Senacare Ltd

Senacare Ltd

Inspection report

87 Station Road
North Harrow
Harrow
HA2 7SW

Tel: 02085720417
Website: www.senacare.co.uk

Date of inspection visit:
13 August 2018
15 August 2018

Date of publication:
18 September 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 13 and 15 August 2018. We told the provider two working days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

The inspection has been rated inadequate for the last two inspections of 24 April 2017 and 13 December 2017. This is because we found that the service was not safe or well-led. We placed the service into special measures following the inspection of April 2017. The service remained in special measures after the inspection of December 2017.

At this inspection of 13 and 15 August 2018, we found that improvements had been made in many of the areas where we had concerns. However, we identified risks which had not been appropriately monitored or managed and this meant that some aspects of the service were still not safe or well-led.

The rating for the question, 'Is the service well-led?' remains inadequate. Where the rating of any key question remains inadequate for more than one inspection, the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Senacare Ltd is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. There were 28 people using the service at the time of our inspection, one person did not receive support with personal care. CQC does not regulate this part of the service. Most people using the service were older adults (over 65 years of age), although some younger adults with physical disabilities received a service. Everyone using the service lived within the London Borough of Harrow and most had their service commissioned by the local authority.

There was a registered manager in post. The deputy manager at the service had applied to be a second 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 and associated Regulations about how the service is run.

There were a small number of occasions when care workers had not carried out care visits as planned. Whilst the provider had responded to these by speaking with the staff concerned, they had not taken action to make sure such instances did not happen again. For example, the electronic call monitoring system had not identified when the most recent incident took place and neither would it do so if the same mistake happened in the future because it did not guard against human error. In addition, the provider's own records of staff compliance with the electronic call monitoring system showed that some staff regularly did not log into visits. No action had been taken in respect of this, meaning that managers did not have a fail-safe way of monitoring whether visits took place or not.

We discussed this with the registered and deputy managers who confirmed that they had not thought about how the system could be improved until we raised the subject. Following our inspection visit they decided to meet with the company who supplied the system to ask if they could make improvements to this.

Medicines were not always managed safely. We found records that one person was receiving support with their medicines, despite the fact the care plan and risk assessment for this person stated that they should not receive support from the agency in this respect. There were no medicines administration records for this person and therefore no checks to make sure they were receiving medicines as prescribed. The managers had not identified that this was taking place even though the staff had recorded this in the logs of their care visits.

In addition, we found errors on the medicine administration records for other people. In one instance, the twice daily dose of one medicine had only been administered once each day for a whole month. The managers had not identified this error.

The provider carried out spot checks, unannounced visits to monitor care workers. We identified that records of these for three of the days we looked at showed that different visits had taken place by the same senior member of staff at the same time. The records of these checks were therefore inaccurate. The registered manager and deputy manager had not identified this and therefore not investigated why the records were inconsistent. Following our inspection, they spoke with the senior member of staff concerned about the expectations for carrying out and recording these spot checks.

Some information about people using the service was inconsistently recorded. For example, one person's preferred name, the date of birth for another person and a third person's religion. In these examples, different records contained different information. This meant that it was not always clear whether records were accurate. Following our inspection visit, the provider addressed the examples we had identified.

Other records included inconsistencies which meant that people may not receive appropriate care. For example, discrepancies in the information relating to one person's capacity to self-administer their medicines. In another person's care records a form detailing how they would express pain had not been completed and there was no other information about this except to say that they could not verbally communicate their needs.

Some people's needs had changed but their care plans had not been updated to reflect this. We discussed some of the examples we saw with the provider and they made the changes to care plans and risk assessments after our inspection visit.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of safe care and treatment and good governance.

You can see what action we told the provider to take at the back of the full version of the report.

The London Borough of Harrow, who had visited the service in May 2018, found that improvements had been made and that the service was meeting most of the standards they expected. We also found that improvements had been made. At the last inspection we issued two warning notices and made five requirements. Four of the requirements had been met with improvements to the way in which staff were employed, the training and support of staff, gaining consent from people using the service and safeguarding people from abuse.

People using the service, their representatives and the staff we spoke with were all positive about the agency and the care they received. People told us they felt they were being safely cared for. They liked the care workers who visited them. They told us that care workers met their needs in a personalised way and offered them choices.

There were examples where care workers had given extra time and shown compassion and commitment to their work. For example, one care worker had stayed after their assigned visit ended to be with a person who was very unwell so the person would not be alone before their family could be with them. The person passed away whilst the care worker was with them. The registered manager told us how much this had meant to the person's family.

People had consented to their care and treatment. They had been involved in planning their own care and took part in regular reviews.

When people made complaints, the provider had responded to these. They had investigated them and learnt from these to improve the service for the individual. The provider also had safeguarding procedures and we saw that these had been followed when staff had identified a concern.

Care plans and risk assessments generally gave information for the staff about how people's needs should be met, including personalised details. They had been regularly reviewed.

The staff were provided with uniforms, protective equipment (such as gloves) and identity cards. The people using the service confirmed that they used these.

