Sevacare (UK) Limited

Synergy Homecare - Stoke-on-Trent

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Synergy Homecare is located in Stoke-on-Trent, Staffordshire The service provides personal care to people in their own homes, some of whom are living with dementia. On the day of our inspection, there were 73 people using the service.

The inspection took place on 2 November 2017 and was announced.

There was a registered manager at this service, but they were absent from work at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

At our previous inspection on 16 and 17 May 2016, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to consent; safe care and treatment; and good governance. The provider was issued with a warning notice in regard to these breaches, which specified they must comply with the Regulations. At this inspection, we found the provider remained in breach Regulation 17, good governance. Additional breaches of Regulation were also identified. These were in relation to receiving and acting on complaints, and notification of incidents.

The provider had not always followed their own recruitment process, which meant there was a risk of unsuitable people being employed to care for people.

There had been a recent period of three months where people's calls had been missed, or the carer had arrived late. Risk assessments were in place in relation to people's individual care and support needs, but more information was needed about how to keep people with certain conditions safe.

People's confidential care records were not always stored securely. Whilst there was a system in place for capturing feedback and complaints, these had not always been responded to or acted on.

Although staff were working within the requirements of the Mental Capacity Act, their knowledge and understanding of this key legislation was not at the necessary level.

The registered provider had investigated allegations of abuse and harm and informed the local authority, but had not informed the Care Quality Commission, as they were required to do.

Medication audits were regularly carried to ensure staff's practice was in keeping with current best practice and that people received their medicines safely and as prescribed.

There was consistency in regard to people's carers, with an understanding of the importance to people of

having regular carers. People enjoyed positive and respectful relationships with staff.

People were supported to maintain their health and with their eating and drinking needs. Changes in people's health and wellbeing needs were responded to.

The provider ensured information was provided to people in a format which suited them. The provider showed regard for equality, diversity and human rights.

Staff felt supported in their roles and were enthusiastic about recent improvements and changes.

The provider's quality assurance systems had identified the current shortfalls in the service, and an action plan was in place to address these.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider had not always followed its own recruitment process and ensured references were in place before staff started working with people. There had been a period of late or missed calls for people over a period of three months.

People were protected from harm and abuse, with appropriate referrals made to the safeguarding team, when required.

People received their medicines when they should, and medicines were routinely audited to maintain safe practice,

Is the service effective?

Requires Improvement

The service was not always effective.

Staff's knowledge and understanding of key legislation and certain health conditions was not always at the required level.

People were supported to maintain their health and with their eating and drinking needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's confidential information was not always stored securely.

People enjoyed respectful and positive relationships with staff. People's individual communication styles and needs were known by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints and concerns had not been responded to over a period of five months.

People benefited from a flexible service and from regular reviews of their care needs. The provider ensured that information provided to people was accessible and in a format they could understand.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not notified the CQC of safeguarding concerns, as they were required to do by law. The provider had identified shortfalls in the service and was addressing these. However, some had been ongoing for a matter of months before being highlighted and remedied.

The provider demonstrated an awareness of, and a commitment to, equality, diversity and human rights. Staff were positive and enthusiastic about the changes already made to the service.

Synergy Homecare - Stoke-on-Trent

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.

We made an announced inspection on 2 November 2017. The inspection team consisted of one Inspector and one Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had knowledge and experience of care provided by domiciliary care agencies.

We gave the registered provider 48 hours' notice of our intention to undertake an inspection. This was because the organisation provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be available in the office.

Before the inspection, the provider completed a 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. This information helped us to focus our inspection.

We looked at the information we held about the service and the provider. We asked the local authority if they had any information to share with us about the care provided by the service.

We spoke with 14 people who used the service and three relatives. We spoke with the area manager and the auditor/trainee manager. We also spoke with the office coordinator; two team leaders; and six care staff. We looked at eight care plans, which included risk assessments; initial assessments of needs; capacity assessments; healthcare information and reviews of people's care. We looked at ten staff pre-employment files; medication audits; complaints and feedback received; safeguarding investigations; the provider's

current action plan; and staff training records.

Requires Improvement

Is the service safe?

