Care Quality Commission

Sevacare (UK) Limited

Sevacare - Tower Hamlets

Inspection report

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Ratings

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

Overall summary

The inspection took place on 11, 13 and 16 November 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The service is registered to provide support to adults living in their own homes with personal care. At the time of our inspection 428 people were using the service. The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was meeting the regulations in all areas we looked at at the last inspection on 3 April 2013.

The provider had recently moved its Haringey branch into the Tower Hamlets location whilst waiting to register alternative premises after the closure of the Haringey office. At the time of inspection, the Tower Hamlets and Haringey branches were operating as two separate branches within the same location. As the services were provided by the same registered provider within one location, the inspection to both branches has been

Summary of findings

combined in this report and judgement ratings are given overall. The branches are distinguished only where we found differences in practice or breaches affecting one branch and not the other.

People who used the service in the Haringey area did not receive care that was appropriate or met their needs as there were occasions where only one staff member turned up when two were required and where single-staff visits were missed completely. This was not the case with Tower Hamlets.

All the people who used the service had support plans showing how the service would meet their assessed needs, with elements of personalisation in them. However, the majority of care plans we looked at did not consistently record all people's assessed needs and how these would be met. There was a disparity between actions identified in care plans and actions completed by staff in care delivery records, which did not always link up. In addition, whilst risks assessments were completed prior to people receiving their service, these risks were not always clear or specific, or addressed as part of an overall plan of care.

The provider could not demonstrate safe practice and management of medicines. Records were not robust enough to show that people received their medicines when they needed. The support people needed with medicines was consistently and accurately recorded and care plans did not always match the care delivery records.

People who used the service and their relatives said they felt safe. Safeguarding procedures were in place to ensure people were safe from abuse and staff knew how to identify abuse and keep people safe.

Staff had limited knowledge of the Mental Capacity Act 2005 (MCA) and its principles. The provider assumed people's lack of capacity to make specific decisions, without testing it first and recording the process. This was not in keeping with the legal requirements of the MCA.

People who used the service were mostly positive about the knowledge and skills of staff who supported them. Staff said the training they received was good and sufficient to assist them in their role. The majority of people and their relatives had confidence in the staff and gave positive comments. There was consistency in staffing as staff had worked with the same people over a long time. This helped staff to know people's needs and preferences, and develop trusting relationships with them. However, people told us the standards of care they were used to were not always as good with replacement staff.

Recruitment checks had been carried out to ensure only suitable staff were employed to work with people.

People were supported to access hospital and community healthcare services to maintain good health and received support, where needed, with their nutritional needs.

People and their relatives told us that most of the staff were gentle and kind and treated them with dignity and respect. Records showed evidence of the caring approach within the service.

The majority of people told us they were happy with their care and the staff who delivered it, praising individual care staff. They said they received care in a way that was personalised to them. Records showed that people received care flexibly, adapted to their changing needs and circumstances. Staff understood the importance of flexible and responsive care. The provider had an appropriate complaints procedure and people knew how to complain.

People's diverse needs were considered when planning their care, taking into account their language and cultural needs when allocating staff to work with them. The service provision people received was regularly reviewed to ensure it met their ongoing needs.

The management of the service had not addressed shortfalls we identified during the previous inspection of the Haringey branch, including missed visits and unsafe medicines management. As such the provider had not effectively operated systems and processes so as to mitigate the risks relating to the health, safety and welfare of people using the service.

The majority of staff in both areas gave positive feedback about the management and support they received. Staff told us there was an emphasis on support, fairness and transparency and an open culture and concerns being dealt quickly with by managers. There was good communication with local authorities about the needs of people who used the service. Managers dealt with professional issues in meetings with staff, including the

Summary of findings

importance of adhering to company policies and procedures. areas and the local authorities about the needs of people who used the service. Managers dealt with professional issues in meetings with staff, including the importance of adhering to company policies and procedures.

We found a number of breaches of regulations in relation to risk management, person centred care, consent and good governance. You can see what action we have asked the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People who used the service did not always receive care that was appropriate or met their needs, as on occasions only one staff turned up instead of two as required, and there were occasions when visits were missed completely.

Whilst risks to the health and safety of people were assessed the risks identified were not always clear or specific. Actions to address the risks were not always included as part of an overall plan of care.

The provider could not demonstrate safe practice and management of medicines because medicine administration records were not always accurate and care plan actions did not consistently match support provided with medicines.

