Care Quality Commission

Sevacare (UK) Limited

Sevacare - Haringey

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place on 15 and 16 December 2014. Our previous inspection of 3 January 2014 found that the service had made improvements and met standards relating to care and welfare of people using the service, quality and risk management, complaints, and safeguarding notifications.

Sevacare (UK) Limited is a national provider of care and support services to people in their own homes. 'Sevacare – Haringey' provides personal care to people of any age living in the local area who need care due to ill health or disability. At the time of this inspection the agency was providing a care service to over 550 people in their own homes. This included over 200 people who started using the service in June 2014 when the provider accepted a contract with a neighbouring local authority to provide services in that area.

At the time of our visit, 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.

Summary of findings

At this inspection, we found that a number of breaches of legal requirements. This put people using the service at significant risk of receiving inappropriate or unsafe care.

People provided us with mixed views on the services they received. Whilst some people praised their regular care workers, some people told us of feeling rushed during care visits and care workers not listening to them. We found that some people received care visits that were shorter than half their allocated time, and that some people did not receive a consistent set of care workers who got to know their individual care needs and preferences. This meant people were not always treated in a caring way that met their individual needs.

We found instances where people's scheduled visits did not occur as planned. This included very late visits or where only one of two planned care workers attended. This compromised people's safety and wellbeing. These matters were not investigated, and were not routinely reported to senior managers, so that action could be taken to prevent reoccurrence.

We found that people were not being supported to manage their medicines safely. Most medicines records we saw had not been consistently filled in to demonstrate that people had been supported to take their medicines as prescribed.

We found that people's recent complaints were not identified as complaints and addressed. Some older complaints had not been addressed in a timely manner. This meant people were not listened to, and action was not taken to prevent any unsafe or inappropriate care that was being reported.

Safeguarding processes did not always keep people safe from abuse. The provider and manager had not informed us of any allegations of abuse relating to services provided by the agency in more than seven months, and had not kept a clear record of these allegations and their responses.

We found that care workers were inconsistently trained, supervised and supported. Many staff who transferred from another agency in June 2014 had not had any supervision or refresher training. Staff were not supported to deliver care to people safely and to an appropriate standard.

Some people's care plans and care delivery records showed that their individual needs were not being responded to, for example, by continuing to schedule home visits when the person was at a regular community appointment.

Most people who started using the agency in June 2014 had not yet had a review meeting, to check how effective their care package was. When review meetings occurred, these did not always result in care delivery concerns being addressed. This approach did not protect people from the risks of inappropriate or unsafe care.

Feedback indicated that it was not easy to access the provider's out-of-hours on-call team. We found that the on-call team relied on there being an accurate and up-to-date statement of each person's care package on the provider's computer system, which was often not the case.

This meant they could not always respond effectively when anyone phoned them, for example, to replace a care worker who could not attend to someone.

Audit tools used to check on the management of the service were not always accurate and up-to-date, and action was not taken when the tools identified risks to the welfare of people using the service and staff.

Records were not always provided to us in full when we requested them, which undermined our confidence in the transparency and management of the service.

Due to the many concerns that we found, we did not have confidence in the manager and provider's oversight of quality and risk at the agency, and concluded that the service is not well-led.

We found overall that people using the service were at significant risk of receiving inappropriate or unsafe care. We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

As a result of this inspection, we served enforcement notices proposing to cancel the registration of the manager and to remove the location 'Sevacare – Haringey' from the registration of the provider Sevacare (UK) Limited.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People provided mixed feedback about how safe they felt during care visits. We found instances where people's scheduled visits did not occur as planned. This included very late visits or where only one of two planned care workers attended. This compromised people's safety and wellbeing.

We found concerns with the provider's safeguarding processes. The provider and manager had not informed us of any allegations of abuse relating to services provided by the agency in more than seven months.

We found that people were not being supported to manage their medicines safely, because medicine records had not been consistently filled in to demonstrate that people had been supported to take their medicines as prescribed.

There was mixed feedback about being able to effectively access the provider's on-call system outside of office hours. We found that the on-call team relied on there being an accurate and up-to-date statement of each person's care needs on the provider's computer system, which was often not the case.

Is the service effective?

Requires Improvement

The service was not consistently effective. People had mixed views on the capability of staff. We found that care workers were inconsistently trained, supervised and supported. Many staff who transferred from another agency in June 2014 had not had any supervision or refresher training. Oversight of these processes was not accurate and staff were not supported to deliver care to people safely and to an appropriate standard.

Arrangements for supporting people with identified food and drink support needs did not assure us that staff were supported to protect people from the risks of malnutrition and dehydration. Staff lacked training on the risks of malnutrition and dehydration.

Is the service caring?

Inadequate

The service was not caring. Whilst some people told us of positive and caring relationships with their regular care workers, we received some feedback about uncaring approaches, care workers not listening to people, people feeling rushed, and people not being kept informed of changes to their care.

We found that some people received care visits that were shorter than half their allocated time, and that some people did not receive a consistent set of care workers who got to know their individual care needs and preferences. This meant people were not always treated in a caring way that met their individual needs.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive. People had mixed views on how well the agency responded to their individual needs including the timeliness of their care visits, and any concerns they raised.