Our findings

Before our inspection, we received information of concern about people's calls being late or missed. Prior to our inspection, people told us that staff were often rushed during their calls and did not have time to spend with people; times of calls were changed without always letting people know; and there were times when the carer did not show up. The local authority shared with us there had been nine missed calls between the end of July 2017 and the end of October.

We spoke with the area manager and the auditor/trainee manager about these concerns. They told us that since taking on the day-to-day management of the service, improvements had been made. The auditor had met with the local authority to discuss the concerns about missed calls, and to look at people's individual call times. As a result, people's call times had been re-assessed and changes made where necessary, and some routes to people's homes being changed to ensure there was sufficient time to get to the call on time. Another improvement had been continuity of carers, with people now having a maximum of five different carers. Initial feedback from people was positive about these changes. One person we spoke with told us, "I think things have been improving recently, especially continuity of the care staff who come. I usually have the same two carers all week now. I really like to know who is coming as everyone works differently."

We spoke with the office coordinator, who told us staff had been urged to let the office know if they were running late, so office staff could then tell people their call time may be affected. The office coordinator told us they had spent time with staff explaining that they cared for vulnerable people, and that some people became stressed and worried if their carer did not turn up on time. The office coordinator told us that since having these conversations with staff and explaining the importance of communication, this had greatly improved. One person we spoke with told us, "I have no complaints about the timings of my calls. If the carers are running late, I always get a phone call to tell me."

We looked at whether the provider's recruitment process was safe. The provider told us before new staff members could start working with people, they needed to be checked by the Disclosure and Barring Service ("DBS"), and that two references must be obtained. Whilst one of the staff pre-employment checks we looked at contained a DBS check, the necessary references were not in place; this person had been working for Synergy for four months. We brought this to the attention of the area manager, who spoke with the provider's recruitment team. The recruitment team looked into the matter, but could not explain the absence of this information in the staff member's file. The area manager told us that if they struggled to obtain references, the protocol was for a director to make the decision on whether to continue with the application or not, and for this decision to be placed in the file as evidence. However, this was not the case with this staff file. Therefore, we could not be satisfied the provider was following their own recruitment procedures, and that their procedure was safe. The area manager told us that all staff personnel files would be checked as a matter of urgency. Prior to our inspection, no audits of staff files had taken place to make sure that all the required references and checks were in place.

At our previous inspection, we found that up-to-date risk assessments were not always in place for staff to follow to ensure that people's needs were met safely. At this inspection, we found risk assessments were in

place for people and covered a range of risks associated with people's care and support needs, including finances; physical environment; medication; and self-neglect. However, we found that where people had epilepsy, their risk assessments could be made clearer so that staff knew to consider possible signs of a seizure; triggers for seizures and different types of seizures. The area manager told us this would be considered in more detail so that the risk assessments were comprehensive for this particular condition.

People were protected from harm and abuse. People were encouraged to report any concerns they had about their care, and we saw examples of where action had been taken by the provider as a result of concerns raised, such as removing a carer from a call. Staff were aware of the different types of abuse and harm, and potential warning signs to be vigilant to. One member of staff told us a person they cared for always tried to give them money at the end of the care call, which the carer told us they always declined, recorded and then made sure the person still had their money when they next saw them and had not given it to another carer or health professional. Where there had been concerns about potential abuse or harm, these had been reported to the local authority and investigated internally. The provider told us they were making changes to their disciplinary procedure as a result of 'lessons learnt' where they had reflected and felt they had perhaps been too lenient with staff in regard to their conduct. The provider told us they wanted to send a clear message to staff that their conduct must never fall below a certain standard, and that there would be repercussions in the event they did not meet this standard.

People we spoke with told us they received their medicines when they should. One person we spoke with told us, "My carer always reminds me to take my tablets as I am quite forgetful." We spoke with the provider's auditor about changes and improvements they had made to the administration and recording of people's medicines. We saw the auditor had identified that body maps were required for people whom had been prescribed creams, and these were now in place. This was so carers could clearly see what affected areas the creams were to be applied to. The auditor had also identified that staff were not always recording and listing the medication frequency, dosage type and amount on people's individual medication administration records ("MARs"). This had been discussed with all staff in team meetings to ensure staff consistently recorded this information on the MARs, in keeping with best practice about the safe administration of medicines. The auditor had been carrying out weekly audits of MARs as there had been concerns that staff did not always sign for people's medicines when they had been administered. This practice had now improved, and the auditor had been able to reinstate monthly MAR audits.

