Sentricare Limited

SentriCare

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
SentriCare is a domiciliary care agency providing personal care to people in their own homes. The service was supporting 39 people from the Walsall location and 74 at the Birmingham location, with personal care in their own homes at the time of our inspection. The Birmingham location is not currently registered, but an application has been submitted. We looked at and considered information about both locations as regulated activities are delivered from Walsall and Birmingham locations at the time of this inspection.

People's experience of using this service and what we found
We were not supported by the provider in carrying out this inspection due to records not being available when requested. This was due to the lack of organisation of stored documents.

There was a lack of provider oversight which meant risks to people's safety had not been responded to appropriately. Systems to monitor the quality and safety of the service were ineffective and placed people at the risk of harm. The systems in place had failed to identify the areas for improvement found at this inspection including the monitoring of the missed, short and late calls .

Risk assessments were not in place for all health conditions, or for people's known risks to enable staff to have the information they needed to meet their needs.
People we spoke to said they felt safe however, two people told us that they had to teach staff how to support them correctly, to meet their needs in the way they wished.
Staff we spoke to told us they had received some training to meet people's needs. However, we saw from records that staff had not completed training on all of the health conditions of service users, to give them the knowledge and skills to support them effectively and safely.

Accidents and incidents audits did not provide a full and clear picture of frequency of accidents or incidents or of actions taken to reduce further occurrences.

We were unable to ascertain if medication recording had improved as MAR charts could not be located and were not provided for us to review. This will be reviewed at the next inspection.

Spot checks of staff visits in people's homes were completed to monitor that people received the support they needed.

Audits need to be improved to provide clear and robust information and evidence of outcomes for people.
Systems and process which were in place were not robust to protect people from potential harm.
We were not provided with evidence of any lessons learnt following incidents or accidents.
Staff we spoke to told us they understood their roles and responsibilities, had received some training and felt supported by the management.

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

Rating at last inspection
The last rating for this service was Good with requires improvement in Safe (26 March 2019). At this inspection we found that the rating had deteriorated to Requires improvement.

Why we inspected
We received concerns in relation to missed, short and late calls and the standard of care and support received. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full 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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

SentriCare

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service does not currently have a manager registered, however, the provider has recruited a manager and they have submitted their application with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the Provider Information Return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

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Before, during and after the inspection
We spoke with ten people who used the service about their experience of the care provided. We spoke with 13 members of staff including the provider, manager, care co-ordinator, care manager and care workers. We also spoke to three health care professionals who have been involved with people using the service.

We reviewed a range of records. This included seven people's care records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures and audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at audits, call records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.
This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Reporting processes were not robust. One person we spoke to told us that she had a personal item go missing, she had told the carer who said she would report it to the office. When we spoke to the manager they told us they were not aware of this and would look into it.
- Prior to this inspection concerns were received around missed, short and late calls. During the inspection we spoke to the manager and care co-ordinator about how these were monitored. At the time of the inspection we did not feel assured that there was an effective system in place as it did not alert managers of missed calls. This places people at risk of not having their needs met.

We also saw from the electronic call records that at times calls were shorter than that agreed length of time. This is something which the provider is aware of and told us they are monitoring these to ensure people are receiving the support they need. However, the care co-ordinator told us they were not concerned if the average length of the calls did not fall below sixty six percent of the allocated time. Call times commissioned should be met as this is the time which is paid for. If the length of calls are consistently less than commissioned time a review of the person's care needs should take place. One person told us, "The call is forty-five minutes, but they never do the full time, she [carer] is like a whirlwind." Electronic call records showed that the majority of their calls were significantly shorter than scheduled.

- Following the inspection, the care co-ordinator advised us of changes they had implemented with how calls are set up and an alert would now be made if the call was later than one hour than the scheduled time. This will be reviewed at the next inspection.
- One service user told us how the late calls impacted on them as they have diabetes and they rely on carers to prepare their meals. They told us late calls impact on their blood sugar levels and they have to drink a sugary drink to keep their blood sugar levels up until carers arrive and prepare the meal. This has been discussed with the provider and they advised they will review how this can be managed better. This will be reviewed at the next inspection.
- People we spoke to told us about their calls, one person said, "They were very short staffed. They don't turn up on time, they tell me they are caring for a lot of people and say we've got to be quick." Another person told us, "There was an issue (with late calls) a few weeks ago but it has improved over the last couple of weeks." Others told us that care workers did stay the right length of time and they would do other things for them if they had time. This indicated that sufficient staff were not always on duty to meet people's needs.
- When we checked with staff why things had recently improved, they told us it was because they now had fewer care packages and it was more manageable .
- People we talked to told us they did feel safe.
- Staff members had a good understanding of how to safeguard people from abuse, they were able to

explain how to protect people they supported. Staff had received training in these areas.
●The care manager carried out observations of the care team when supporting people in their homes, to assess their competencies and ensure that care plans are followed. Records showed observations had taken place and the people we spoke to told us they saw the mangers and spoke to them on the telephone.

Assessing risk, safety monitoring and management
● The provider had care plans in place which detailed the support people required. However, these were not always sufficiently detailed. For example, care plans for people's specific health conditions such as epilepsy or diabetes had no signs and symptoms recorded to help staff identify concerns. People who display behaviours that may challenge did not have behaviour support plans in place to inform staff of what may trigger behaviours and what steps to carer should take to offer assurances, to enable them to reassure the person to reduce their distressed behaviour.
● During a conversation with a family member we became aware that one person's care plan did not mention they had a health condition that required the use of specific equipment. Care records didn't reference this condition, but staff spoken with were aware of the persons needs in this area.
● One person told us when asked if staff knew how to support them, "I've taught them, initially they didn't know, but they do now."
● We were told and saw records that people received telephone reviews to discuss their support needs. This ensured that any changes in people's needs were identified and the plans of care adjusted accordingly.