Some people's care plans and care delivery records showed that their individual needs were not being responded to.

We found that people's recent complaints were not identified and addressed. Some older complaints had not been addressed in a timely manner.

Is the service well-led?

Inadequate 

The service was not well-led. People had mixed views on the management of the agency. We found that audit tools used to check on the management of the service were not always accurate and up-to-date, and action was not taken when the tools identified risks to the welfare of people using the service and staff.

We found that missed visits were not investigated, so that action could be taken to prevent reoccurrence. Missed visits were not routinely reported to senior managers.

Records were not always accurate and up-to-date. They were not always provided to us in full when we requested them, which undermined our confidence in the transparency and management of the service.

Sevacare - Haringey

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 16 December 2014 and was unannounced. The inspection team consisted of six inspectors, an inspection manager, 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 service.

Before our inspection we reviewed information we held about the service such as safeguarding alerts and the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we spoke with 17 people who use the service and seven relatives to obtain their views on the service provision. This included visiting nine people in their homes with their permission. We sent 40 questionnaires to people to ask their feedback. Ten people sent us their comments regarding the service along with one relative.

During the inspection visit we spoke with the registered manager and the area manager along with eight staff members. We looked at the care records of 18 people using the service, eight people's medicines administration records, and the personnel records of 11 care staff. We also looked at electronic care planning and delivery records, and various records used for the purpose of managing the service. The manager provided us with further documents at our request after the inspection visits.

Inadequate

Is the service safe?

Our findings

Many people told us they felt safe using the service. Positive comments included, "I feel perfectly safe with my carer, I look forward to their visits" and "I feel very safe with them and have no concerns. I'm very happy using them."

However, some people told us of occasions when they did not feel safe when using the agency. One person said, "I'm safe with some not others. Sometimes I am thrown around like a piece of meat" in reference to being supported to move position. Another person told us, "I'm not safe when I go in the hoist, they don't use it properly. The carers haven't got a clue and they hurt me." A third person commented, "With one carer, I nearly fell five times in the shower, this carer had only been there two weeks." They added that another care worker went to write the visit record whilst they were still in the bathroom needing help.

Some people told us they experienced occasions when their planned care visit did not occur. One person told us, "When my carer is on holiday they should fit somebody in when you depend on it. On Monday when I called, a guy answered the phone and said someone was coming. They didn't, so I left it. Then on Wednesday someone called and said they realised I hadn't had care." Another person explained the agency's approach to their 10pm visit at the weekend: "Sometimes the office ring up and say that they cannot find someone to come but will keep trying. Then they ring back as they cannot find anyone to cover and will say, 'Do you still need someone to come?'" The person told us her husband then had to try and assist her into bed which he could not manage well.

Some people assessed as needing two care workers to attend together told us of this not always occurring. There was also feedback from care workers that this sometimes occurred. One person's relative told us that one of the two care workers "never came in the morning or lunchtime" on one occasion and so their relative "laid in bed all day." Another person said of care workers, "I should have two but maybe one comes an hour later, sometimes I go without."

Care records confirmed that people sometimes did not receive the second care worker when two were assessed as needing to attend together. The provider's computer records about one person from 1 November 2014, demonstrated five occasions when they received care from one care worker alone, resulting, for example, in the person's husband assisting the care worker. There was also an occasion where the night time care workers were too late and so the person cancelled the visit entirely. The person was assessed to be at risk of pressure sores, and so would not have been able to reposition safely if only one care worker attended to them. We additionally noted that almost half the records of care workers logging in and out at the person's home were manually overridden, undermining the authenticity of those records. The planning and delivery of care to this person so as to meet their needs, did not protect them against the risks of receiving inappropriate or unsafe care.

Amongst the nine people for whom we received electronic visit records of their care delivery since 1 November 2014, six had evidence of receiving at least one care visit where the second care worker did not attend at the same time as the first, or attended much earlier or later than planned, for visits assessed as needing two care workers to attend. The planning and delivery of care to these people so as to meet their needs, did not protect them against the risks of receiving inappropriate or unsafe care.

The evidence above demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that the provider operated a national on-call team. Phone calls to the office outside of the hours of 9am to 5pm weekdays were diverted to this team, and responses were expected within 20 minutes.

Some people told us of the difficulties speaking with, and getting responses from, the provider's on-call team, which particularly caused concern if they had not received their planned visit. One person said, "Ringing the Sevacare call centre at weekends is a complete waste of time as nobody answers and even when you leave a message on their answerphone nobody calls back: Awful service." A relative told us of their experience on a recent Sunday when a care worker had not turned up at 9am as planned: "I tried phoning the office but there was no answer, my calls kept going to voicemail all day long." A care worker told us of not being informed of who was to visit someone with them. When they phoned the on-call team to find out where the other care worker was, they received no response for at least half an hour. They therefore attended to the person alone, as the person was "wet".

Inadequate

Is the service safe?

