Sevacare (UK) Limited

Sevacare - Coventry

Inspection report

441 Foleshill Road
Coventry
West Midlands
CV6 5AQ

Tel: 02476662758
Website: www.sevacare.org.uk

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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

Sevacare - Coventry is a domiciliary care agency which is registered to provide personal care support to people in their own homes. At the time of our inspection the agency supported approximately 150 people with personal care and employed 90 care workers.

The service was last inspected on 20 June 2016 when we found the provider was not meeting the required standards. We identified a breach in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. This was because the provider was not ensuring the quality and safety of the service provided was being effectively monitored, and had not made improvements to the service based on feedback from people who used the service.

We gave the home an overall rating of requires improvement and asked the provider to send us a report, to tell us how improvements were going to be made to the service. The provider sent us their action plan which detailed the actions they were taking to improve the service. The provider told us these actions would be completed by 31 October 2016.

At this inspection on 11 April 2017 we checked to see if the actions identified by the provider had been implemented and if they were effective. We found sufficient action had been taken and there was no longer a breach in Regulations of the Health and Social Care Act 2008. However, further improvement was needed.

The service had a registered manager. This is a requirement of the provider's registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had developed systems to gather feedback from people, relatives and others so they could use the information to improve the quality of the service provided. Audits and checks to monitor the quality and safety of the service were being regularly completed. However, further improvement was required because some issues we found during our inspection had not been identified during the auditing process. Complaints were managed in line with the provider's policy and procedure.

Some known risks related to the delivery of care and support for people who used the service had not been assessed. Some risk assessments did not reflect people's current needs. This meant staff did not always have the information they needed to support people safely and effectively. The registered manager took action to address this. People who used the service told us they felt safe with care workers. Staff understood how to protect people from abuse.

The registered manager had an understanding of the principles of the Mental Capacity Act 2005 and their responsibilities under the act. However, some people's capacity to make decisions had not been assessed.

Care workers did not have the information they needed to understand which decisions people could make and those they needed support with. Care workers sought people's consent before care was provided.

People's care plans were personalised and contained information about how people preferred their care and support to be provided. People were involved in planning and reviewing their care.

There were enough care workers to provide planned care and support to people. The provider conducted employment checks prior to staff starting work, to ensure their suitability to support people in their own homes. Staff completed an induction when they joined the service and had their practice regularly checked by a member of the management team. Care workers received training the provider considered essential to meet people's needs safely and effectively. Most people told us care workers had the right skills and knowledge to provide the care and support required.

Some people did not always receive care and support at the agreed time. This was being addressed by the management team. People told us regular care workers stayed the agreed length of time at care calls and knew how they liked to receive their care.

People told us their regular care workers were kind and respectful and understood how people wanted their care and support to be provided. Care workers respected and promoted people's privacy and dignity. People were encouraged to maintain their independence, where possible.

People were supported with their medicines by care workers who were trained and assessed as competent to give medicines safely. People who required support had enough to eat and drink and were assisted to manage their health needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some known risks associated with people's planned care had not been risk assessed and arrangements to manage risk required further improvement. People felt safe with their regular care workers. Staff were recruited safely and there were enough care workers to provide people's planned care calls. Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse. Medicines were administered safely and as prescribed, by staff who were competent to do so.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The registered manager had an understanding of their responsibilities under the Mental Capacity Act 2005; however people's capacity to make decisions was not always established and recorded. Care workers had completed the training needed to ensure they had the knowledge and skills to deliver safe and effective care to people. Care workers gained people's consent before care was provided. People were supported with their nutritional needs and were supported to access healthcare services when required.

Is the service caring?

Good

The service was caring.

People were supported by care workers who they considered kind and respectful. Care workers prompted people's privacy and dignity and encouraged people to maintain their independence. People were able to make everyday choices which were respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were personalised and informed care workers how people wanted their care and support to be

provided. People did not always receive visits from care workers at the times they needed. However, action was being taken to address this. People and relatives were involved in planning and reviewing care needs. Complaints were managed in line with the provider's policy and procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had implemented systems to monitor and improve the quality and safety of the service. However, further improvement was needed. Care workers felt supported by the management team. People and relatives were given opportunities to share their views about the service and improvements were made in response to their feedback.