Safeguarding issues were well handled.

Is the service effective?

Requires improvement

The service was not consistently effective. The provider did not act within the principles of the Mental Capacity Act 2005 when seeking consent from people to provide care. Best interest processes were not followed where people lacked capacity to make specific decisions.

Staff were knowledgeable about people's needs and how to meet them and received training and support to assist them in their roles. However, we were not assured that appraisal processes were being productively used to support staff to provide appropriate care for people.

People received sufficient support with food and drink, and appropriate support to maintain good health, including through referrals to community healthcare professionals.

Is the service caring?

Good

The service was caring. People who used the service said that staff were kind and compassionate and they were treated with dignity and respect. People praised individual staff who provided them with care.

People received a consistent set of care workers with whom they developed positive, caring relationships. Care was tailored to match people's needs and preferences in relation to the language they spoke and cultural needs.

Is the service responsive?

Requires improvement

The service was not consistently responsive. Whilst people each had support plans, there was sometimes a blanket approach taken to the way their needs were recorded in care plans. Care plans did not always clearly and consistently include all assessed needs and how these would be met.

Summary of findings

People received care flexibly, adapted to their changing needs and circumstances.

People were aware of how to complain if they needed and the provider investigated and responded to any complaints raised according to their procedure.

Is the service well-led?

Requires improvement 

The service was not consistently well-led. Whilst systems were in place to check that procedures were followed, these were not always timely or robust enough to check and improve the quality and effectiveness of the service.

Previous breaches of regulations arising from the Haringey service were not duly addressed so as to mitigate the risks relating to the health, safety and welfare of people using the service. However there was a positive approach demonstrated from the new senior management to address the concerns going forward, for which there were already improvement plans and positive changes taking place.

Sevacare - Tower Hamlets

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 gave the provider 48 hours' notice that we were undertaking this inspection. This was because the location provides a domiciliary care service and we needed to be sure that someone would be in.

This announced inspection took place on the 11, 13 and 16 November 2015. The inspection team consisted of six inspectors, a pharmacist manager, and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. They telephoned 24 people who used the service to ask about their experience of the care services provided.

Before the inspection we looked at the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to CQC within the past 12 months.

The provider had recently moved its Haringey branch into the Tower Hamlets location whilst waiting to register alternative premises after the closure of the Haringey office. The Haringey and Tower Hamlets branches were led by two separate managers. The registered manager referred to in this report is the manager for this registered Tower Hamlets location. As part of the inspection process, we spoke with both the Tower Hamlets registered manager and the branch manager for the Haringey service (referred to within this report as 'the manager').

In total across both branches we spoke with 24 people who used the service, eight relatives and 14 care staff. We also looked at 28 people's care records, 14 staff files, 24 people's medicine administration records, 11 electronic care delivery monitoring records, call visit audit sheets, complaints, compliments and satisfaction surveys. We spoke with office staff in both areas and the south locality director covering both areas including care coordinators.

On 11 November 2015, the Haringey area listed 226 active people who used the service and 130 active staff (including office staff). The Tower Hamlets area listed 202 people actively using the service and 99 active staff.

Inadequate

Is the service safe?

Our findings

In the Tower Hamlets service, the majority of people said staff always arrived on time or occasionally were only a little late. They also said staff stayed for the allowed time and that they or office staff would inform them if they were running late and find replacement staff where necessary. Feedback from people in the provider's telephone surveys and monitoring visits confirmed this. Staff used a telephone and electronic monitoring service and signed timesheets enabling office staff to closely monitor their time-keeping. These systems worked well to ensure people received calls at the times they needed to help prevent any risks to their safety as a result of late or missed calls.

Sevacare operated a zero tolerance approach to missed visits in their 'missed calls to service users' policy. We did not receive any direct feedback about missed visits. The oversight of the electronic visit records used for staff to phone in and out of 19 people's homes had also not identified any missed visits. However, we found 24 instances of missed visits in recent Haringey visit records we reviewed, according to the provider's policy definition of not being visited in accordance with the person's care plan. People did not receive care that was appropriate or met their needs on those occasions.

