care records evidence of the telephone and face to face monitoring which included favourable comments such as "[Name] is very happy with the carers and the support they are providing" and "it is an excellent overall service, carers complete all the tasks at the correct time."

One care worker said "Overall, I'm happy working here as the rotas fit my needs." Another care worker told us "I'm alright with everything." The only concern staff in south Kirklees raised was a lack of an office from which to pick up equipment in their area as they felt travelling time to Dewsbury was too far. They had been told plans were in place to address this which the registered manager confirmed.

The new registered manager was registered with the Care Quality Commission on 20 February 2017 but had been working in the branch since January 2017 to try and resolve some of the issues following the previous inspection. They were also the registered manager of another branch. There were still three care co-ordinators covering north and south Kirklees, and the community support service respectively. The previous registered manager was additionally providing support for south Kirklees due to the pressures of staff availability in this area.

The registered manager had sent out a new quality survey to all people using the service in February 2017 to gain their views but had had a poor response. We did see evidence of people's comments recorded in the telephone monitoring. One comment said '[Name] does not want to go bowling any more. Everything else is fine.' Another comment read '[Name] is very happy with the care staff and doesn't have any concerns.' We also records of face to face reviews with people. One record said 'Everything is excellent.'

Audits of all communication records and medication administration sheets were in the process of being completed since January 2017. The auditor (external to the branch) was considering whether there was evidence of choices being offered to people in their daily logs, and if there were any concerns regarding a

person's ability to make such choices. For example, the registered manager said if a person consistently refused personal care intervention, they wanted to see evidence of what staff had done to manage this, hopefully reporting any ongoing concerns back to the branch. The auditor was also assessing if the communication logs matched people's care plans in terms of tasks undertaken and time of visits. Any identified issues were raised with the staff member directly through the registered manager. We saw evidence of a summary of their findings with clear action points showing they had a good appreciation of the key issues and how to address them.

Medication audits had identified themes such as medicines not being labelled correctly and people's allergies not being listed. A list was created and the registered manager spoke directly with the staff involved to discuss the importance of completing medicine administration records correctly. However, Sevacare Kirklees were still not conducting home visits to check if the information on the sheet was accurate according to the person's dosette box. We discussed our concerns with the registered manager who raised it with senior managers and before the inspection had been completed it had been agreed by the registered provider random home visits were to be completed to ensure the information being placed onto the medication administration sheet was accurate.

Team meetings took place on alternate weeks. The next one was scheduled for 21 March 2017 and we observed staff visiting the office for this. These had been complimented by the training sessions which all staff had attended since the start of 2017 and meant all had seen the new registered manager. There were additional team meetings for members of staff who worked specific rounds in a particular area to ensure all had the same information and were aware of any significant changes to people on their rounds. Minutes referenced discussions around the importance of timely and correct care record recording including legibility of notes, time of arrival and departure, what support was provided, the details of the person's mood, what they ate and drank and choices offered to the person. Other topics included medication, feedback from the last CQC inspection and the importance of keeping contact with the office to enable staff to liaise when necessary. Staff had also discussed dignity and the importance of respecting individual needs.

We asked the registered manager what they felt the key risks to the service were. They felt recruitment was a constant issue but were actively involved in this. They also acknowledged some supervisions were overdue for staff but felt confident due to the recent training received by all staff and the increased staff meetings, staff were being seen and had the opportunity to raise concerns if needed. We saw a programme of scheduled supervision sessions.

We also asked what the registered manager felt they had achieved since their arrival and they said "I am more aware of what's going on and where more work is needed." They spoke about the implementation of the electronic call monitoring and the mixed evidence this had produced but there were plans in place to tackle this. The registered manager was proud all staff had been re-trained in all the key areas and going forward the branch would be in a stronger position. Where issues around call times and staff conduct had been noted these were in the process of being addressed and people's views more actively sought around their preferences.

The registered manager was fully aware of what needed to be addressed in the near future. This knowledge had been assisted by an internal branch audit completed at the beginning of March 2017. This had considered care plans and risk assessments, staff files, and other quality indicators such as accidents and complaints. The action plan generated as a result of this evidenced specific issues which needed to be addressed in relation to care records and risk assessments. Each care co-ordinator had signed a letter to indicate they agreed to taking the necessary action and how to minimise the likelihood of repeat concerns in the future.

The registered manager was keen to ensure all staff had been competency checked, received at least one supervision, attended staff meetings and that all were aware the branch was 'moving forward.' They felt confident in their role and told us they were receiving the support they needed to continue the progress which had been made. They had developed a clear set of action plans and ensured these were regularly reviewed to check progress. Actions were assigned to specific staff and review dates set to ensure compliance.

They registered manager were aware of the importance of focusing on good practice and told us they were keen on "putting wrong things right." They did this through personal letters to staff rather than generic staff memos if specific conduct issues were identified which meant staff had more opportunity to address any shortfalls in their understanding and be offered more training if needed which we saw. The registered manager said progress had been slower on the reviewing of all people's care plans but this was a continuing piece of work.

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 11 HSCA RA Regulations 2014 Need for consent The service had still not completed mental capacity assessments for people who were unable to consent to their care.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not completed any quality assurance checks for three months following the previous inspection until the appointment of the new registered manager and some issues had not been addressed quickly enough.

The enforcement action we took:

Warning notice