There were appropriate systems for recruiting staff and checking they were suitable to work with people using the service. There were enough staff to care for people. Care visits took place on time and staff reported they had enough time to travel between visits.

The staff told us they were well supported. They liked the registered manager and deputy manager and felt they could approach them to discuss any concerns. They had opportunities for training, supervision and promotion. They told us they could contact managers whenever they needed. We witnessed the registered manager complimenting one care worker for an important piece of work they had undertaken.

The provider had improved the systems for managing the service, including hiring a consultant to help them make the improvements, updating care plans and record keeping systems, improving monitoring and quality audits and moving the location of the office so that it was closer to where people using the service lived. This meant the care workers could visit the office and meet with managers more easily.

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

Some aspects of the service were not safe.

The provider did not ensure that people received their medicines in a safe way.

The provider had not always identified risks and did not take enough action to mitigate risks when things went wrong.

They had made improvements to the way in which staff were recruited and there were sufficient numbers of staff employed to meet people's needs.

The provider had improved their practices around safeguarding people from abuse and had followed their procedures when they had identified someone was at risk.

People were protected by the prevention and control of infection

Is the service effective?

Good

The service was effective.

People's needs and choices were assessed in line with current legislation and best practice guidance.

People were cared for by staff who had the training, supervision and support they needed.

The provider was working within the principles of the Mental Capacity Act, ensuring that people consented to their care or that decisions were made in their best interests, when they lacked the mental capacity to make decisions for themselves.

People were supported to access healthcare services when needed.

People had enough to eat and drink to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion. They had good relationships with the staff who cared for them.

People were given choices, able to express their views and were involved in planning their care.

People's privacy, dignity and independence were respected.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The provider had not always recorded when people's needs had changed so information within their care plans and risk assessments was not always up to date.

However, when speaking with people using the service, care workers and managers there was evidence that the provider had responded to changes in people's needs. In particular, they had liaised with other professionals to make sure people had the services they needed.

People were able to make a complaint and these were investigated. However, the provider had not always recorded the action taken when people raised a concern which was not a formal complaint.

People were cared for in a way which reflected their needs and preferences.

People being cared for at the end of their lives received the support they needed.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's systems for identifying and mitigating risks were not always effective.

The provider's systems for improving the quality of the service were not always effective.

The provider has breached two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and been in special measures since April 2017.

The provider had made improvements to the service and the registered manager was receptive to our feedback, making

further improvements after the inspection visit. However, the seriousness of risks we identified and their failure to identify these themselves or act to mitigate these before our visit showed a lack of governance.

Senacare Ltd

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 15 August 2018. We told the provider two working days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people. The second day of the inspection was so that we could take photocopies of evidence we looked at. We told the provider that we would be doing this.

This was a comprehensive inspection. The first day of the visit was conducted by an inspector and an assistant inspector. The second day of the visit was conducted by two inspectors. As part of the inspection we contacted people who used the service, their representatives and staff to ask for feedback about their experiences. Telephone calls to these people were made by 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 care service.

Before the inspection visit we looked at all the information we held about the service. This included the last inspection report and the provider's action plan which told us how they planned to make improvements, notifications from the provider and contact from members of the public. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

We spoke with representatives of the London Borough of Harrow, who commissioned care from the service; and looked at the report of their most recent audit of the service which took place in May 2018. We looked to see if any information was recorded about the service on pubic websites, such as home care review websites, as well as the provider's own website.

During the inspection we spoke with three people who used the service, the representatives of three other people and six care workers by telephone. At the inspection visit we met the registered manager, deputy

manager, field care supervisor and one care worker.

We looked at the care plans and logs of care visits for five people who used the service and parts of the care records for one other person. We examined the medicines administration records for seven people. Three people whose medicines records we looked at had stopped using the service in either July or August 2018, so we looked how the provider monitored whether they were receiving medicines as planned for the time they were using the service. We looked at the recruitment, training and support records for four care workers and parts of the information kept about staff for one other care worker. Other records we viewed included records of complaints, compliments, safeguarding alerts, quality monitoring and the provider's own audits of the service.

At the end of the first day of the inspection we gave feedback about our findings to the registered manager, deputy manager and the owner of the company managing the service, who was also the nominated individual. At the end of the second day of our inspection visit the registered manager updated us on action they had taken following our initial feedback.

Requires Improvement

Is the service safe?

Our findings

At the inspection of 13 December 2017, we found the provider had a policy in place in relation to the administration of medicines but care workers were not provided with appropriate information to enable them to administer the medicines as prescribed.

At the inspection of 13 and 15 August 2018, we found that staff received training and information about medicines administration. We also found there had been improvements with some records relating to medicines. However, the provider did not always ensure that medicines were managed safely and this placed people at risk of harm.

It was not clear whether people always received their medicines as prescribed. Medicines administration records (MAR) were designed to show whether medicines had been administered as prescribed and included a coding system which staff should use in event of non- administration. The medicines administration for one person included the twice daily administration of eye drops. The MAR for June 2018 had only been signed by staff for the administration of these eye drops every morning and there was no record to show whether these had been administered in the afternoon for the whole month. The June 2018 MAR for another person included 11 times when medicines had been signed for as given, and then crossed out, at a time of the day when these were not prescribed to be administered. There were also two gaps where there was no signature (or symbol to denote the reason for non-administration) for medicines which should have been administered. The staff had crossed out or changed the administration details for 18 occasions on the same person's MAR in April 2018 and there was one gap where no administration was recorded for this month. The April 2018 MAR for third person included four signatures which had been crossed out or changed.