The manager told us that the on-call team were informed of people's care needs through the information about each person on the provider's computer system. We checked ten people's information with the manager. Seven did not have clear information about their care needs and the services planned, for example, just the person's house entry code. Three of these had no information. Amongst these seven, we were able to access one person's care plan directly from the computer system. This meant that for six of the ten people, on-call staff who would not have had local knowledge of the person, did not have sufficient information about the person's care needs and agreed services from which to address any questions or concerns being raised such as what cover was needed if a planned care worker was running late or not able to visit the person.

The computer 'instructions' for 19 people sent to us after the inspection visits showed some updating of the information for some people. We found that seven did not accurately reflect people's needs and the services to be provided. For example, the guidance information for one person did not include some relevant needs such as that they experienced shoulder pain and were easily bruised due to Warfarin medicine. The guidance information for the person's evening visit was also an exact match of their morning visit, including "breakfast preparation." Inaccurate guidance information about people on the provider's computer systems put people at risk of inappropriate and unsafe care when office staff planned care visits for them, and particularly when on-call staff responded to emergency situations in respect of the person's care delivery.

The evidence above demonstrates a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us that they received good support with managing their medicines, however, a few people said that they did not. One person told us of instances where care workers got annoyed or angry when medication had not been taken correctly by them. Another person said that after an error by care workers, "My husband said 'that's it, I will deal with your medicines.'" Someone's relative told us that although medicines had to be given early in the morning, the care workers visited too late.

We found that records of supporting people to take their medicines were inconsistently documented. Seven of the eight medicines administration records (MAR) that we looked at had gaps in the record of supporting the person to take prescribed medicines or recording other outcomes to the support. Arrangements for the recording and safe administration of medicines for these people did not protect them against the risks associated with unsafe use and management of medicines.

For example, one person's MAR for November 2014 had four gaps which did not explain what medicines support they received at those visits. There was also a code used for nine morning visits that did not have an explanation of what it meant. The MAR did not clarify when during the day the person was to be supported with their medicines. We noted that the person's care instructions on the provider's computer system stated that they were to be assisted four times a day with medicines. The MAR showed they were only supported with administrations three times a day. We noted that there had been no senior staff review of this person's care package with them in over nine months. When we visited this person with their permission, we found that the current MAR had two further gaps in the record of supporting them with their medicines. This person was not protected against the risks associated with unsafe use and management of medicines.

The MAR for another person showed they were having medicines support twice daily. However, there were 23 occasions where nothing was recorded across the 31 days, and 11 occasions where there was only a tick recorded. The MAR did not clarify when during the day the person was to be supported with their medicines, and on one occasion, the medicines were recorded as missing. This person was not protected against the risks associated with unsafe use and management of medicines.

The evidence above demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recent computer records for one person identified that they had blisters on their stomach as a result of being given a hot water bottle by a care worker who was not employed by the provider. However, despite reporting this concern to the office and actions being taken to address the health concerns, the matter had not been reported to the relevant

Inadequate

Is the service safe?

local authority as a possible safeguarding alert. Staff did not recognise this possibility of abuse and so it was not raised with the local safeguarding team as an allegation of abuse.

The provider and manager have a legal duty to notify us of any allegations of abuse that occur during, or as a consequence of, the agency's delivery of personal care to people in their own homes. The last time we received a notification from the provider or manager about this agency was in May 2014.

Since then, we have received information from local authorities that there have been a number of safeguarding alerts raised involving the agency's care workers. This included one allegation that the agency raised directly to the local authority but did not inform us of. After our inspection visit, we received information from a local authority of a further allegation of abuse that pre-dated our inspection visit, and one that occurred shortly after our visit. However, we received no notifications from the agency in relation to these allegations. These were not appropriate responses to allegations of abuse, which undermined the suitability of the provider's arrangements to ensure that people using the service are safeguarded against the risk of abuse.

The evidence above demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Some people made positive comments about care workers' skills and abilities to provide effective care. Comments included, "Any carer that is sent seems to know what they are doing, so I do not have a problem" and "My carer knows exactly what they are doing, they are well trained." A relative told us, "His regular carer is very good and knows exactly what to do."

However, some people told us that some staff were not well-trained. One person told us, "Some don't know what to do, haven't a clue. It's not my place to show them what to do." Another person said, "With the catheter only some know how you deal with it." Relatives' comments included, "Carers at times turn up not knowing what to do" and "Replacements are poor. A lot of the staff are not trained. Sometimes they turn up and my mum has to show them what to do. They don't know."

Senior staff told us that new care workers attended a three-day training program during which they received face-to-face training from a specialist trainer and worked through a training handbook. We saw that the training included topics appropriate to the care that the new staff would be asked to deliver, for example, on personal care, pressure care management, and medicines. New staff then worked with an established staff member for approximately a week before being assessed for capability to work alone. Care workers we spoke with confirmed that this process occurred and that they felt they received enough training for the work they did.

We reviewed the training oversight document for the service. This listed 214 staff members and showed when they were next due to receive further training on a variety of topics such as health and safety, and manual handling. The document indicated that staff training was up-to-date, although some entries were highlighted as needing training by the end of January 2015. The manager explained that was the agreement for staff who transferred from another agency in June 2014. When we were shown the document in the office none of these staff had entries for dementia training. As a number of people using the service had dementia, the lack of training in this area for the many new staff, when there was an indicator of them needing it, did not enable them to deliver care to people safely and to an appropriate standard.