Sevacare - Coventry

Detailed findings

Background to this inspection

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

Before our visit we looked at the 'Report of Actions' the provider sent to us after our last inspection in June 2016. This detailed the actions the provider was taking to improve the service.

We looked at information received from statutory notifications the provider had sent to us, and contacted commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or the NHS. They had no further information to tell us that we were not already aware of.

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

The inspection took place on 11 April 2017 and was announced. The provider was given 48 hours' notice of our visit. The notice period ensured we were able to meet with the registered manager and staff during our visit.

The inspection was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service.

During our office visit we spoke with the registered manager, the deputy manager, a team leader, three care coordinators and three care workers.

We reviewed four people's care records to see how their care and support was planned and delivered. We looked at three staff files to check whether staff had been recruited safely and were trained to deliver the care and support people required. We looked at other supplementary records which related to people's care

and how the service operated. This included checks management completed to assure themselves that people received a good quality service including the service's quality assurance checks and records of complaints.

Requires Improvement

Is the service safe?

Our findings

During our last inspection we identified some risk assessments, related to people's care contained conflicting, out of date and inaccurate information. This meant care workers did not have the information needed to minimise and manage identified risks.

At this inspection we reviewed all the risk assessments for three people using the service. We found whilst some improvements had been made further improvement was needed to ensure staff had the information required to keep people and themselves safe.

We found one file contained information provided by the local authority about a range of known risks to the person. These risks had not been assessed by the service. This meant care workers did not have the necessary information to ensure they provided care and support safely.

For example, the person had a known risk of choking which was increased due to 'frequent' muscle spasms resulting from a specific medical condition. A local authority support plan detailed one of the risk reduction measures was for care worker's to assist the person with eating and drinking, to cut food into '5 pence piece sizes' and to thicken the person's drinks. A risk assessment dated June 2016 informed care workers of the action needed if the person choked but did not include the essential guidance on how to reduce and manage the risk.

We asked a care coordinator if the person needed assistance with eating and if their drinks needed to be thickened, they told us, "I'm not sure if thickening drinks is just what [Person's relative] does. I don't think the staff do it." They added, "We have completed the swallowing protocol as we think that is what [name] will need. We will discuss it at the review meeting next week." We saw the swallowing protocol contained the required information for staff to follow. However, we were concerned it had been completed on an 'assumption' of what the person may need and without specialist advice being sought. Furthermore, despite the service being aware of a known risk, an up to date risk management plan was not in place.

The local authority support plan also identified the person was at 'risk of falling out of bed." Daily notes completed by care workers showed some, but not all staff were placing a 'crash mat' (bedside mat) by the person's bed. However, the risk of falling or the need to use specialist equipment was not recorded in the person's care plan. A falls risk assessment had not been completed. We discussed this with a care coordinator who told us they were not aware the person was at risk of falling and staff had not reported they were using this equipment. Bedside mats are designed to be placed on the floor adjacent to the bedside of a person at risk of falling out of bed.

Daily notes also showed some staff were assisting the person to 'put on and take off a boot'. We asked what type of boot the person was using. A care coordinator told us, "It's just a normal slipper boot." However, the local authority support plan detailed the person's history of developing pressure sores on their heels and the need to wear a padded boot to reduce this risk. The support plan explained staff needed to assist the person to 'put the boot on and off' when assisting the person in and out of bed. The information was not detailed in

the person's care plan and a pressure care risk assessment had not been completed. This meant we could not be assured a known risk was being effectively managed.

We were concerned the volume and range of inaccurate risk management information, within this care file, could present significant risk for the person using the service. We discussed our concerns with the registered manager who gave immediate assurance the care file would be reviewed and updated. Since our inspection the registered manager confirmed the action had been completed.

Risk assessments on the other files we reviewed were up to date and provided staff with the information needed to manage and reduce each risk. For example, one person was at risk of their skin becoming damaged. The risk assessment instructed care workers to check the person's skin at each visit and to apply cream to reduce the risk of the skin becoming sore. Staff were instructed to contact the office if the person's skin was broken. Another person needed assistance to move around their home safely. The assessment detailed the equipment needed and the number of care workers required to support the person safely. Daily records completed by care workers confirmed they were following the risk assessment.