In the Haringey branch, four people's recent records showed that there had been 20 visits where only one staff member turned up instead of the two required or where the two staff did not attend together. This included where two staff were required to attend to one person for reasons of safety. Recent electronic visit records identified 10 scheduled visits when the second staff member did not attend or visited after the first staff member had left. By having only one not two staff members attend, this person, and others who experienced missed visits, did not receive care that was appropriate or met their needs on these occasions. We also found four visits that were missed completely amongst two other people who needed one staff member to attend. They both needed support to take their medicines when visits were missed, which meant they did not receive the care they needed.

The above evidence demonstrates a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people who used the service were assessed and planned against close to the start of them receiving a service. These included risks related to people's environment, cognitive ability, physical or mental health, ability to manage personal and domestic care, medicines, finances, and moving and handling people.

In the Haringey service, where one person was noted to be at risk of falling, there was guidance for staff on what could happen and how to mitigate the risk. In addition, a letter had been sent to an occupational therapist for advice on moving and handling the person. These processes helped to protect people who used the service against foreseeable risks to their health and welfare.

In the Tower Hamlets service, whilst risks were assessed in a wide range of areas, these were not always clear in some files we looked at. For one person, a risk was generally stated as being dementia without being specific about what the risks were to the person from this condition. Action identified in the risk assessment was that staff should monitor the person and report to the office if there were any concerns, without further guidance on what to monitor or how best to support the person and reduce their risks. We found that it was not always clear how risks to people as defined in risk assessments linked up with people's support plans.

Where another person received personal care support in a way that varied from day to day, their risk assessment did not clearly show risks associated with the person's ability to manage their personal care, An assessment we saw in one person's file identified the need for staff to monitor a person's skin due to their skin condition. The risks linked with the need to monitor the person's skin was not included in the person's care plan. Six risk assessments in total did not include risks associated with people's dry skin conditions and their need for cream and risks associated with them not having their creams. The documents we saw could not evidence that risks to people were adequately assessed in order that they received a service that was appropriate and safe to meet their needs.

The above evidence demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks to the health and safety of people receiving care and how to minimise them were not always clearly assessed or included in their support plans. The provider could not demonstrate they did all that was reasonably practicable to mitigate against risks.

Inadequate

Is the service safe?

We found that the recording of support with medicines in both services was inconsistent and improvements were needed.

In the Haringey branch, we found poor practice in medicines management with inaccurate or incomplete medicines administration records (MARs) and unexplained omissions in staff signatures. This meant it was not clear if people took their medicines on those occasions. All MARs seen had been hand written although a programme of typing them had begun to make records clearer. Most of the MARs did not match people's care plans and records.

Amongst the 12 Haringey MARs we looked at for October 2015, seven people's medicines were not specifically recorded on the MARs, so it was not clear what medicines staff had supported the person with. Nine MARs showed one or more gaps for medicines administered across the month, meaning it was not clear if these people were supported to take their medicines or not. For one person with five gaps on the MAR, there was one occasion where care records showed a staff visit but failed to show any medicines support for them, despite the person's care plan including prompting for medicines support at all of their daily visits. Additionally, staff recorded the morning medicines as 'client states medicine has already been taken' with no staff signature on 13 occasions across the month. A blank November 2015 MAR had been typed up for this person based on a photocopy of their medicines blister pack. However, it failed to specifically prompt for any lunchtime medicines within the 'time' column despite listing the lunchtime medicines under the 'morning' column. This put the person at risk of staff failing to prompt them for their lunchtime medicines and failing to record the support provided.

The October 2015 MAR for another person clearly stated what medicines they were to be supported with and at what time. However, across the person's three daily visits there were four morning omissions, 19 tea time omissions and four night omissions. It was not therefore clear if the person was supported with their medicines on those occasions or not. However, we established above that the person had not received a tea visit on three out of four consecutive days during this period, which had only come to light after the person raised a concern about the missed visits at a review meeting with a social worker. This demonstrates a failure to ensure the proper and safe management of medicines for this person.

We were told by one staff member that only medicines from a monitored dosette system (MDS) were administered. This is unsafe as not all medicines can be put in an MDS and could lead to people not having their medicines. The Sevacare policy did not stipulate or recommend that MDS must be used except in certain circumstances.

In Tower Hamlets, we found examples where care plans mentioned the need for creams to be applied. However other documents, such as risk assessments, did not include creams as a form of medicine administration, with several stating 'no involvement' with medicines. Where only administration of creams were required (homely remedies included), these were not included in people's care plans.