We found that six of the 11 care workers whose files we checked were not listed in the training oversight document. Only one of them had transferred into the agency in June 2014. The other five had start dates listed as between 2004 and 2010. Each of them had at least one out-of-date training topic based on records within their files. The range of out-of-date training was from 2012 to February 2014. One care worker had seven training courses that were due for refresher training in 2013. Three of these care workers were due for food safety refresher training. These training arrangements did not enable staff to deliver care to people safely and to an appropriate standard.

The training oversight document was also inaccurate for two of the five care workers listed on it. One care worker's file showed that their food safety training was due for refresher training in 2012, however, the oversight document listed them as not needing further training for food safety until 2017. The other care worker had transferred to the agency in June 2014. Their file showed that their training for food safety and safeguarding was due in 2012, however, the oversight document listed them as not needing further training for these topics until the end of January 2015. These training arrangements did not enable staff to deliver care to people safely and to an appropriate standard.

The provider's supervision policy stated: "All care staff will have a minimum of three sessions per year of formal supervision and one appraisal." However, we found this was not being followed. When we checked the staff support oversight document, we found that of the 249 staff listed, 126 lacked a supervision entry. 120 lacked a valid entry for a 'spot-check' which is when a senior staff member checks on how the care worker delivers care to someone without the care worker knowing this in advance. Amongst those 120 care workers, only eight had a supervision entry, and 86 were recorded as having worked for more than three months. It total, we found that 119 care workers had been working for over three months without supervision, spot-check or carer assessment. We saw nothing in the 11 care worker personnel files we checked to indicate that more support for staff had taken place than was recorded on the oversight document. These arrangements were not following the provider's policy, and did not enable staff to deliver care to people safely and to an appropriate standard.

Requires Improvement

Is the service effective?

The evidence above demonstrates a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us the support for eating and drinking was good, for example, that staff were "thoughtful" when it came to preparing the person's meals, that they were offered meal choices, and that the person got an extra cup of tea if they asked.

However, some comments were critical of the support, for example, "Carers are turning up over two hours late, should come for 6.15pm, but turn up at 8.15pm, far too late for dinner" and "one carer was even unable to interpret the cooking instructions for a meal that she was preparing and asked for help in reading the instructions." This person added, "On a separate occasion I noticed that the carers were cooking out of date meat, and when I mentioned it one carer said, 'it's OK it's only five days out of date!'"

A relative was concerned with their experienced of a care worker turning up in-between two scheduled visits, for breakfast and lunch. They told us, "The carer would come at 11am and give breakfast and then she would leave so my Mum wouldn't have her lunch."

A recent safeguarding investigation confirmed that one person received their mealtime care visit over two hours later than planned. This did not assure us that the support being provided to this person protected them from the risks of malnutrition and dehydration.

We noted that people's care plans had specific sections on what food and drink support they needed at each visit. One person's care delivery records made a specific note of what they had eaten, in line with the plan in place for them. However, people's food and drink support needs were not always part of the information on the provider's computer system, so that office staff could easily see people's needs, and so that on-call staff addressing a call about a person could easily identify if the person was at risk of malnutrition and dehydration. One person's instructions noted that staff were to prepare breakfast and lunch, however, their written care plan added that staff were to support them to eat and ensure they received soft food in line with social worker instructions. These arrangements did not assure us that staff were supported to protect people from the risks of malnutrition and dehydration.

The pre-inspection paperwork sent to us included that whilst all staff had been trained on food hygiene, no-one had received training on malnutrition. The induction and refresher workbook did not include questions about nutrition and hydration except in relation to pressure care and catheter management. These training arrangements did not assure us that staff were supported to protect people from the risks of malnutrition and dehydration.

Inadequate

Is the service caring?

Our findings

Some feedback we received about care workers, especially those who attended to people regularly, was positive. Comments included, “I could not wish for a more caring person" and “I greatly appreciate the help that I receive from the care workers. They are very polite and very conscientious about my needs and they do their job properly.” One person told us, “The carers are very good. They do the things I can’t do, not the things I can do, but if I ask them they will do anything for me.” They gave, as example, asking for an extra cup of tea before the care workers left. Some relatives made similar comments.

However, some people raised concerns about the caring approach of staff, particularly those who did not attend to them regularly. One person told us that although care workers were kind, they “don’t listen.” Another person said, “When I've had alternative workers in the case of staff holiday etc. the experience hasn't always been as good. For example, one replacement was quite judgemental and asked a lot of personal questions which were not necessary.” One person’s relative praised the regular care workers: “They show respect and talk to my relative and know his needs very well.” However, they were concerned about other staff, telling us, for example, “Recently the carer pulled his catheter bag out, not taking the time to remove his trousers, and he screamed.”