Care workers told us they knew about the risks associated with people's care who they visited regularly, and how these were to be managed. Care workers told us they read people's care records which gave them the information they needed. A care coordinator told us risk assessments were completed with people when the service started. They told us, "I always go out on the first visit so I can do my assessments and explain to staff exactly what to do. I think this is very helpful for the carer's because they can ask questions." However, this conflicted with some of our findings during the inspection.

People told us they felt safe with their regular care workers. When asked what made them feel safe, one person told us, "They [care workers] do everything they can to make sure I am ok, especially before they leave by making sure all the doors and windows are secure." Another person described how care workers checked their key was in the key safe at the end of each visit. They told us this made them 'feel safe'. People and relative's knew who to speak to if they didn't feel safe, people told us they would speak with, "Their care worker, office staff or their relative."

Staff received regular refresher training in safeguarding and were confident about their role in keeping people safe from avoidable harm. Staff knew what to do if they thought someone was at risk of abuse. One care worker told us, "I have a duty to keep people safe, I learnt in training the importance of being vigilant and reporting my concerns if I was ever worried about someone being harmed." Another said, "If I saw someone had bruises I know to report it so it can be investigated and if nothing happened I report it to CQC or the police." Staff told us they were confident the registered manager would take appropriate action if they did report any concerns.

People were protected by the provider's recruitment practices which minimised risks to people's safety. We looked at three recruitment records and spoke with staff about their recruitment experience. We found the provider checked staff were of good character before they started working at the service. They obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. Staff confirmed they were unable to work at the service until checks had been completed. One newer member of staff told us, "I was told at interview I would have to wait for all my checks to come back. I was really lucky my references and DBS came through in just over a week."

Care coordinator's confirmed there were enough care workers to allocate all the calls people required. Care workers agreed. One said, "Yes, there are enough of us; I go to the same people most of the time." Another

told us, "I work both on single and double up calls, there is enough of us to provide care to people." The registered manager explained whilst staff retention at the service was 'very good', some staff had worked at the service for over 10 years, they had an on-going recruitment drive. They said, "We work closely with the local job centre and hold an open day every two weeks. We can have up to 10 people attending for interview. Recruitment has been so successful we have had to ask for more induction training."

People and relatives told us care workers supported them to take their medicines if this was part of their care package. One person said, "They give me my tablets every day with a glass of water." Another person told us care workers completed records at each visit to show they had supported the person to take their medicines.

Care workers told us they had completed training in the management and administration of medicines. One care worker said, "We do medication training as part of our induction and then the office staff observe us doing it." Another care worker told us, "If we make a medicine error were not allowed to support people with their medicines until we re do training."

We looked at three people's medication administration records (MAR) which showed medicines had been administered and signed for at the specified time. Known risks associated with particular medicines were recorded, along with clear directions for staff on how best to administer them.

Monthly medicines audits were completed by the provider to ensure people had been given the right medicines at the right times. Records confirmed any issues identified during medicines audits were discussed in one to one meetings with care worker and actions were agreed. This ensured care workers continued to have the skills and knowledge needed to administer people's medicines safely.

Accidents and incidents were logged and appropriate action was taken to support the individual and to check for trends or patterns in incidents which took place.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way possible.

The provider had trained staff in understanding the requirements of the Mental Capacity Act. One care worker said, "It's all about if people can choose what to do or if they need help to make a decision." A care coordinator told us, "Knowing if they [people] can make decisions is important." They told us care coordinators discussed people's capacity to make decisions with people and relatives when the service started.

Mental capacity assessments were not always completed when people could not make decisions for themselves. We were told four people using the service were living with dementia which could, at times, affect their ability to make decisions. People's care files contained care plans and 'dementia' assessments, however these did not conclude whether people did or did not have capacity to make decisions. We asked to see the mental capacity assessments for these people but were told they had not been completed.