The main issue with the Tower Hamlets service was the disparity between information recorded in risk assessments and care plans, how these were updated when needs changed and actual practice. This put people at risk of being supported with medicines in an unsafe way. One person's MAR at night was coded as P, prepared to self-administer later. This was not reflected in the care plan, risk assessment or medicines agreement, which identified that staff must administer medicines. Another person's care plan said 'prompt medicines from dossett box', but there was no medicines administration record sheet (MAR) to show this was happening. This was because the person no longer needed prompting with their medicines, according to their care worker whom we spoke with. However the care worker said they did administer cream to the person. We saw this was not in the person's care plan but recorded in their daily care records as being given. Another person's need for cream was stated in their care plan summary but not in their care plan daily tasks or risk assessment, potentially leading to confusion about this care need.

The majority of MARs we looked at in the Tower Hamlets service had been accurately completed to show people received their medicines when they needed, however we found two MAR charts completed in error, for example, in which staff signed prompting with medicines four days running, when medicine was only required every other day. Another similar error had not been picked up in three medicine audit forms, concluding there were no issues with medicines. However gaps and recording errors in other MAR charts we looked at were picked up and action taken in the majority of cases, by following this up with staff.

Inadequate

Is the service safe?

This above evidence demonstrates a failure to ensure the proper and safe management of medicines. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the Tower Hamlets service, all medicines record sheets were typed from the pharmacy list and put into booklets with care record sheets and checked for accuracy. Medicines were audited in a timely way and issues picked up with staff, including provision of extra training. Managers undertook 'care worker assessments' with staff in which they checked staff knowledge of medicines management.

All the people we spoke with and their relatives said they felt safe with staff who currently visited

them. For example, people told us, "I feel safe with my carer who comes around" and "I feel

confident with my carers, they do make me feel safe and looked after." Staff we spoke with thought people were safe from abuse and in the care they received.

Both branches had followed their policies and procedures to report any allegations of abuse or neglect of people who used the service. This included alerting and working closely with the local authority safeguarding teams. Every allegation we looked at, investigation, outcome and action taken to protect people was recorded. Actions taken were appropriate to safeguard people, for example, where staff were involved in allegations, they were suspended pending investigation. Where allegations were upheld, staff were disciplined and their performance and activities closely monitored. Correspondence with a local authority related to an allegation of abuse clarified the care provided for one person, for example, and that senior staff reviewed the person's needs and risks to protect them in response to the alert. Incidents were reported to the Care Quality Commission as legally required.

Staff told us they had been on training about how to safeguard adults from abuse and keep people safe, as we saw confirmed in their files. Staff showed they had good awareness of how to prevent and recognise the different types of abuse; what actions to take if they had concerns; procedures for coping with medical emergencies, fire safety, and dealing with aggression and violence.

Staff files we examined showed interview procedures were thorough and explored issues related to staff skills, abilities and their attitudes towards care. Recruitment checks had been carried out to ensure only suitable staff were employed. Files contained proof of identification, criminal record checks (DBS), references and evidence of a 12 month probationary assessment period.

Requires improvement

Is the service effective?

Our findings

Most of the people we spoke with were unable to remember whether they had given their consent to the service or been asked to sign something or not, however some told us they recalled signing some documents.

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 and found that staff were aware of the importance of individuals having the right to make choices about their care and were prompted to consider people's wishes in key documents such as assessments and care plans. However, people's rights may not have always been protected because the provider had not applied the principles of the MCA when seeking consent to care from people who used the service. The Care Quality Commission is required by law to monitor the operation of the MCA and Deprivation of Liberty Safeguards (DoLS). All the staff we spoke with had limited MCA knowledge and its use in their work, and there was a lack of practice and adequate training in this area. Assessments and care plans identified people's mental health needs but made no reference to mental capacity issues.

We noted that the component in induction for both dementia and the MCA was scheduled to last only 75 minutes. Whilst knowledge of this was tested by the workbook that followed, the training and subsequent support staff received did not adequately enable staff to work within the MCA principles.

People's assessment records were sometimes unclear about whether a person had the capacity to consent to decisions about their care and sign forms about this. There was contradictory information in some files, for example, regarding capacity to consent to managing medicines. Instead there was a reliance on 'next of kin' to sign consent forms when it was not known if the relative had legal powers allowing them to sign such forms.