The provider’s Statement of Purpose included, “If there is a problem and we can foresee that your service is going to be delayed for any reason we will do our best to let you know and try to agree alternative suitable arrangement with you, but this should be exceptional." However, some people told us of not being kept informed about changes to their care arrangements, which meant they were not treated with consideration and respect. One person said, “I call the agency, but sometimes it takes a long time to answer.” One person told us that they were never phoned if the care worker was running late, adding, “I do not like ringing the office as you have to wait a long time and then you get music playing, I give up sometimes.” Some relatives gave us similar feedback. Comments included, “The office do not tend to phone if the carer is going to be late.”

A few people were concerned about some care workers’ ability to communicate and listen, for example, “I do not like the hurry.” A relative told us, "Some carers do not speak or understand English." One person said, “On the whole I’m fairly satisfied with the carers but the lady I have at the weekends is not good. She is too fast, and although I’ve asked her to slow down with me, she ignores me and can get quite ‘uppity’ with me.” Another person added, "Sometimes carers have to travel a long way to get from one person to the next and they are rushing things. If they’re stressed out then it makes me stressed too.” Another person told us, “Staff I know are alright, but some don’t ask, they just do it” in reference to their care. They added that it was sometimes difficult to understand care workers, and referred to one care worker who was “brutal” but added “the ones now try to be helpful.”

Electronic visit records for nine people showed that four people experienced a number of care visits that were much shorter than planned, which meant there was a risk that they were rushed during their care or did not receive the care that was planned. Additionally, the electronic visit records for all nine people had a number of manually-overridden entries, for 82% of visits in one person’s case. This meant those entries may not have been a true reflection of when, and for how long, care workers attended.

One person’s electronic visit records showed that on 16% of occasions, at least one of the two care workers scheduled to attend at the same time stayed for 15 minutes or less of their planned 45 minute visits. This included a care worker staying for three minutes on three occasions. The person’s records were manually-overridden in 36% of cases. During this period, the records of care being delivered started to record that the person was developing signs of a pressure sore, which was not referred to the agency’s senior staff for over a week. The approach to this person showed they were not always treated in a caring way that met their individual needs.

The electronic visit records for another person showed that on 7% of occasions, both of the two care workers scheduled to attend at the same time stayed for 15 minutes or less of their planned 30 minute visits. Their records were manually-overridden in 17% of cases. Their recent local authority care review noted that the person needed time to express their needs, and that the person could otherwise get flustered and become aggressive. However, the approach to this person showed they were not always treated in a caring way that met their individual needs.

Some people told us about receiving inconsistent staffing. Comments included, "I never know who comes at the

Inadequate

Is the service caring?

weekend" and "Sunday is always a problem, I never know who is coming." Five of the nine electronic visit records demonstrated a lack of continuity of care workers. This included two of the people we highlighted as receiving too many short visits. One of these people was attended by 24 care workers from 1 November 2014. Another person was attended by 20 care workers in the same period. This inconsistency of care workers contributed to the failure to deliver care to these service users in such a way as to meet their individual needs and ensure that their care and welfare were being protected.

The above evidence contributes towards a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke with staff, they were aware of enabling people to make choices. For example, one care worker told us, "I always ask the service user what they want me to do before I start my care with them." We saw that many people's care plans guided staff towards enabling people to have choice and encouraging independence. However, we noted that five of the care plans we looked at lacked a signature of who had been involved in agreeing the care, to confirm that the person receiving the service, and appropriate others, had been involved in making decisions about their care and support.

Staff demonstrated that they had developed positive and caring relationships with people they provided care for. They knew people's needs in good detail. For example, one staff member told us about how one person communicated in a particular way, along with giving us examples about their life history which helped inform the behaviour of this person who had dementia. However, care plans did not usually have this level of detail and life history, by which to help care workers to understand people's needs and develop positive relationships. As one care worker put it, "There is no history on the care plan. It would be helpful to know some history in advance."

Inadequate

Is the service responsive?

Our findings

People had mixed views about how responsive the service was. There was positive feedback about people's regular care workers, such as, "My carer is very good, a great help" and "I find the care workers visit me at regular times." Many people said they were asked about their care preferences such as for the gender of the care worker. "They asked what I wanted from the carers," one person told us. "My preferences were respected," another person said, explaining that the care workers supported them just for the things they could not do. A relative told us that the regular care worker "understands exactly what my relative's likes and dislikes are."

However, some people told us about their care visits occurring too early or too late to suit them. Comments included, I'm very happy with the carers who come, but often they are very late or too early", "Some carers have been getting to me far too early, 5am sometimes" and "Some of the carers can be quite late arriving , especially at the weekend. When I asked the carer to come at the agreed time she told me that she's giving me a lie-in. But I never have a lie-in because I'm always up by around 6am because of the pain I am in. I need her earlier." One person told us of late weekend visits, but "I do not complain as I know they are busy." Another spoke of difficulties attending a day centre when their regular care worker was on their day off, as replacements came too late meaning the person missed attending or a relative had to help them instead.

Amongst the people we checked, we found examples where people were not receiving personalised care that was responsive to their needs. The guidance for one person on the provider's computer systems did not state some key points from the local authority's agreement such as care workers needing to reposition the person and report any pressure care concerns.