Care coordinators did not have a clear understanding of their responsibilities to complete the providers 'Assessment of Mental Capacity/Consent to Care' form. When discussing the completion of mental capacity assessments with the registered manager they told us, "An initial assessment is completed when the service starts. Then a draft care plan which includes consent to care form. If people can't consent then we do a mental capacity form." However, when we asked care coordinators why the providers assessment of mental capacity had not been completed for the four people living with dementia we received mixed responses, "I don't know about those.", "I really don't know. I thought they had." And, "We don't do them the social workers do."

We reviewed the provider's 'Mental capacity Act (2005) Policy Guidance' but were unable to find clear instructions for staff to follow about when an assessment should be completed and by whom. We were concerned care coordinators did not have a clear understanding of their responsibilities. This meant staff were not given information about people's capacity to make decisions, or if decisions needed to be made in their 'best interest' and by whom. We discussed this with the registered manager. They said, "I'm trying to develop their [care coordinators] knowledge of mental capacity. I need to look at new ways opposed to face to face training." They told us they would also speak with the provider about the possibility of further developing the guidance.

Some people's care records informed care workers of people's capacity to make decisions and the level of support people needed. For example, one person's care plan stated, "[Person's name] has capacity to make simple choices and decisions in regards to her daily care however her family takes major decisions on her behalf.' However, it was not clear if the person's family had the legal authority to make decisions on their

behalf which is a requirement of the Act.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager understood the relevant requirements of the Mental Capacity Act (2005). They confirmed no one using the service at the time of our visit, required a DoLS authorisation, however they were aware of when this may be applicable for people.

People had been asked to sign to consent to their care and support being delivered by the service. We saw where people had the ability to be involved in decisions about their care and support needs, their involvement had been recorded. However, one person's care records confirmed the person had capacity but the 'Consent to Care' form had been signed by a relative. This 'consent' was instead of a 'best interests' decision being made by an appropriate person. We asked the registered manager why the person had not signed the consent form they told us, "People can be nominated to sign on their behalf." This demonstrated that the provider was not always acting in accordance with the principles of the MCA.

People told us care workers sought consent before providing any care or support. One person said, "…staff ask me before they do anything for me, but my main carer has been coming for so long that she just gets on and does things ." Care workers told us they understood the importance of gaining consent from people before they supported them. One said, "People have the right to refuse care and I respect their wishes." They told us they had learnt about their responsibility to 'seek consent' during training.

People and relatives had mixed views about whether care workers had the skills and knowledge needed to support them effectively. One person told us, "They [care workers] know exactly what to do and how to do it." Another said they felt 'younger' care workers needed more training because "they don't always know what to do." A relative recalled a recent time when their family member was not well. They told us, "They [care workers] did call the ambulance which was good. But they didn't really have the basic first aid knowledge to deal with [person's name] while they were waiting."

Staff told us they had been inducted into the organisation when they first started work. This included completing training the provider considered essential to meet the needs of people using the service and new staff working alongside more experienced staff. When discussing induction one care worker told us, "… I did a week of shadowing, I could have had more if I wanted but I felt confident." A care coordinator described their induction as, "Informative and valuable."

The provider's induction included working towards the Care Certificate which assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. One care worker said, "I have just completed the Care Certificate and it's given me the knowledge I need to do a good job." Care workers told us in addition to completing the induction programme; they had a probationary period to check they had the right skills and attitudes to work with the people they supported.

On-going training was planned to support staffs' continued learning. Care workers spoke positively about the training they received. One care worker said, "The training here is really good. They showed me how to use a hoist; we all had a go in it so we know how it can feel for people." Care workers said training was also linked to people's specific needs which enabled them to support people effectively. For example, care workers had undertaken re-enablement training to develop their skills to work with people on 'short term'

packages where the aim of the care was to promote independence.

The registered manager maintained an electronic record of all staff training. This showed staff training was up to date. Staff told us the provider also invested in their personal development, as they were supported to achieve nationally recognised qualifications. One care worker said, "I have done my NVQ 2 and am completing my level 3 now." They explained they had applied for a more senior role at Sevacare and being supported to complete level 3 had given them the confidence to apply.