In the Tower Hamlets service we found documents previously signed by people who used the service when later they were signed by a relative, also known in many of their documents as their best interest representatives. One care plan had been signed by a person's husband, and the reason given was that the person had suffered a stroke. There was no record that the person's capacity to consent to their care, despite their physical inability to sign the form, had been explored. The registered manager said, "We go by whatever information is given by the local authority." A care coordinator also told us they relied on information provided by the local authority and said, "Once we see the person has dementia, we immediately liaise with the next of kin to carry out an assessment." They consulted one person's daughter for any and all decisions about the person's care based on the advice of a referring local authority. This presumed that the person did not have capacity to consent to their care, which did not protect people's rights to be supported to make decisions for themselves wherever possible.

Similarly in the Haringey service, some people had signed forms, but at other times a relative signed without a documented process explaining how the person's capacity to make the decision had been assessed and a best interests process followed. The medicines risk assessment for one person stated to have dementia was signed by the person's son as the person was recorded as being "unable to sign." Where their care plan required the person's consent, this also stated "unable to sign" with no other follow-up and no capacity assessments undertaken. This did not demonstrate that the principles of the MCA had been followed.

We asked to be shown an example of a recent mental capacity assessment carried out by the Haringey service. We were shown a needs and risk assessment for someone identified as having dementia. The person's medicines assessment stated that staff were required to prompt the person to take medicines as the person was said to be unable to sign the medicines agreement. There was no documented capacity assessment of the person's ability to

Is the service effective?

make decisions around their medicines, nor a signature from a known best interests representative about their involvement with the decision. This did not demonstrate that the provider was following the principles of the MCA.

The above evidence demonstrates that the provider's practice was not in keeping with the legal principles and requirements of the MCA, thereby failing to ensure people's rights were protected. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were mostly positive about the knowledge and skills of staff and their training. People using the service and their relatives gave positive comments such as, "They seem to know what to do to support my needs and are qualified." One person using the service said, "She (the care worker) has been here so long she knows what she is doing." Some of the written compliments from people using the service and relatives reflected these views, including, 'Both excellent workers, they know how to look after him very well'.

Staff in both service areas said they had supervision where they could discuss their work with people using the service, including any training or development needs. One staff member said there was plenty of casual, informal supervision. All staff were required to visit the office weekly to collect their schedule of visits, submit timesheets and use this time to speak face to face with office staff to discuss any issues. The Haringey manager said there was a hub in Haringey for Haringey-based staff to do this, at which one office staff member attended daily.

Staff we spoke with were knowledgeable about people's needs and how to support them, such as one staff member who knew what a person with diabetes needed to eat and drink, when they were at risk and when to call an ambulance. They said how their training was helpful in understanding how to manage the situation.

The local area director told us that all staff received a supervision meeting, spot-check, competency assessment and appraisal each year. The provider's staff support oversight tool showed that staff were being supported to that frequency. It showed that both branches involved in this inspection were achieving a minimum compliance of 85% against the provider's expectations, indicating no overall concerns with ensuring the support of staff.

Staff received a three-day induction and refresher training. The induction programme covered a broad range of areas. New staff worked with experienced staff before working alone. We spoke with the staff member who ran the provider's training. They said new staff were not signed off as fit to work if they failed to demonstrate a basic competency when completing the induction workbook and could provide additional training if they needed. Staff told us the training was good and useful in their work. We saw all staff had received core training, including safeguarding, handling medicines, risk management, dealing with emergencies, food safety, health and safety, personal care, policies and procedures, pressure sore care, record-keeping, fire safety and moving and handling. Training was updated regularly.

Staff in the Tower Hamlets service gave us several examples of highlighting with managers the need for extra training, such as training in catheter care, and said this was then provided. Individual staff who through audits were identified as needing refresher training attended this day in September 2015. The need for training was highlighted through a traffic light system for individual care workers and logged on the computer for monitoring and audit.

However in annual appraisal forms and records of supervision meetings we looked at, we found that training and development needs were not recorded, apart from one example where 'needs dementia training' was stated but there was no evidence this had been provided. Another stated the staff member 'does not require any training'. Annual appraisals did not have clear, detailed assessments or targets and plans for the future staff capabilities. One office staff member told us, "A lot of them don't have much to say when they have meetings." Our findings for appraisals did not assure us that these processes were being productively used to support staff to provide appropriate care for people.

Some staff told us they valued a 'care worker group support' meeting they had recently attended where they had an opportunity to discuss issues such as recording medicines and CQC inspections in depth.