Requires Improvement

Is the service effective?

Our findings

We looked at how the provider was maintaining and promoting people's individual rights. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

At our previous inspection, we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not been trained on the MCA and so did not understand the relevance of it to their daily practice. Additionally, where decisions had been made on behalf of people who lacked capacity, the best interest decision-making process had not been followed. We found the provider was no longer in breach of this Regulation.

All staff had received training on the MCA, and its key principles had also been discussed with staff in team meetings and staff supervisions. Despite this, staff we spoke with still demonstrated a limited understanding of the Act. One member of staff asked what capacity was when we spoke with them about the Act. Another member of staff told us when we asked what their understanding of the Act was that, "It's about just generally taking care of people." We fed this back to the area manager, who told us the provider's training and development team would do more work with staff to ensure they had a working knowledge of the Act, and understood the principles of capacity and consent.

However, although staff did not show a full understanding of the Act, people we spoke with told us that staff always sought their consent and respected their choices. One person we spoke with told us, "They (staff) always ask if it is OK to do something first, such as tidying things away for me. They don't just assume that is what I want them to do." A relative we spoke with told us they had observed staff seeking consent from people, as well as giving them information to help them to make informed choices.

We found that people had decision-specific capacity assessments and, in the event they did not have capacity to make a particular decision, this decision had been made in the person's best interests by health professionals and family members.

We considered whether staff had the skills and knowledge needed to do their jobs effectively. Since our previous inspection, staff had received training in areas such as person-centred care planning, risk assessments and refresher training in medication and manual handling. People we spoke with told us they felt staff were skilled and competent. One relative we spoke with told us, "The carers who visit [person] appear to be very well-trained. They can do anything we need them to; nothing is too much trouble." Another relative told us, " [Carer] is very good at interacting with [person.] [Person] is very relaxed in their presence. "

We asked staff if they felt they were given the right guidance and training they needed to carry out their roles effectively. Staff we spoke with told us they felt they would benefit from more in-depth dementia training. One member of staff told us it was overwhelming for some new starters who had never worked in care before when they first started to care for someone living with dementia. Other staff told us they wanted to know more about all the different forms of dementia and their effects. We spoke with the area manager about this, who told us that whilst dementia training was already provided to staff, they would look at additional training for them.

We spoke with staff about how they supported people with epilepsy. Staff told us they had received First Aid training, which had covered what to do when someone has a seizure. However, they did not know about different signs and symptoms to be vigilant to when someone was about to have a seizure; different triggers; and different types of seizures. As the service supported people with this condition, we raised this with the area manager as a possible training need for staff.

People were supported to maintain their health. On the day of our inspection, one carer had called the paramedics out to a person who needed urgent medical attention. We also saw that staff worked alongside other healthcare professionals, such as district nurses and physiotherapists, to ensure that people's healthcare needs were met, We saw recent feedback from one relative, which said, " Thank you to the staff for their hard work in communicating with the occupational therapist to sort out equipment for [person]."

People received the help they needed with eating and drinking. Staff were able to tell us what individual support people needed, and this information was also reflected in people's care plans. Staff knew people who were at risk of choking and the help people needed to prevent this, such as sitting with the person and making sure they ate slowly. Where there were concerns around people's weight loss, this was monitored and discussed with the relevant healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection, we received information of concern regarding people's confidential care notes not always been stored securely by staff. We spoke with the area manager about this concern, who confirmed that loose care notes had been stored by some care staff in their cars, which meant personal information was not kept secure. The area manager had taken action to change this practice. Care notes were no longer recorded on loose pieces of paper, but were recorded in a care file and kept in people's homes. At the end of the week, carers had to ensure the care notes were returned to the office for secure filing. A reminder notice had been placed at the end of each weekly care file to prompt staff to bring the files to the office. We spoke with staff, who told us that some care staff still forgot to bring the care notes into the office at the end of the week and that not all staff were ensuring the safe return of care notes. The area manager told us this was being addressed with all staff, and they were being reminded of the importance of data protection.