Staffing and recruitment
● We looked at staff recruitment records. We found that the previous employer references looked at during the inspection did not always match the referees noted on the staff members' job application form. One staff file we looked at had two references from the same employer and no further references had been sought from other employers detailed on the application form.
● We also saw that records did not have a full employment history and gaps in employment had not been explored.
● Staff told us they received an induction, shadowing and training for them to be able to carry out their role safely. The training records we saw confirmed this.
● Staff told us they received regular supervisions and we saw evidence in staff records.

Using medicines safely
● At the last inspection we found, 'record keeping with regards to medication administration required improvement. Medication charts stated that medication was administered at the agreed time the person's visit was supposed to start. However, this was not accurate, as on some days, people's visits did not start until over half an hour later than the agreed start time. This meant that the actual time people's medicines were administered was not recorded. Staff needed more guidance on how to administer people's prescribed creams.' At this inspection we were unable to check if improvements had been made as the provider was unable to locate any Medication Administration Records following an office move. This will be reviewed at the next inspection.
● Staff we spoke to told us that they had received training in the safe administration of medication.
● One service user told us when asked if they get their medication on time, "Yes, one tablet, they bring it in for me."
● When people required medicines to be administered on an 'as and when required' there was no guidance in place for staff to follow so they would know when to give the medicine.

Preventing and controlling infection
● Prior to the inspection we had received concerns that care workers were not wearing the correct personal

protective equipment during some calls. Personal protective equipment (PPE) includes items such as gloves, aprons, masks and eye protection. People's care plans provided staff with clear guidance on what personal and protective equipment to use when providing support.

● Some of the people we spoke to told us that staff wore PPE, "They come bound up with a mask and everything" and "Yes, they always wear a mask, gloves and aprons." However, others told us, "No gloves or apron, she wears a scarf around her face" and "They only wear them sometimes, not all of the time."

● We saw that there were no individual risk assessments relating to the current pandemic for people using the service or staff members. People's individual health conditions and ethnicity had not been considered, the impact this may have and no actions had been taken to reduce the risk to people.

● We saw that checks were completed on carers when supporting people in their own homes to check they were wearing the correct PPE, no issues had been identified during these checks.

● Staff completed an environmental risk assessment on people's home environment. This included issues associated with cleanliness or infection control.

Learning lessons when things go wrong

● Accident and incidents were not consistently and clearly documented and did not always show the action taken by staff to support the person's wellbeing at the time the accident or incident occurred.

● Records showed that accidents and incident were not always thoroughly investigated. During the inspection we did not see that the provider was using accident and incident information to learn from and prevent similar accidents or incidents occurring in the future.

We could not improve the rating for Safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Due to the poor monitoring and reporting systems in place, the provider did not always identify when an incident was a CQC notifiable event, such as safeguarding concerns and the reporting of these incidents was inconsistent. This meant the provider could not be assured they had notified us, as they are legally required to do.

●Systems in place for the oversight of safeguarding and complaints management were ineffective and failed to identify the risk of potential abuse and poor care and where preventive measures were needed.

●The management of safety, risk and governance had not been effective. We identified concerns about people's safety during the inspection.

●There was an auditing system in place, but this had not been operated effectively and had failed to identify the concerns we found during the inspection.

●Systems in place to assess and monitor risks in relation to falls, accidents or incidents, failed to take action to mitigate risks and prevent reoccurrence.

● Audits had failed to identify that accurate records relating to people's care were not being maintained and to ensure staff had access to consistent and accurate information about people's support needs. For example, risk assessments were not always completed.

● We saw from records that service users' feedback was gathered on the quality of the service. However, when we spoke to the provider about what actions had been taken based on the service users who were not happy with aspects of their care, they could not provide evidence of measures they had put in place to improve in these areas .

● Audits had failed to identify that staff allocated to a persons call were not always able to communicate in the persons preferred language

The lack of governance systems and poor oversight meant people were receiving poor quality care and were placed at risk. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager understood their responsibilities about duty of candour and promoting an open and honest culture.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Three people we spoke to told us about carers speaking in their own community language when supporting them, and this meant they were unable to communicate effectively with them, or understand the conversation. One told us they had complained to the provider about this. When we spoke to the provider, they said they had addressed this. We were not provided with any evidence of this during the inspection, although we did request it. Other service users told us they had difficulty communicating due to some carers having poor English language skills. During our calls to staff, we also experienced difficulty when speaking with two staff members and the calls were ended due to language barriers.

● Staff we spoke to told us that they felt supported by the management team and said if they made suggestions they would be listened to.

● People we spoke to told us that they knew how make a complaint, others told us that they had never had to make a complaint as they were happy overall.

● One person told us they had spoken to the office as they were not happy and the care co-ordinator had been really helpful and made some changes to their carers, and they were now happy with this.

● Some people told us they had received a care review and had the opportunity to discuss the service but a couple of people said they had not received a review. Records we saw showed telephone reviews had taken place.

● People's care records for supporting with personal care was not always detailed, clear and reflective of their current support needs and wishes. They did not include details about people's diverse characteristics such as; sexuality, their religion and how this is reflected in the support they receive.

Working in partnership with others

● We contacted health professionals before the inspection took place and those we spoke to were complimentary about how responsive the care co-ordinator had been, involving everyone in the decision making and being responsive to changing needs. They also said communication was good between the provider and health care professionals.