Support plans identified people who required help to maintain their nutrition or hydration and where they needed assistance with meal preparation, including how

Requires improvement

Is the service effective?

and when meals should be prepared and help with feeding. Care plans showed people's meal preferences. Care delivery records showed that care provided was in line with assessed needs.

Care delivery records showed that people were supported to access hospital and community healthcare services to maintain good health. We saw examples of where care staff raised concerns about the health and wellbeing of people with their relatives, GP and community health and social care professionals. We also saw records of ambulances being called and care staff staying with the people until the ambulance arrived. Staff told us that social services, community mental health teams and other professionals were regularly in touch with people and with staff as they were involved in planning their care. Records we saw confirmed this.

Good

Is the service caring?

Our findings

People who used the service told us that the staff were gentle and kind and treated them well. Comments included, “My carer is great. She maintains my dignity and treats me with great patience and respect”, “The carers make me feel like I am human and look at me with compassion” and “My carer always ensures that I'm okay when she's at my house. She is lovely and knows me very well, inside out.” All said staff asked how they would like things done, such as how they wished to be washed, what they wished to eat or wear and how they wanted their tea. A relative told us, “Mum’s current carer is very kind and friendly and will chat with Mum even when she is rushed.” All the people we spoke with stated that they felt their care staff would respect their confidentiality.

Records showed evidence of the caring approach of staff at the services. For example, one person phoned the office due to being unable to access pest control services after seeing vermin in their home. Support was provided to arrange pest control visits as part of a review of the person’s care package. We saw records where staff were advised or sought to find out about people’s usual expectations before they visited a person. People’s care plans informed staff about how they should address the person, and they were reminded about offering choice and respecting dignity, for example, using towels to keep someone warm and covered as far as possible during personal care.

Staff all talked about people with consideration, emphasising the need to be gentle and compassionate in their dealings with people. Staff gave us examples where they had ensured people were offered support when upset or anxious, of responding promptly to meet people’s needs and how they offered choices. One support worker told us they found the work very rewarding. They said, “You get to know people. Some you can have a banter with. You have to go in with a smile on your face, if for half an hour or 45 minutes.”

Some of the written compliments we saw included, ‘My wife never felt rushed and they did a first class job’, ‘Nothing was too much for them, they showed a compassion beyond what anyone would expect’ and ‘Showed professionalism, integrity, respect and showed mum immense dignity’.

People told us that a manager came round, spoke to them and explained all the details in a way they could understand prior to starting their service. Others told us they were provided with useful information about the service.

The provider made efforts to ensure that the same staff were provided to people each week, by setting up a weekly template of agreed visits and assigning regular staff to each visit. One staff member said, “I visit the same people every time.” All the people we spoke with told us how much they valued having care that was consistent. Management records checked how well the weekly templates were kept to each week. These demonstrated that both areas were consistently amongst the best performing of the provider’s fifty-plus services nationally in this respect. Many staff had cared for people for a long time. By supplying people with the same staff, staff knew the person’s individual needs and preferences better, and trusting relationships could be developed. However, the standards of care people were used to was not always as good with replacement staff, for example, people experiencing occasional missed visits. We saw records where these had been followed up and others where we questioned what action was taken.

People in both services told us they felt involved in planning their care. People said they could choose their preferred gender of a care worker. Senior staff told us that they always asked people for their preferences before allocating staff to them. Staff told us they were matched with people from a similar cultural background where necessary who could speak their language. We found however that none of the assessments or care plans we looked at had highlighted needs related to people’s culture or spiritual needs in order to ensure people’s holistic needs were clearly identified. This made it more difficult to assess if people had other diverse needs that were not being met.

A large number of care plans were personalised, including personal preferences and histories to help plan care. There were others, which whilst prompting staff to consider people’s preferences, did not explicitly state what these were, increasing the possibility of people receiving care that did not always meet their individual wishes. However, staff showed us they knew the people they were caring for well and had a very detailed understanding of people’s history, preferences and needs.

Requires improvement

Is the service responsive?

Our findings

The results of the latest 'Annual Service User Satisfaction Survey' showed 41 replies were received at the provider's head office and that the majority of the feedback was positive. Only one person was "less than satisfied" with the overall care they received from the agency. This reflected the views of people who used the service whom we spoke with.