Care workers told us their practice was regularly checked by a senior staff member. They said this was to ensure they continued to have the skills and knowledge needed to support people and were following the provider's policies and procedures. One care worker told us, "Checks happen every few months; a manager is there when I arrive. I do not know they will be there." The staff member told us they thought these checks were positive because, "It's good to be kept on my toes." Records showed checks included the carer's arrival time, the length of the call, management of medicines, carer's attitude and whether they were following company policy by wearing their identification.

People's nutritional needs were met by care workers if this was part of their planned care. One person told us, "I can manage most things myself but the carers always do my lunch..." They added, "My girls [care workers] tell me what's in the freezer so I can choose what I fancy." Care workers told us they ensured people who required assistance with meal preparation were always offered choice. One told us, "There is some information as to what people like in care plans but I always ask them as they may want something different."

People told us they managed, or were supported by a family member to manage their day to day healthcare. Care workers said they informed people's relatives or the registered manager if a person was unwell and needed a visit from the GP. During our visit we heard the deputy manager inform a relative staff had reported their family member's feet were causing some discomfort. The deputy manager suggested the person may benefit from a visit from their GP which the relative agreed to arrange. Records showed the service involved other health professionals with people's care when required including doctors and district nurses.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the care workers who supported them. Comments made included, "The carers who look after me are great they couldn't do more if they tried.", "My carers are so kind nothing is a trouble to them at all." And, "My carers are brilliant."

We asked care workers what being 'caring' meant for them. One care worker told us, "Providing good quality care…being patient and gentle with people." Another staff member explained to be caring they had to ensure people were treated with kindness and respect.

People told us their regular care workers knew about their care needs and supported them in the way they preferred. One person told us, "Now I have the same carers they know what I need help with. They understand me." Another person told us, "The carers who come have got to know me well as I have used Sevacare for two years."

Care workers had a good understanding of people's care and support needs. They told us this was because they visited the same people. One care worker told us, "I think I know people well. I talk to them about all of the things they like so I know how to care for them." Another care worker told us they learnt about people's needs by talking to the person, their relatives, and reading care plans.

People's privacy and dignity was respected by care workers. One person said, "My carers always knock the front door and ask if they can come in." A relative told us, "Everyone who comes into my house couldn't be more respectful to both my mother and I." Care workers told us they understood the importance of promoting people's dignity and privacy. One said, "I have had dignity training. I treat people how I like to be treated." Other care workers gave examples of how they promoted people's privacy and dignity including, waiting outside the bathroom and closing curtains and doors.

Some people and relatives told us they were involved in making decisions about their care and had been involved in planning their care when they started to use the service. One person said, "They [care coordinators] came out to my home. We talked about what I needed and how I liked things done." During our inspection we observed office staff contacting people and relatives to arrange to meet with them to discuss their planned care.

People were supported, where possible, to maintain their independence and the support they received was flexible to their needs. One person told us, "I am encouraged all the time to do what I can for myself by all the care staff." Another person described how care workers started each care call by asking what assistance the person needed. They told us this was because the level of support required could change on a daily basis. The person added, "They [care workers] know I like to do things myself if I can."

Care workers told us encouraging people's independence was important because it enabled people to remain 'in control'. One told us, "….our job is to promote people's independence. I always encourage people to do as much as they can for themselves." Another described how they prompted a person's

independence by ensuring the person's walking frame was by the chair so the person 'can get up and move around'.

When we asked people if care workers were allocated sufficient time to carry out their calls without having to rush we received mixed responses. One person said, "I sometimes think they forget that I am 94 and just need to take my time a bit to get sorted." Another person told us, "My carer's do everything I need. I can't say I ever feel rushed."

Care workers told us they had sufficient time allocated for each care call and had flexibility to stay longer if required. One care worker told us they felt this was because 'travel time' had been added to their work rota. They said, "Now we have the time to do the visit properly." Another told us, "I am never rushed, I can sit and talk with people or have a cup of tea, some people just enjoy a bit of company." They added, "I really enjoy my job; I love the people, that's why I do it." The call monitoring records we reviewed confirmed the length of time allocated to staff for each call matched the times planned.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection people and relatives told us care workers were regularly late arriving to provide their care call which caused them concern.