There were audits of most of the MAR in place completed by one of the managers. These had not identified any gaps or errors and therefore no action had been taken to make sure people had received their medicines as prescribed or to mitigate the risk of reoccurrence by addressing the issues with the staff concerned.

The staff had not always recorded the reasons why they had not administered medicines. For example, one person's MAR for August 2018 included seven occasions when the symbol ''O'' had been used. The MAR instructions were that the symbol ''O'' meant non-administration and that the reason for this should be recorded. The reason had not been recorded for these occasions.

Some medicines were being administered without proper assessment or agreement as part of a care plan. During the inspection we identified that that one person was being administered medicines although this had not been planned for and the administration had not been correctly recorded. The care workers had recorded that they had given the person their medicines within the logs of their visits. There were no medicines administration records for this person. We looked at the whole care plan, risk assessments and other records for this person and these stated that the agency should not administer medicines as this task was completed by the person's family.

Information about people's medicines and how these should be administered was not always clearly recorded. For example, the MAR for six people did not specify the actual medicines prescribed to people. All six people's MAR referred to ''Blister pack'' as the pharmacist had supplied the medicines within a pre packaged container where all the tablets in a single dose were stored together. Whilst this practice helped staff to identify which tablets should be given at each time, there was a risk that the staff and person concerned would not always know which tablet was which medicine. The pharmacy information for one person included instructions that one tablet should be swallowed whole and not with or after food, whilst another tablet needed to be chewed. These details were not recorded on the person's MAR or within their care plan. This meant there was a risk that medicines had been administered to this person in a way which was different to the prescription requirements.

At the inspection of 13 December 2017, we found risk assessments were not reviewed following an incident and accident.

At the inspection of 13 and 15 August 2018, we found improvements had been made. The staff had recorded accidents and incidents and the action they had taken in respect of these. The records had been reviewed by a manager. We also saw that the provider had responded when care staff had identified a change in a person's needs.

However, the provider had not always acted to mitigate risks which they or others had identified. For example, the provider's records showed that there had been two missed visits which had taken place since the last inspection. The most recent missed visit was in August 2018. In this instance, a care worker had misread their rota and visited the wrong person. The electronic call monitoring system did not pick up on this because it allowed the care worker to record they had undertaken a visit but there was no process for ensuring the right person was visited. The person who was visited by mistake contacted the agency office but the error was still not picked up. The missed visit took place on a Friday morning but managers told us they were not aware of this until the following Monday and only because the person's relative, who they lived with, reported the missed visit. Fortunately, the person was with their relative and came to no harm. However, this could have been a serious risk to someone who was alone or required time specific care. Most worrying, was that the managers having been made aware of the incident took no further action to mitigate the risk of this happening again. The provider's records showed that they had recorded the missed visit, with the only additional notes as, ''Care staff got service user's details mixed up and went to the wrong service user. Apologised.'' There was also a signed statement from the care worker. However, a planned supervision meeting with the member of staff which took place six days after the incident made no mention of the incident.

The provider's electronic call monitoring system required the care workers to use an application on their mobile phones to view rotas (telling them which people they would be caring for) and to log into these visits to show when they had arrived and finished. However, the provider's own records of staff compliance with this system showed that there were inconsistencies and that some staff did not log in or out of visits.

The provider had printed out records which showed staff compliance with the system from 25 June to 29 July 2018. The provider had recorded that they had investigated four different instances when the care workers had consistently failed to log into calls between 2 and 15 July 2018. However, there was no record to show that they had investigated other care workers who had consistently failed to use the system. For example, one care worker failed to log in for 107 out of 149 of their visits from 9 to 29 July 2018. This care worker had been known to have missed a visit to a person in March 2018. Their statement following this recorded that they had forgotten to check their rota. Another care worker had not logged in to 27 of 75 planned visits, one for 83 of 288 visits and one for 80 of 245 visits. There was no evidence that these had

been investigated or action had been taken in respect of these or other failures of the staff to log in. Therefore, the provider had not taken action to mitigate the risks associated with this, which could mean the visits had not taken place.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the feedback to the registered and deputy managers after the first day of the visit, they made improvements to the way in which medicines were managed. For example, they created records to accompany the MAR which detailed the specific tablets contained within these. They also spoke with the family of the person who was receiving medicines when this was not part of the care plan so that this need could be assessed and planned for. They improved the format of MAR to make sure staff could record any reasons of non-administration on the back of the record and they had arranged a training session for all care workers about how medicines should be managed and recorded for 27 August 2018.

On 15 August 2018, the registered manager told us they had arranged a meeting with the company who supplied the electronic call monitoring system so they could discuss how this could be improved to lessen the risks of missed or late visits not being identified.

At the inspection of 13 December 2017, we found people were supported by care workers with their shopping but a financial transaction recording system was not in place.