All the people who used the service had support plans showing how the service would meet their needs. However, we noted the blanket use of the word dementia on assessment forms without a clear indication about how this impacted on the person's care. For example, there was a lack of detail about how their dementia affected them day to day and how this contributed to their individual support needs. The approach to people's dementia care needs risked failing to support them receiving care that may be responsive to their daily and variable needs.

There was a disparity between actions identified in care plans and actions completed, as recorded by staff, which did not always link up. In the Tower Hamlets service, one file we looked at identified continence care as a need in the completed assessments but there was no reference to this need in the care plan. The records of care delivery we saw showed that staff were providing personal and continence care assistance in a number of ways that included catheter care, strip washing and assisting the person onto a commode at various times. The care coordinator we spoke with explained that the type of continence care provided depended on the person's abilities to manage their own care at the time. The care plan did not include this detailed information to ensure the person's needs were clearly identified and increased the risk of their needs not being met. Records of care delivery to the individual were inconsistent and did not always mention continence care meaning it was not clear if and how this care was provided.

The visit times of one person in their care records did not tally with the times specified in the person's care plan. Whilst we saw that the registered manager had advised staff in a meeting to ensure they were kept updated of any changes, the care plan did not correspond with the actual care being delivered.

Where cream was a need or requested by people and where assessments stated 'monitoring' of skin was required, none of the care plans made actions required clear to staff, whether cream was to be applied or not, what type and how often.

Whilst people's service provision and care plans were systematically reviewed, at least annually, and the majority updated, we found some plans that had not been updated when their needs changed. In both areas, the majority of care plans did not accurately reflect the service people received to meet their assessed needs. Therefore staff were not always provided with accurate, up to date information to help ensure that they were able to meet people's individual needs.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people told us they were happy with their care and the staff who delivered it, sometimes praising individual care staff. They said they received care in a way that was personalised to them. Comments included, "I get a good service, I've got no problems. I use the service on a regular basis" and "We don't need to discuss certain things as she (the carer) already knows our routine and completes all tasks required." These comments reflected the outcome of the most recent Tower Hamlets and Haringey service survey results, which showed that people had a high level of satisfaction with their care in both areas.

People's pre-service assessment documents in both areas covered a wide range of possible needs, for example, related to mental health, physical health, finances and health and safety. Staff, including office staff we talked with, were able to describe people's circumstances in their homes, their care needs and the service they received, demonstrating that staff knew about people's individual needs and preferences well.

In both areas, care package reviews, monitoring visits and calls were regularly undertaken. Records of these were available in individual files and the provider's oversight reports. Most reviews raised no concerns but action was taken where improvements were identified. There was also reassurance that specific care needs were being met, for example, that a repositioning chart was being completed in response to a recent safeguarding case, which matched a copy of the chart sent to us on request.

Requires improvement

Is the service responsive?

Records showed that people received care flexibly, adapted to their changing circumstances. One person was provided with a later visit on their weekly schedule as staff identified the later visit would help meet the person's needs. It was arranged for staff to be present during community health professional's visits to people where this was thought to be helpful. One person said, "If I need them to come a bit earlier or later they do their best to accommodate this, like if I have a hospital appointment or when I might want to stay in bed a bit longer." Staff showed us they understood the importance of flexible and responsive care. They told us they passed on people's views to managers and gave us examples of how the provider responded positively to the needs of some people for more input from care staff. This reflected what we saw in the sample of files we looked at where service provision was increased or decreased to meet people's changed needs.

Several people mentioned to us a lack of communication from the main office, such as, "Sometimes communication from the office is not good. For example, They didn't tell me that my personal carer had left." Similarly, "Communication from the office is poor. They don't inform me of any change of carer or if my carer is going to be away. I need to get to know people" and "The office don't phone you back." However, feedback we received directly and saw in telephone and visit monitoring records showed that the majority of people were satisfied with communication from the office. We saw many examples of where staff promptly responded and took action to address issues, needs and any requests of people who used the service. In Tower Hamlets, these included records of where incidents of missed or late visits were discussed and followed up with staff responsible.

People we spoke with who had previously been dissatisfied with the service said the office had become better at responding to their concerns. For example, one person who had complained to the office about the actions of one staff member when escorted out said, "I did tell the office and they must have spoken to her as this has improved. Everything I ask her to do now she will do for me." A relative told us, "Previously lots of different carers were coming and going, not at the times on the care plan and only staying for a short time. I complained several times with no change. But now it has improved." One person said, "They quickly replace the normal carer if she is away and they phone to let us family know. I'd be happy to complain if necessary but I'm happy with the care they give."