At this inspection some people and relatives told us inconsistency of calls times continued to be an issue. Comments made included, "They are late most of the time. It can sometimes be more than an hour. " And, "…I never know what time they are coming, sometimes they can be very late. They never stick to the times they tell me. I don't know why they even bother to give me a time." Another person told us they were unable to book transport to go out during the day because they never knew what time their care call would take place.

In contrast, other people told us they had, recently, experienced improvement in the timing of their calls. One person said, "At the moment they come on time. It's been like this for a few weeks. I hope it lasts." A relative told us, "Call times are hit and miss but at the moment they seem to be here at the same time every day."

Staff told us they were able to make 'most' care calls at the allocated time because a 'set rota' had been introduced. One told us, "It's much better now. We have enough time on our rotas so we can do everything people need and time to get to the next call." A care coordinator told us, "We are focusing on making sure people get their calls at the time they want. We are nearly there. We just need to make some tweaks." They explained this was being addressed by allocating a 'small team' to provide people's care and support calls. They added, "Consistency is very important so the service user and carer can establish a rapport."

We discussed people's concerns about call times with the registered manager. They told us, "We have worked hard and are still working to address concerns about call times. All rotas are now templated (pre-set) and travel time has been included. It is working because we have definitely seen a reduction in the number of concerns we receive." They added, "There is more work to be done but we are getting there."

We looked at the call schedules for twelve people who used the service over a four week period. These showed people had received all planned care visits. Seven records showed staff had arrived and stayed the agreed amount of time and visits had been completed by regular care workers. The remaining call schedules did not provide accurate information because some staff had not followed the provider's procedure to log in and out at each visit. This meant we could not be assured these calls had taken place as planned. However, we saw one to one meetings had been held with these staff member's to ensure they understood and followed the required procedure.

At our previous inspection we found care plans provided very limited information about people's individual preferences and contained inaccurate and out of date information.

Care plans reviewed during this visit had been personalised and gave staff more detailed information about how to meet people's needs. For example, one person's care plan informed care workers the person liked

staff to wait outside the door, whilst they used the bathroom. Another plan told staff to provide the person with a bowl of warm water as they were able to independently wash their face, arms and chest, but needed assistance to wash their feet. People or relative's had signed care plans to confirm they had been involved in reviewing their care.

Previously, we had concerns about the way in which the service was managing complaints. This was because people told us they were not satisfied with the way their complaints were handled. We also found the number of complaints recorded was not consistent with what some people had told us about their experience of using the service.

At this inspection we found improvements had been made.

People told us they knew how to complain and felt able to raise any concerns with the management team, or care workers if they needed to. One person said, "Yes I would complain and I have. The other day I rang up and complained about the carers being late again." Another person told us, "I would contact the office and tell them what was wrong but I have never needed to my carers are all fine "

Records showed the service had received twelve complaints since January 2017. The majority of complaints related to call times which reflected what people had told us. We were satisfied complaints had been managed according to the provider's complaints policy and procedure.

The registered manager told us since our last inspection they had reviewed the way in which complaints were recorded and managed. They said, "We are now being proactive. If a service users [person] says they are not happy we look into the issue straight away. Dealing with 'niggles' helps stop the escalation to a complaint."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in June 2016, the provider had breached Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. This was because there were no systems in place to ensure people received the service they required or to show people's concerns about the service provided had been addressed. Quality monitoring systems were either not in place or were ineffective. People's care records were not up to date and feedback about the service had not been used to make improvements.

We asked the provider to take action to implement effective quality assurance systems. In response they sent us an action plan outlining how they would make improvements. They told us the actions would be completed by October 2016.

At this inspection we found the provider had completed the action they said they would take. However some systems were not fully effective.

Previously, we found audits to monitor the safety of the service were either not in place, or were ineffective.

During this inspection we found some improvements had been made. Records showed regular audits and checks were being completed by the provider, the registered manager and office staff, including medicine management, care records, complaints, call monitoring, staff files and training. Where the need for improvement had been identified as part of the auditing process the actions required and taken were recorded. For example, a medicines audit in March 2017 had identified the prescribing instruction for one medicine was incorrectly recorded. Immediate action had been taken to update the MAR with the correct information.