At the inspection of 13 and 15 August 2018, we found that improvements had been made. Two people using the service were supported by care workers who shopped for them. The transactions were clearly recorded, the care worker and member of staff had signed these to show the transactions had been completed, there were receipts of purchases and the transaction records were regularly returned to the office and checked by a manager.

At the inspection of 13 December 2017, we found the provider did not always follow their own recruitment procedure to ensure that staff they employed were suitable for their role.

At the inspection of 13 and 15 August 2018, we found that improvements had been made. The provider undertook checks which included an initial telephone screening of potential staff, a formal interview with one of the managers, a written English and numeracy test and checks on their identity, eligibility to work in the United Kingdom, references from previous employers and checks regarding any criminal records from the Disclosure and Barring Service (DBS). The staff were required to record a full employment history. We saw evidence of all of this in the staff files we viewed.

The registered manager described how they assessed any risks associated with information they received as part of staff recruitment. We saw evidence of this in the file for one member of staff.

The staff we spoke with explained that they had been invited for a formal interview with the registered manager and that the provider had sought references and checks on their suitability before they started working at the service. Some of their comments included, ''I had an interview and they took references and I couldn't start without my DBS'', ''I found out about the job on the internet and completed an online application, then they invited me for an interview'' and ''They took references and once they had received these I had an induction and training before I started work.''

We asked people using the service and their relatives if they felt safe with care workers from the agency. One

person told us, ''It depends on the carer, but on the whole yes. The majority are brilliant but some are only there to earn money.'' They did not explain their concerns further and the other people we spoke with told us they felt safe and did not have any concerns about the reliability or trustworthiness of care workers.

The provider had assessed the risks to people's individual safety and wellbeing in relation to their mental and physical health and the use of certain equipment. We saw that assessments included guidance for staff about how to support people safely and they had been regularly reviewed.

There were enough staff employed to keep people safe and meet their needs. The staff explained they were allocated enough time to travel between visits and also that they had enough time to carry out each visit. The provider had a contingency plan which included a procedure for dealing with adverse weather or travel disruption. They had implemented this earlier in 2018 when snow had impacted on care workers ability to travel. The registered manager told us that they and the nominated individual had helped by driving care workers to their place of work. One relative had sent a compliment to the provider which stated, ''I was very happy with the service over the snowy weather period.''

People using the service and their relatives told us the care workers usually arrived on time and stayed for the agreed length of time. They also told us they usually had the same familiar care workers and they liked this. They explained that new care workers were introduced to them. They also told us that the agency usually told them if care workers were running late or there was a change of care worker.

The logs of care visits which we viewed indicated that the majority of visits took place at the same time each day. Some logs indicated that some visits did not last for the full duration allocated for that visit, however, the provider's printed out records from the electronic call monitoring system for July 2018 showed that where this had been used care workers usually stayed the full duration of visits or longer.

The provider had procedures for safeguarding adults and whistle blowing. The staff told us they understood this and we saw that they had up to date training in these areas, as well as discussion about safeguarding taking place at team meetings. The staff were able to tell us what they would do if they suspected someone was being abused. The provider had a record which showed that the care workers for one person had taken appropriate action and reported potential abuse when they had a concern about the person's safety. The care workers, and then the managers, had followed local authority procedures and made sure the person was safe. They were working with the local authority to investigate what had happened and to put in place a plan for the person's future safety.

People were protected from the spread of infections because the staff followed good hand hygiene practices and wore protective clothing, such as gloves and aprons. People using the service confirmed this and the staff told us they were given enough supplies of protective clothing. All staff wore uniforms. This and infection control procedures were checked as part of care worker inductions and spot checks of them carrying out care visits. They received training regarding infection control as part of their induction.

Good

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. 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. We checked whether the service was working within the principles of the MCA.

At the inspection of 13 December 2017, we found the provider was not always working within the principles of the Mental Capacity Act 2005 to ensure people were given the opportunity to consent to their care or that decisions were made in their best interest.

At the inspection of 13 and 15 August 2018, we found that improvements had been made. The provider had undertaken assessments of people's mental capacity. Where people had the mental capacity to make decisions about their care they had signed agreements to their care plans and been involved in the development of these. For people who lacked mental capacity, there was evidence that their representatives had been involved in planning and reviewing their care. There was information where representatives had the legal authority to make decisions.

The staff told us they had received training regarding the MCA. They were able to tell us some of the principles of the Act although some staff said they would like more information and training in this area.

At the inspection of 13 December 2017, we found care workers completed the Care Certificate but their understanding of the training and their competency was not assessed. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

At the inspection of 13 and 15 August 2018, we found improvements had been made. The staff training included competency assessments to show how they had learnt from the training and any areas where they needed further guidance.

The staff told us they received the training they needed. They told us they had training when they first started and shadowed experienced members of staff. One member of staff told us, ''The induction programme was with the manager and it covered everything from safeguarding to communication. It was useful and helped me.'' Another member of staff told us, ''I had an induction and some training, I learnt about manual handling and then I shadowed another member of staff – it seemed very thorough.'' The staff also told us they had training updates. They explained that these included competency assessments and real-life scenarios which helped them to learn.