Computer records for another person showed that there had been no answer at their home one Sunday. A relative explained the person was at church, and so care workers attended later. The same issue was recorded as occurring on two of the four following Sundays, with no amendment to the planned visit times on the electronic visit records. Care workers were additionally being scheduled to visit the person an hour earlier than on the person's plan for Sundays, meaning the person was receiving the next visit too early to meet their hydration and continence needs.

The guidance for this person on the provider's computer systems did not mention anything about church attendance on Sundays. The planning and delivery of care to these people did not respond to their individual needs.

The evidence above contributed to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A number of people told us they had no complaints but that they felt they could raise issues if needed. A few people reported positive experiences of raising concerns, for example, "I wasn't happy with the chap they sent to do my shopping, so I contacted the office and they arranged a replacement with whom I am now happy with." Another person told us they made a "mild complaint" to a care worker about coming too late in the evening, after which the care worker came earlier.

However, some people and their relatives told us of negative experiences of raising concerns. People's comments included, "I made a complaint; they said it would change but it got worse", "You don't get feedback", and of being told that the issue "would be sorted out" but not experiencing that. A relative told us they contacted social services due to the many issues they were having with the agency.

The provider's complaints policy noted that complaints were any expression of dissatisfaction, that they were to all be recorded within the agency's complaints file, and that they would report on investigation findings within 28 days unless 'exceptional' circumstances arose.

We saw records of one person experiencing instances of their second care worker turning up after their first care worker had left, or not turning up at all, for visits that required two care workers to work together. This still occurred after they had a review meeting with a senior staff member at which they raised this complaint. We noted that the complaint was not recorded within the agency's complaint file. The complaints system had not been used effectively to prevent or reduce the impact of unsafe or inappropriate care for this person.

When we looked at the agency's summary of the 16 recorded complaints for 2014, we found that investigations produced a range of outcomes which indicated that the agency accepted where service shortfalls had occurred.

Inadequate

Is the service responsive?

However, the time taken to respond to complainants since May 2014 had been in excess of 28 days in six out of nine cases, including two cases that took over two months. These delays meant the complaints system had not been used effectively to respond to people raising complaints.

When we checked the agency's two complaints files we found that the last date a complaint was raised was over three months before our visit. However, we found evidence of complaints being raised in this timeframe, but without evidence of action being taken to address matters. This meant the complaints system had not been used effectively to prevent or reduce the impact of unsafe or inappropriate care.

One person's 'notes' section on the agency's computer system recorded two separate instances of a relative phoning in within the previous 28 days to raise concerns about the two planned care workers not turning up together, to assist with manual handling. These complaints were not recorded within the complaints files, and there was no evidence of the complaints being investigated within the care file for the person.

The complaint files had a record of a person complaining about their care visits being late and staff not staying long enough. The agency's response letter apologised and stated it would not happen again as a more consistent care staff team would be provided. However, a weekly report sent to senior managers referred to a further complaint made by this person, and another person, about late staffing. These complaints were not recorded within the complaint files.

When we visited people in their homes, we found that two people had very old information about how to make complaints. For example, both complaints documents referred to contacting a predecessor regulatory body if dissatisfied with the agency's response, and gave a phone number that had not been in use for over six years. These people did not have up-to-date details on how to contact us, which meant that if their complaints were not resolved to their satisfaction, they did not have accurate information on how to contact the regulator about their unresolved complaints.

The evidence above demonstrates a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People gave us mixed views on the agency's services and how well it was managed. Some people reported being happy with the service. Comments included, "I am quite happy, you can pass that back" and "I'm happy with Sevacare." However, some people reported negative experiences. Comments included, "They have been horrible Sevacare" and "I would like to go down that office and organise them myself, I would do a better job." Some relatives referred to the service being worse than before, and one told us, "Sevacare needs to be struck off, it's diabolical."

Providers are expected to regularly seek the views of people about their service, to enable them to come to an informed view on the standard of care provided and manage risks identified from that. Some people told us of not being asked for their views on the service. Comments included, "No one comes to ask me about the service." Other people told us that this had occurred but that their views had not been considered. One person said, "Yes they send questionnaires, but we are not able to fill them in." Another person told us, "I was promised a survey, but nothing happened." One person stated, "I made a complaint, they said it would change but it got worse."

The service's manager was registered with us in March 2013. He told us that he was confident that an excellent service was being provided. He showed us a number of online audit tools that the provider used to oversee all of its services. The tools could be filtered to this specific agency. When we looked at copies of these tools in detail after our visits, we found that they identified concerns with how quality and risk at this agency was being assessed, monitored and managed.

We looked at the tool used to check that people using the service had had their care packages reviewed in a timely manner. It showed that 83% of people who started using the service from a neighbouring borough in June 2014 had not yet had a review meeting, over five months after starting to use the service. The manager confirmed there had not yet been surveys of people from this borough for feedback about the quality of the service, and that he was relying on review visits to provide feedback. This audit tool had not been used effectively to ensure that people using the service had their care needs reviewed in a timely manner, so as to protect them against the risks of inappropriate or unsafe care.