However, we also found some audits were not effective. This was because the issues we found during our visit had not been identified. For example, a care file audit in March 2017 had not identified inaccurate and out of date information in care plans. Auditing of 'daily records' in April 2017 had not identified staff were using equipment which was not detailed in the person's risk assessment. We discussed our findings with the registered manager. They told us, "Auditing of care plans itself needs to be looked at. At the minute it's more about auditing the care file to see the documents are there." The registered manager told us this was an area for further development.

During our last inspection the registered manager's overview of the service was not sufficient to ensure the service always operated effectively and safely by monitoring whether care workers arrived, and remained at care calls for the agreed length of time.

At this visit we found improvement had been made.

Records showed care coordinator's checked the electronic 'call monitoring' system on a daily basis. A care coordinator told us this approach had been effective because they were able to respond 'immediately' if a

care worker had not arrived at a care call. They explained if a care worker was late or left a care call early they were contacted by telephone to discuss the reason for this, and where necessary, the staff member was 'called in for a meeting'. The care coordinator told us, "Then we monitor to make sure they are going at the right time."

The service had also improved the way they responded to 'informal' concerns. Any issues raised by people or relatives were recorded on a 'service user dissatisfaction report'. This detailed the concern raised, the actions required and those taken to address the issue. Each report was reviewed and signed by the registered manager.

At our last inspection we identified the provider had not always responded to people's feedback about the service by making improvements.

During this visit records showed the provider had gathered feedback from people, in March 2016. 80 questionnaires had been issued and 41 returned. The feedback received had been used to develop an action plan identifying where improvement was needed and the actions being taken. For example, the registered manager had responded to people's feedback about 'not knowing the office staff' by arranging a coffee morning. They told us whilst attendance at the coffee morning had been 'low' the event was welcomed by those who attended and requests for further similar events had been made. The registered manager said, "We are looking at how we can open the event up and make it more accessible to people who don't have any transport." The provider was also in the process of gathering views from relatives and health and social care professionals.

We found the provider was no longer in breach of Regulation 17. However, we reminded the provider we expect continuous improvement in the completion and accuracy of audits and checks to ensure the safety and quality of service provided.

When we asked people who used Sevacare Coventry if the service was well managed we received mixed responses. One person told us, "I know they have a manager but I have never met anyone. My call times are an ongoing thing. So perhaps it's not good management." Another person told us a member of the management team was 'always' available if they needed to speak to someone. They added, "They [management] are very easy to contact. They always answer the phone when you ring. If they are busy they ring you straight back."

There was a clear management structure within the service; this included the registered manager, a deputy manager, a team leader and three care coordinators. The registered manager was actively involved in the day-to-day running of the service and was available to provide guidance and support to staff, when needed. The registered manager told us they were supported by the provider through 'daily' telephone contact and weekly meetings. The registered manager also attended meetings with managers from within the provider group. They told us, "These meeting are really helpful. We can share experiences, what's working well or not working well and discuss how these issues have been managed."

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

Staff spoke positively about the support they received from the management team. Comments made,

included, "[Coordinators name] is great, she is really helpful.", "We have had a few management changes but it's more settled now.", "I feel the service is well run, there is good management here." And, "Everyone is really supportive here, we all get on and team work is good. I feel part of a good team."

Previously, care workers told us the provider's 'out of hours on call' system was not effective because of 'poor communication'. At this visit care worker told us improvements had been made and they now felt supported outside office hours. The registered manager explained the system had been strengthened by adding a 'branch back up' tier to the system. They said, "Now one of the team is always available outside of office hours… because we have the local knowledge we can respond quickly. It is working well." The registered manager was also available if there was a need to 'escalate' an issue.

Since our last inspection, the management team had met with staff at regular intervals. Care workers said these meetings gave them the opportunity to discuss any changes, things that were working well and any ideas for developing the service. One staff member said, "We have meetings, we are listened to here." Records of the latest staff meeting in February 2017 showed a range of issues had been discussed including, medicines management, dementia awareness and improvements made by care worker in the completion of records. The registered manager had 'thanked' staff for their hard work to achieve this.