We found the provider recognised the importance of upholding people's dignity and treating them with respect. For example, one person had expressed dissatisfaction about their carer's approach, and felt it was not respectful the way in which the carer discussed their own personal matters with them. We saw this concern was shared and discussed with the carer, with their practice being challenged by the provider. The provider reiterated the importance of dignity and respect to the carer, and there had been no further concerns expressed by the person, or any other person cared for by the member of staff. People's care plans reflected their preferences in terms of male or female carers, and also what personal care they required. For example, one person's care plan stated that their appearance was important to them, and they always wanted their hair done. Staff we spoke with were aware of this and that personal grooming mattered to people and was a way of maintaining their dignity. Another person requested for staff to remove their shoes before entering their home. Staff told us they always ensured they did so as a way of respecting the person and their home.

People and relatives told us they were happy with the approach of their carers, and that they enjoyed positive relationships with them. One person we spoke with told us, " I couldn't ask for better carers. The ones who visit me are all brilliant and nothing is a trouble to any one of them." A relative we spoke with commented, " From what I have observed, the staff show real empathy to [person]. I notice it most when I hear them talking with [person]; they are so kind, at all times." Staff we spoke with knew people well and spoke of them with warmth and affection. One member of staff we spoke with told us, " I love getting to know them (people) as individuals. For many people we care for, we are their link to the outside world."

Staff were able to demonstrate to us an awareness of individuals' communication styles and needs. For example, one person had a particular faith, which meant they did not like staff to blaspheme in their home. Another person needed staff to tailor their communication and language in a particular way to help the person to understand. Staff also spoke about the importance of encouraging people, whilst respecting their choices. For example, staff told us that one person often said they did not help with their continence needs, even when it was apparent they did need staff assistance. Staff told us they gently encouraged this person at first and if that was unsuccessful, they asked the person a bit later if they would like some help and the person would usually agree at that point.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we found that people's care plans were not always reflective of their current needs, and were not reviewed as people's needs changed. At this inspection, we found the provider had reviewed everyone's care plan to make sure they contained a current full assessment of need, as well as person-centred support plans. Care plans also contained people's preferences and likes and dislikes, particularly in relation to how they wished to be cared for. Staff we spoke with were familiar with people's individual care plans and preferences. Staff told us about one person in particular who had a routine in place as to how they liked their care to be given, which was of great importance to them. We reviewed this person's care plan and found it reflected what staff had told us about the person's preferences.

Registered providers must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints and concerns raised. Whilst the provider had an accessible complaints system in place, we found that formal complaints had not been responded to over a period of five months. We spoke with the area manager about this issue, who was aware that complaints had not been responded to and was in the process of addressing this. The area manager had spoken with people who had raised complaints and concerns to apologise for the lack of response and to offer meetings with them to discuss their complaints. We saw that where complaints had been upheld, the area manager had offered an apology to the complainant, and had also signposted them to the relevant Ombudsman organisation if they wished to take their complaint further. The area manager had also contacted the local authority to find out if there were any complaints made to them about Synergy so they could ensure these were also responded to. Whilst action was now being taken to investigate all complaints received, the provider had failed to respond to these for a period of five months.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a team leader, who told us that because they had once been a carer at Synergy, they were very familiar with the people using their service and their needs. They also had an understanding of when people's needs changed, and the importance of re-assessing people's needs and establishing whether the care needed changing. For example, the team leader had recently met with one person and their family member and added a shorter call for the person in response to their changing needs. The team leader told us, "We are dealing with people's lives; it is too important to get wrong." This was reflected in what people told us. One person we spoke with praised the flexibility of the service. They told us, " I find (area manager) very accommodating. If I need to change my call times because I need to get to the hospital, the carers come early to help get me sorted."

We considered whether the provider was following the accessible information standard. This standard tells publicly funded organisations how they should make sure people using their services, and their relatives, can access and understand the information they are given. The provider ensured that information was provided to people using their service in a way they could understand. One person's care plan had been translated into their native language so that they could understand their plan, and so their relatives could

also follow it when helping the person with their care needs. There was also the provision for information to be provided to people in a range of different formats, including Braille. The provider demonstrated an understanding of the accessible information standard, and of its importance.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection. However, the registered manager was absent from work, with the overall running of the service currently being overseen by one of the provider's area managers, and an auditor/trainee manager. This was a recent development, and the area manager had only been overseeing the service for a period of two weeks at the time of our inspection.