The staff also told us they had individual meetings and appraisals of their work with their line manager. They said that they usually had the information they needed to carry out their roles. They said they had read the policies and procedures and if they had any questions they could ask senior staff. One member of staff told us they would like to have more information about people they cared for sometimes as they felt the care plan did not always describe the person's medical conditions.

The staff felt supported by the managers and the agency. They said that they could speak with a manager whenever they needed. One member of staff told us, ''they always pick up the phone if we ring.'' Another member of staff said, ''I can come into the office at any time and they are pens down ready to help me.''

The provider organised monthly team meetings which took place over two different days each month so that care workers who could not attend the first meeting could come to the second one. The meetings included general discussions and updates as well as training sessions. For example, the team meeting in July 2018 included a training session about diabetes, end of life care and the MCA. Earlier in the year the meeting had included an update regarding safeguarding training. The care workers told us they found these meetings useful.

The management team also had regular meetings, aiming for a meeting each week. They discussed changes to the service, updates and the needs of individual people and staff. Both the registered and deputy manager demonstrated a good knowledge of people using the service and their care needs.

One of the managers met with people before they started using the service to assess their needs and preferences. The registered manager described the process for this which included an initial telephone consultation, followed by a visit and then another visit after the service started to make sure people were happy with this. We saw that assessments of people's needs had been made and records of these were kept within their files. In some cases, sections of the assessments had not been completed. However, the care plans which had been created following the assessment contained more details. People had signed their assessments and care plans to show their agreement with these. People using the service and their relatives told us that they had been involved in the assessment process so that their needs and choices were known to the agency.

Care plans included information about people's healthcare needs, any conditions they had and any required interventions from the care workers. There was information about people's doctors and other healthcare professionals.

There was evidence that the care workers had acted when people became unwell or following an accident. They had completed accident records which showed when GPs or emergency services were contacted. The provider's own records included a compliment from a relative about how well the care workers had responded to an emergency and given information to paramedics who had attended.

We also saw records of communication between the provider and other professionals to request specific interventions and support when the care workers had identified a need. For example, changes in people's mobility.

People who needed support at mealtimes told us they were happy with the support they received from the care workers. They said that they were offered choices, and that the care workers supported them to make sure they had everything they needed.

Care plans included information about people's dietary needs and any special requirements, including the

support they needed from the service. Risk assessments and care plans reminded the care workers to ensure people had access to drinks when they left them at the end of a visit.

Good

Is the service caring?

Our findings

At the inspection of 13 December 2017, we found some care workers did not always use wording in documents that referred to people in a respectful way.

At the inspection of 13 and 15 August 2018, we found that improvements had been made. However, we noted that there was some confusion about the preferred name for one person as this had been recorded differently on different documents. In some logs the care workers had recorded the name of the person as their surname only. The registered manager spoke with the person's family to confirm their preferred name. They updated care documents and spoke with the staff who cared for this person to make sure they used only the person's full name or preferred name when recording care visits in the log books.

People using the service and their relatives told us the care workers were kind, compassionate and caring. They said they had good relationships with the care workers. Some of their comments included, ''[Care worker] has exceeded our expectations, she is very good with [person]'', ''They are very careful and considerate'', ''The lady we have is perfect – she is brilliant with [person using the service]'', ''[Care worker] is fantastic'', ''They are very caring'' and ''[Person] has high expectations but the carer is fantastic and has a rapport with [person], they stick to the same routine which [person] likes and we find them very caring.''

The provider's own records of feedback from people using the service and their representatives also showed that the majority of people found the staff kind and caring. Some comments they had received included, ''The carers are brilliant'', ''They are very kind and patient with [my relative]'', ''Absolutely first class'' and ''The carers make every effort to understand [person's] needs.''

The registered manager described some of the care which had taken place which went beyond the expectations of care workers. For example, one person was very unwell and nearing the end of their life. The person had expressed a wish to stay at home. When their regular care worker visited them one day they thought that the end was very near. The person's family were not with them so the care worker decided to stay with the person after the allotted time for the care visit had passed. They stayed with the person until they passed away. The registered manager explained that the family of this person had expressed their gratitude for this act of kindness.

When the staff spoke about the people who they cared for they demonstrated a genuine fondness for them and the role they played in caring for people.

People using the service and their relatives told us the care workers respected their privacy and dignity. Their comments included, ''They are very respectful and careful when moving [person]'', ''I am very lucky with the way they treat me and maintain my privacy'' and ''They close doors and give me a bit of private time if I need it.'' The staff told us they did their best to provide care which respected people's privacy and dignity. One care worker told us how they covered people with a towel when washing them. Others told us that they closed curtains and doors to maintain privacy. The care workers explained they offered people's choices and respected these, they told us they tried to make sure people were comfortable and had

everything they needed from the care worker.

People also told us the care workers respected their choices and that they were involved in choosing how they wished to be cared for. They said that they were asked about their preferences at each visit. They and/or their representatives, had been involved in planning their care. This was evidenced in care plans, which they had signed, and which also contained information about their personal preferences. Also people confirmed this. Some of their comments included, ''I met with social services and the agency'', ''The whole family have been involved and we have a folder in the house'' and ''The process was pretty straight forward, we were able to explain the care we needed.''