The tool used to check that care staff were being supported in their role, showed that 51% of staff did not have a record of having had a supervision meeting, and 48% had not had a spot-check by a senior staff member of their care they provided to someone in their own home. 54% of staff who had been working for over three months, had not had a supervision, spot-check, carer assessment or appraisal in that time. This audit tool had not been used effectively to identify and manage risks in relation to ensuring that staff were being appropriately supported to deliver care to people safely and to an appropriate standard.

We noted that the above tools did not include all applicable people. For example, the staff tool had 249 staff listed on it, in contrast to the 325 staff declared on the paperwork sent to us shortly before the inspection visit. This also showed that the audit tools had not been used effectively.

The tool used to monitor complaints and safeguarding allegations noted a most recent complaint as dating from over three months before our inspection visit. We saw evidence of complaints being made within more recent records on specific people on the service's computer system, and within weekly service reports to senior managers. The audit tool failed to capture details of the one complaint recorded in the paper file for the new borough that the service was providing care in. It failed to capture any of the safeguarding cases that local authorities had made us aware of in 2014, despite the manager confirming that it was used for this purpose. This audit tool had not been used effectively to identify, assess and manage risks in relation to complaints and safeguarding cases.

The manager showed us a report on the agency written by the provider's national quality auditing team. The manager told us this was an annual audit. It took place two weeks before our visit. It mainly focussed on checking the files of ten people using the service and ten staff members. It did not specifically state what had been checked within each file. For example, comments for nine of the files only stated "All fine." The report made one recommendation along with a few comments about the audit's findings. It did not include anyone using the service in the neighbouring

Is the service well-led?

borough or staff associated with that newly acquired service, despite the audit tools above indicating that greater risks were involved for people using the service in that borough. This audit process had not been used effectively to identify, assess and manage risks in relation to the health, safety and welfare of people using the service.

The manager showed us reports that were prepared weekly for oversight of the services provided in each of the two boroughs that the agency provided care in. These considered, for example, complaints, supervisions, and client reviews. They did not, however, prompt for information on safeguarding cases or missed visits that occurred, and so we were not assured that information about these matters was passed onto senior managers so that they could ensure that the matters were being appropriately managed. These weekly reports were not being used effectively to identify, assess and manage risks in relation to the health, safety and welfare of people using the service.

The manager told us of weekly care file audits that he undertook. We looked at the most recent audit. It checked five people's files on key matters to do with risk assessments, care plans, and records of care delivery including for medicines and shopping. The last audit was dated 1 August 2014, and stated that the audits were to be sent to the area manager weekly. The manager told us he had been too busy to keep this audit up-to-date, and confirmed that no such audits were in place for the new service being provided to people in the neighbouring borough.

We saw separate audits of the care delivery records, medicines records and financial transactions that had been moved from people's homes into the office. However, these were not always effective at capturing concerns. For one person, the audit stated "no issues/concerns" but when we reviewed the daily records, we saw evidence of increasing concerns around pressure care management of the person's sacral area, but with no evidence of referral to the office about the concerns until over a week later. The manager confirmed that no such audits were in place for the new service being provided to people in the neighbouring borough. This audit processes had not been used effectively to identify, assess and manage risks in relation to the health, safety and welfare of people using the service.

The 'missed visit' policy stated that each missed visit would be investigated, with reports placed onto both the file of the affected person and on that person's entry on the provider's computer system. We found no records of investigations on people's files or computer entries. This was despite there being evidence of missed visits from recent safeguarding alerts that we were made aware of, and recent notes on the provider's computer records for some people. The approach to identifying, assessing and managing risks to people's health and safety as a result of people's scheduled visits not occurring in a manner that met their needs, was not effective at protecting people from the risk of inappropriate or unsafe care.

When the manager submitted pre-inspection paperwork to us on 11 December 2014, it was recorded that there had been no missed visits in the last 28 days. However, when we checked the weekly reports sent to senior managers, the report for week commencing 24 November 2014 stated that a staff supervision had taken place due to someone experiencing a missed visit. The relevant local authority confirmed that this matter was raised as an allegation of abuse and was substantiated. Our checks of electronic visit records and other records at the agency found evidence that two other people, scheduled to receive two care workers together for care needs, also had missed visits within the previous 28 days. The impact of these instances put the people using the service, and attending care workers, at avoidable risk to their health, safety and welfare. These examples of missed visits, show that systems to identify, assess and manage risks to people's health safety and welfare were not being operated effectively. This failed to protect people from the risks of inappropriate or unsafe care.

The ineffectiveness of the provider's system of quality and risk auditing was also demonstrated through the breaches of regulations we found during this inspection that had not been identified by the provider before our visit. For example, in the pre-inspection pack sent to us, we were told that care workers' time-keeping was the primary complaint being raised and that actions were being put in place to address this, including spot-check visits and review meetings with people using the service. However, we have explained in this report how there are breaches of regulations as a consequence of evidence that spot-checks and review meetings are not kept sufficiently up-to-date.

Inadequate

Is the service well-led?

The evidence above demonstrates a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we identified that some people's service plans were not available on the provider's computer system, or did not accurately reflect their needs and service delivery. This did not support office and on-call staff to plan people's care delivery in a safe and appropriate manner.