At our previous inspection, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because their quality assurance systems had not identified the shortfalls in the service, nor how this had affected the quality of care people received. Although improvements had been made since our previous inspection and the issues identified then had been addressed, there had been managerial failings at this branch, which affected the quality of care people received. For example, staff had been given autonomy regarding call times, which had resulted in missed and late calls for people for a period of three months.

At this inspection, we found the area manager had already identified and acted on most of the concerns we raised. For example, they had identified that complaints had not been responded to, and had taken action to remedy this. However, a period of five months had elapsed before the provider had been aware of this. Additionally, the provider was unaware that statutory notifications had not been submitted to the CQC, nor had they identified that their recruitment process had not been consistently followed. Therefore, we could not be satisfied on this inspection that the provider's systems and processes were operated effectively.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection, we looked at the statutory notifications we had received from the provider. Statutory notifications include notifications of safeguarding concerns, and serious injuries or accidents. The provider is required to notify the Care Quality Commission of these as part of their registration requirements so that we can monitor the service and be aware of any risks to people who use it. We contacted the local authority about safeguarding concerns they had been notified of, and these were greater than the notifications we had received.

During our inspection, we looked at the provider's safeguarding and incident file, and found there were 13 notifications in total we should have received over a six month period, but had not. The provider told us these had been missed by the registered manager, and that they would ensure we now received all the statutory notifications we should. We asked the provider to ensure we were notified of five particular recent safeguarding concerns, so that we had a record of these. The provider subsequently submitted these to us after our inspection. Whilst the provider had informed the local authority of safeguarding concerns and had investigated these internally, they had failed to ensure they had also notified the CQC, as they were required to do.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The area manager was able to demonstrate to us the action taken by the provider since the previous inspection to remedy the previously identified breaches of Regulation. The area manager also had compiled an action plan in regard to current concerns and shortfalls in the service, and how to address these. The concerns identified by the area manager largely reflected the concerns we identified at this inspection, and action had already been taken in regard to outstanding complaints; call times; missed and late calls; and medication audits. The area manager told us, " We know what the issues are, we have a plan and we are getting it sorted."

Staff we spoke with told us they thought the area manager had already made improvements to the running of the service. One member of staff we spoke with told us, "I am back with my regulars now (people), which they are happy about and so am I. [Area manager] is very good; they get on top of things." Another member of staff told us, "I feel incredibly supported by [area manager]. They met with us all and spoke about what needs sorting, from our point of view. Now they are acting on what we have said."

We spoke with a team leader about the ways in which they monitored staff's ongoing competence in their roles. This included spot-checks of carers to observe their practice and provide feedback. In addition, people were asked at their care reviews if they were satisfied with the approach and attitude of their carers. Where dissatisfaction was expressed, we saw this had been acted on.

The provider told us about the importance of meeting people's needs in regard to equality, diversity and human rights, as well as the needs of staff. The provider supported people with a range of disabilities, as well as other protected characteristics under the Equality Act 2010. We spoke with the provider about one of these protected characteristics, and made them aware of relevant legislation they should consider when supporting people to whom the characteristic applied to. The provider and staff told us how they supported staff who had disabilities. This included moving one member of staff to an office-based role after they had encountered practical difficulties in a care role. The office-based role was more suited to the member of staff, and they were enjoying this.

The area manager told us that all staff had been reminded of the whistle-blowing policy and process. This was in response to the fact that staff were aware that some aspects of the service needed improving, but had not escalated this to the provider. Staff we spoke with told us that should they have such concerns in the future, they would alert senior management to this.

The provider had clearly and visibly displayed their current CQC rating on both their website and at the office, as they were required to do.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Although incidents of suspected harm or abuse had been investigated internally and reported to the local authority, there were 13 safeguarding concerns which the registered provider had not notified the CQC of, which they were required to do so.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Whilst there was a system in place for capturing complaints, the registered provider had not responded to complaints and concerns for a period of five months.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There had been managerial failings at the service, which had been allowed to continue for a period of months before being identified and acted on by the provider. Once the provider identified these shortfalls, immediate action was taken to remedy this.