People's interests, religious and cultural needs were recorded in their care plans. However, one person's care plan contained conflicting information about their religion. The registered manager told us they would address this when we discussed this with them. People told us that the staff respected their religion, cultural, family traditions and the household rules. One person using the service could not understand English. However, they also lacked capacity and could not verbally communicate their needs. The registered manager told us the person's family lived with them and were present during care visits so they could translate any information and help with communication.

People told us they were supported to maintain their independence where they were able to. Care plans included information about things the person could do for themselves. The provider's feedback from people using the service included a compliment from one person who had explained that, ''I am grateful that the carers encourage me to do more for myself.''

Requires Improvement

Is the service responsive?

Our findings

At the inspection of 13 December 2017, we found care plans identified how people wished their care to be provided but the records had not been reviewed if a change to the person's supports needs had occurred. Other records of care were still focused on care tasks and not the person.

At the inspection of 13 and 15 August 2018, we found improvements had been made to care records. The provider had responded to people's changing needs but they had not always updated records to reflect this.

For example, one person's care plan stated that they stayed in bed all the time. There was evidence that the provider had responded to a request from the person's relative and the observations from the care workers that the person would like to spend some time out of bed. We saw good evidence of communication between the deputy manager and the local authority requesting an assessment for the right equipment and support to meet this need. However, the care plan we viewed showed that no changes had been made. We discussed this with the deputy manager who explained that the person now had the right equipment and spent some time out of bed. However, their care plan and risk assessment had not been updated to reflect this. Following our visit on the 13 August 2018, the deputy manager updated the care plan and risk assessment. They told us that copies of this had been sent to the person's home.

In another instance, communication between the provider and the local authority showed that the care workers had identified changes to one person's health and wellbeing because of an addiction they had. The provider had responded appropriately by requesting additional support for this person, but they had not updated the care plan or risk assessments to reflect the person's current need. We discussed this with the provider who said that as the person was in hospital at the time of the inspection they would update the information when they returned home.

Failure to make sure care plans were an accurate reflection of people's needs meant that people were at risk of receiving care and treatment which was not appropriate.

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

The care records we viewed were clear and included some information about people's preferences and how they liked to be cared for. The plans reflected the assessments from the local authority.

The provider carried out regular reviews. These included managers visiting people to ask them about their care, satisfaction surveys and telephone monitoring. We saw that people using the service and their relatives had the opportunity to contribute to their care planning and took part in these reviews. The majority of feedback from these sources indicated people were happy with the care they received.

People told us that care was provided how they wanted. They were able to express a wish for specific gender

care workers and women were only ever supported with personal care by female care workers. People told us that they usually had the same care workers and they knew their needs.

People using the service and their relatives told us that they knew what to do if they had any concerns. They told us they would speak with the managers and they were confident these concerns would be dealt with. One person told us, ''They listen'' and a relative explained, ''We had an issue which we spoke with them about and it has improved now.''

One person told us they had made a formal complaint about a care worker. They explained the provider took immediate action. Another person told us that they had raised a concern which the provider dealt with by speaking with the care worker concerned.

There was a policy and procedure for dealing with formal complaints and concerns. We saw records to show how these had been responded to. The provider kept a file of compliments. However, we noted that some compliments also contained concerns from people using the service and their relatives. There was no evidence that these had been investigated or responded to. For example, a form entitled compliments and stored within the provider's folder of compliments included a comment from a person, ''I do not want the carers to stand and watch me.'' Another 'compliment' from a relative included the requests for care workers to, ''Try not to flood the shower room'', ''Keys to be left in key safe'' and ''Try not to hurry the client as it makes them nervous.'' Another relative had commented that care workers were often late. Two months later the same relative had written that some care workers did not brush their relative's hair and left it wet. A third relative had raised a concern that care workers did not ''pay attention'' to their relative's face when washing them. Likewise, some of the responses to the provider's satisfaction survey undertaken in January 2018 included some concerns from one respondent about food preparation and the management of the service. There was no action plan in respect of this to say how these concerns would be investigated or addressed.

There was however, evidence in one 'compliment' that the provider had taken action. The person had recorded, ''Since my last discussion about concerns everything is now going well.''

People being cared for at the end of their lives were treated with respect and supported to be comfortable. No one using the service at the time of our inspection was receiving end of life care. However, the registered manager and one care worker told us about some people who they had cared for who had recently died. They explained they had worked closely with the GPs and other healthcare professionals to make sure people had access to the services they needed.

Inadequate

Is the service well-led?

Our findings

At the inspection of 13 December 2017, we found that whilst audits had been introduced, these did not provide appropriate information to identify areas requiring improvement.

At the inspection of 13 August 2018, we found that audits were not always effective at identifying problems and people using the service were at risk.