We found that five of the 18 people's care files that we checked did not contain their most recent records, such as of care reviews and risk assessments. For example, one person was recorded as having a review meeting on 4 February 2014, however, the last review in their file was dated 05 September 2013. The last risk assessment review for one person was recorded as 10 July 2014, however, the risk assessments on file for this person and those seen at their home were dated August 2013. These inaccurate records did not protect these service users from the risks of unsafe or inappropriate care.

The management team told us they expect both care workers to sign records of care delivery at people's homes when two care workers were assessed as being needed for the care visits. Our checks of these records found that this did not consistently occur. For example, one person's visits across the month lacked information on the second care worker on seven occasions.

Another person's care delivery records for 13 days in November lacked information on the second care worker on seven occasions. There was also no entry for either care worker on one occasion. The electronic visit record for almost all of these occasions showed that the care workers' visit times had been manually entered, which did not assure us they had attended. Other records demonstrated that this person experienced occasions when only one of the two care workers attended, included one of the seven occasions referred to above. That record, on the provider's 'notes' section of their computer system, stated that the care worker "has done the call herself" after the other care worker had been unable to find the person's home. Records for this person did not help to ensure they were protected against the risks of unsafe or inappropriate care.

We asked the manager to send us the computer 'notes' section for 19 people since 1 November 2014. In the above person's case, we had a record of this information from our visit, which had entries on seven occasions. When the record was sent through to us as requested, three of the entries had been omitted. These were all entries that demonstrated that only one of two care workers had attended to the person. This undermined the accuracy of records that were provided to us at our request and failed to assure us that the agency operated in a transparent manner.

We also requested copies of on-call records relevant to the agency since 01 November 2014. Whilst much of these were supplied, nothing was supplied for the period 07 to 09 November 2014, 30 November 2014, and 07 December 2014. On other days, records relating to part of the day were missing. These inaccurate records, and records that could not be located promptly when required, did not protect people using the service from the risks of unsafe or inappropriate care.

The evidence above demonstrates a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In advance of the inspection, we asked the manager to send us the contact details of a representative sample of people using the service, so that we could send them questionnaires asking their experience of using the agency. We found that the list sent to us failed to include anyone from the new borough that the agency had been providing services to since June 2014. This was almost half of the people the agency was providing personal care services, and was therefore not a representative sample of everyone using the service. The positive feedback arising from the surveys was in contrast to the feedback we received from phoning and visiting people. This also failed to assure us that the agency operated in a transparent manner.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered persons did not take proper steps to ensure that each service user is protected against the risk of receiving care that is inappropriate or unsafe, by means of the planning and delivery of care in such a way as to meet the service user's individual needs and ensure their welfare and safety. The registered persons did not have procedures in place for dealing with foreseeable emergencies that would affect, or be likely to affect the provision of services, in order to mitigate the risks arising from such emergencies to service users. Regulation 9(1)(b)(i)(ii)(2)

The enforcement action we took:
We served a Notice of Proposal to remove 'Sevacare - Haringey' from the provider's registration and to cancel the registered manager's registration.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered persons did not protect service users against the risks of inappropriate or unsafe care, by means of the effective operation of systems designed to assess and monitor service quality, and identify, assess and manage risks. Regulation 10(1)(a)(b)(2)(b)(i)(iii)(c)(i)(e)

The enforcement action we took:
We served a Notice of Proposal to remove 'Sevacare - Haringey' from the provider's registration and to cancel the registered manager's registration.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered persons did not make suitable arrangements to ensure that people using the service are safeguarded against the risk of abuse, by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and by means of responding appropriately to any allegation of abuse. Regulation 11(1)(a)(b) (3)(a)(b)(c)(d)

The enforcement action we took:
We served a Notice of Proposal to remove 'Sevacare - Haringey' from the provider's registration and to cancel the registered manager's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered persons did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording and safe administration of medicines. Regulation 13

The enforcement action we took:
We served a Notice of Proposal to remove 'Sevacare - Haringey' from the provider's registration and to cancel the registered manager's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered persons did not have an effective system in place for identifying, receiving, handling and responding appropriate to complaints and comments made by service users, or persons acting on their behalf. Regulation 19(1)(2)(a)(c)(d)

The enforcement action we took:
We served a Notice of Proposal to remove 'Sevacare - Haringey' from the provider's registration and to cancel the registered manager's registration.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered persons did not ensure that service users are protected against the risks of unsafe or inappropriate care arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user, and appropriate records in relation to employees and the management of the service; and by means of ensuring that records could be promptly located when required. Regulation 20(1)(a)(b)(2)(a)

The enforcement action we took:
We served a Notice of Proposal to remove 'Sevacare - Haringey' from the provider's registration and to cancel the registered manager's registration.

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered persons did not have suitable arrangements in place to ensure that staff were appropriately trained and supervised to deliver care to service users safely and to an appropriate standard. Regulation 23(1)(a)

The enforcement action we took:
We served a Notice of Proposal to remove 'Sevacare - Haringey' from the provider's registration and to cancel the registered manager's registration.