The provider had undertaken audits of most of the completed medicines administration records (MAR) which had been returned to the office. However, these did not identify errors. The June 2018 MAR for one person included 11 times when medicines had been signed for as given (at times they were not prescribed for) and then crossed out and two gaps where no administration had been recorded at the prescribed dose times. The audit of this MAR on 2 July 2018 stated there were no gaps and no problems identified. The April 2018 MAR for the same person included 18 occasions where the administration signature had been crossed out or changed and one gap where no administration details were recorded. The audit of this MAR on 1 May 2018 recorded that there no problems with the MAR or gaps. The April 2018 MAR for another person included crossed out or changed information. The audit of this record on 1 May 2018 identified no problems.

Some MAR listed only ''blister pack'' rather than all the medicines prescribed for that person. However, audits of these MAR included the question, ''Do the MAR list all the medicines prescribed for the person?'' to which the auditor had answered ''Yes.'' The audits also asked the question, ''Has the person's name, address, date of birth and GP been filled in on each MAR in use?'' All of the audits we viewed stated that these details had been completed. However, the only one of these details which was recorded on all MAR was the name of the person. The audit of the April 2018 MAR for one person who no longer used the service asked, ''Do the entries show any additional information/warnings?'' To which the auditor had answered, ''Yes.'' However, the instructions to swallow one tablet whole and another tablet to be chewed had not been recorded.

Therefore, these audits were not a reliable check on whether medicines had been administered, and whether this administration had been recorded, correctly.

There were not always audits in place for completed MAR. For example, the June 2018 MAR for one person did not record the administration or otherwise for the afternoon dose of a twice daily medicine for the whole month. There was no audit of this so the provider had not identified that the person may not have received this medicine. The provider had not obtained or audited the July 2018 MAR for two of the people using the service. The August 2018 MAR for a person who had died earlier in the month contained seven entries where staff had recorded the symbol ''O'' denoting non-administration but had not recorded the reason for this. The MAR had not been audited and therefore this omission had not been identified. Therefore, they had not ensured that these people had received their medicines as prescribed for this month.

The provider conducted spot checks (unannounced visits to observe care) on care workers. Most of these had been carried out by field care supervisors. Records of these showed some discrepancies which the

managers had not identified. For example, on 3 June 2018 the supervisor had carried out four separate spot checks. The records of these showed that some of the visits had taken place at the same time by the same supervisor in different people's houses. The record of one visit stated it lasted from 9.30am to 10.10am, whilst a second visit was recorded as starting at 10.05am and finishing at 11am and a third visit was recorded from 10.30am – 11.30am. On the 23 May 2018, one visit was recorded as lasting from 8.30am – 11.30am and a second visit recorded as taking place between 9.45am and 10.20am. The records included the questions, ''Did the care worker arrive on time?'', ''Did the care worker stay for the full length of time?'', ''Were the tasks carried out in full according to the care plan?'' and ''Does the care worker logging in care providing time in the timesheet after visit?'' All of these questions were answered positively within the records. These questions could only have been answered if the supervisor had been present for the whole of the visits. Therefore, it was not clear how the supervisor could have attended different visits at the same time.

Following our feedback on the first day of the inspection, the registered manager told us they had asked the supervisor about these examples. They told us the supervisor had reported they had left one visit early to attend another visit. Therefore, the times given to show how long the visits lasted were not accurate and some of the information within the record was inaccurate and these audits could not be relied upon as an effective audit of the care being provided.

The registered and deputy manager completed audits of visit logs. However, they did not check all logs and only checked selected days. When we found errors or problems within logs that had been returned to the office, such as the incorrect dates, referring to a person by their surname only and the recording of medicines to a person who was not supposed to receive this care, these inconsistencies had not been identified by the provider and therefore not addressed. In addition, we found that there was no audit of any logs for five people whose care records we looked at. Two audits did not contain the name of the person whose logs they were auditing and in one case the log record did not contain the name but the registered manager had recorded that no improvements were needed to the log. Therefore, the provider's systems for ensuring care had been delivered in accordance with the care plans was not always effective because they were not checking the logs of visits sufficiently.

Records were not always accurately maintained and the provider's systems did not effectively identify this. For example, an audit of the whole service carried out by the registered manager on 31 July 2018 stated, ''We are currently not involved in the administration of medicines to any service users'' under the section regarding the audits of medicines management. We pointed this out to the registered manager who said that this was an error as they were administering medicines to people. The same document stated that the provider worked in accordance with the Hertfordshire policy on safeguarding. We questioned whether the provider supported any people in Hertfordshire and they explained they did not and the audit should have referred to the London Borough if Harrow instead. The registered manager changed this information and printed out a new copy of the audit during our visit.

Other records included inaccurate information, for example the date of birth for one person was recorded differently in different sections of their care plan, the preferred name of another person was recorded as three different names in parts of their care plan and the religion for a third person was recorded differently on their profile and care plan. The registered manager changed these records during the inspection. However, they had not previously identified the inconsistencies.

Some of the discrepancies within care records meant that people were at risk of receiving care which was not appropriate. For example, one person's care plan, dated March 2018 stated that they were, ''Unable to communicate [their] needs.'' The person's care records included a pain management plan which had been

signed by the registered manager in April 2018. This document was designed to be a useful guide for staff to judge whether the person, who could not communicate their needs, was in pain and how they would express it. However, the document had not been filled in, except for the registered manager's name, signature and the date. There was no other information within the care records which showed how the person expressed pain. Another person's care records included a mental capacity assessment, signed by the deputy manager in February 2018, which stated the person could not manage their own medicines. Their care plan dated March 2018 stated that they could manage their own medicines and the care records also contained a form signed by the person in April 2018 which stated, ''I wish to maintain responsibility for my own medication and self-administer medication prescribed for me.''

The provider had not always acted to make improvements to the quality and safety of the service. For example, the electronic call monitoring system did not identify which person a care worker had visited. Earlier in August 2018, there had been a missed visit because the care worker had signed to say they had visited someone when they had not. The provider had not identified that the system they used to monitor calls needed to be improved to mitigate the risk of this happening again. During the inspection visit we discussed this with the registered and deputy manager. We asked them whether they had thought about making changes to the way calls were logged to minimise the risk of this event reoccurring and the registered manager responded that before talking with us they had not thought about this.

At the last inspection of the service, we issued warning notices against the provider and registered manager for breaches of regulations relating to safe care and treatment and good governance telling them they must make the required improvements by 1 May 2018. At this inspection of 13 and 15 August 2018 we found continuing breaches of these regulations.

The provider was registered to provide personal care in August 2016. The first inspection of the service in April 2017 resulted in an inadequate rating and they were placed in special measures. A further inspection in December 2017 found that there were not enough improvements and the service remained in special measures. At this inspection of August 2018, there were still areas of risk which had not been identified or mitigated. Whilst we note that there have been improvements these were not sufficient.

Therefore, the systems and processes designed to assess, monitor and improve the quality of the service were not always effective.

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

People told us they thought it was a well-run service and they were very happy with this. Their comments included, ''[Deputy manager] is very efficient, they all are actually, they are flexible and rearrange visits if I need them to'', ''I think it is a good service'', ''Every morning they cheer me up and make sure I am comfortable'', ''They are very good and I am very satisfied'', ''We are very happy with the whole service'', ''They are very flexible with us, and have really helped me, my [relative] and our health'' and ''They have weekly meetings and the care worker tells us the outcome of these, they always answer calls and the managers make themselves known to us.''

We asked people using the service, their representatives and staff what could be improved about the service. Everyone we spoke with told us they were happy and could not think of anything they would change.

The staff we spoke with enjoyed working for the agency and felt valued and supported. Some of their

comments included, ''I like to meet different people'', ''I love helping people'', ''I enjoy helping the elderly and all my clients love me and I enjoy what I do'', ''I enjoy the communication with service users'', ''I find it fulfilling when I help people, it brings me joy and is something I love doing'', ''Working for Senacare is the best of both worlds – I have good customers and good managers'', ''I enjoy talking to my clients, I like when I know I have made them happy – they depend on me'', ''The managers are very helpful'', ''We work well as a team'', ''They are very understanding and really do care about the staff'', ''I love my care work- I'd like to think that I'd have the same treatment if I was in that position'', ''Senacare is amazing I love working for this company – it is like my second family, if I need time off I ring them and they cover me'', ''I had a bereavement a short while back and they were very supportive'', ''They have helped me so much as well as the clients'' and ''They are very supportive and have taught me a lot.''

Following our inspection in December 2017, the provider had sourced an external consultant who had supported them to make improvements. These included updating record keeping systems, introducing new audits and reviewing policies and procedures.

The provider had also relocated their office to be closer to where people using the service lived to reduce travel time for managers and for staff wishing to visit the office.

The London Borough of Harrow carried out an assessment of how well the service was meeting their requirements and key performance indicators. They last visited the service in May 2018. The report of their findings showed that they found the service had improved in all areas. In addition, this was confirmed by a representative of the local authority who spoke with us. They also told us the provider had been responsive to any concerns they had addressing these and following their guidance to make improvements.

At the end of the first day of our inspection on 13 August 2018 we gave feedback to the managers and nominated individual. They took immediate action to address some of the areas of concern we had identified. For example, they had improved the systems for recording medicines administration and had arranged training for the staff regarding this, they had spoken with members of staff about specific areas we had identified, they had reviewed and updated some of the care plans and risk assessments and they had also spoken with the supplier of their electronic call monitoring system to see how improvements to this could be made.

The managers were receptive to our suggestions and showed a commitment to improving the service further. However, the seriousness of risks we identified and their failure to identify these themselves or act to mitigate these before our visit showed a lack of governance. In particular, the failure to manage medicines effectively and missed visits presented a significant risk of harm for people using the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did always provide care and treatment in a safe way for service users because they had not always assessed the risk to health and safety or done all that was reasonably practical to mitigate these risks. The registered provider had not always ensured the safe and proper management of medicines. Regulation 12 (1) and (2)(ab), (b) and (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always operate effective systems and processes to assess, monitor and improve the quality and safety of the service or to assess, monitor and mitigate risks. The registered person did not always maintain accurate, complete and contemporaneous records in respect of each service user. Regulation 17(1) and (2)(a), (b) and (c)