We asked both managers and staff how the service encouraged complaints and supported people to tell them if something was wrong. They told us everyone was given information at the assessment stage on how to complain, which was contained within the file placed in every person's home.

The provider's complaints policy stated, 'Complaints are to be welcomed as valuable, unsolicited feedback on shortcomings in the service that we delivered.' In both branches, complaints recorded this year were fully investigated and recorded. These included whether complaints were partially or fully upheld or not, including disciplinary action being taken with staff where appropriate. Investigation responses were fed back to complainants in a timely manner. Whilst complaints were investigated and recorded, records did not all show if people were satisfied or not with the outcome of their complaints or what improvement measures could be or were implemented to minimise the recurrence of similar complaints.

Requires improvement

Is the service well-led?

Our findings

The management of the service had not addressed, and in some respects not identified, shortfalls we identified at previous inspections related to the Haringey service, particularly in relation to breaches of regulations 9 and 12 that we found during this inspection. Therefore the registered provider had not effectively operated systems and processes to ensure that previous breaches of regulations were duly addressed so as to mitigate the risks relating to the health, safety and welfare of people using the service.

We asked if there was an action plan in response to our last inspection report of the Haringey branch. The manager showed us a four-point action plan that did not capture some of our concerns from that inspection, although it referred to two new auditing roles as outlined below. It did not make reference to some contributing evidence for the breaches also found at the previous inspection, for example, that this was not the first time the action plan had not been sufficiently robust, and that the registered provider's quality auditing team had not revisited the branch since December 2014 despite our concerns. That team may have helped identify and address the breaches we found at this visit.

The action plan also failed to address that we had previously found the Haringey branch's safeguarding file lacked sufficient records to demonstrate effective operation of safeguarding processes. This continued to be the case at this inspection. The last three safeguarding cases did not have recorded information on how the matters were investigated, what the outcomes of the cases were, and any actions that the agency needed to take as a consequence. The safeguarding entry for one person was a single email from the local authority acknowledging an alert sent by senior staff. However, there was no other information, meaning it was not clear what the allegation of abuse was in this instance or the actions taken, over two months later.

For another person, the safeguarding file contained information alerting the local authority of the person returning from hospital without necessary medicines causing them to become unwell. However, almost two months later, there was no other documented information on the case in either the safeguarding file or the person's care file in line with the provider's safeguarding policy.

There was additionally no reference to this safeguarding case within a copy of the provider's computer records held for this person, nor the manager's oversight spreadsheet of safeguarding cases, both of which were emailed to us following our inspection visits.

Discussions with the manager demonstrated that appropriate safeguarding actions were taken in response to the above cases. However, the above evidence demonstrated a continuation of a matter we raised as contributing evidence of breach of regulation 17 within the report of our last inspection of the Haringey branch. The matter was additionally not part of the provider's action plan in response to our last report.

Minutes of the Haringey branch's July 2015 staff meeting recognised that improvement with medicines management was needed. The October 2015 meeting minutes referred to ongoing gaps in people's medicines records, and that the manager would be arranging a workshop for staff identified as being in need of support. The local area director also advised us that they had identified the need for improvements in the management of medicines and they had a plan in place to address this. Whilst this planned to address the concerns, it had not occurred in a timely manner given that we had highlighted these medicines risks in our last two inspection reports for the Haringey branch.

This above evidence helps to demonstrate that the provider had not effectively operated systems and processes by the time of this inspection to ensure the previous breaches of regulations were duly addressed so as to mitigate the risk relating to proper and safe management of people's medicines in the Haringey part of the service.

Quality monitoring improvements were not sufficiently robust in the Tower Hamlets service. The registered manager checked a sample of files regularly so that all files were looked at by the end of the year to check that all essential documents were in place. Whist audits were evident in every file we looked at, these focused on the availability of the documents rather than their quality. They did not ensure that people's care plans were accurate, including actions to meet all assessed needs and risks or that daily records showed that people received care as stated in their care plans.

Requires improvement

Is the service well-led?

We found that medicines audits in both areas were occurring but were not robust enough and in Haringey, also not timely enough, to sufficiently check the quality and effectiveness of the service. In Haringey a medicines administration record (MAR) audit had not been completed, for September or October 2015. They were in two boxes, not all attached to daily records. Staff could not locate records when asked. In Tower Hamlets audits completed of MARs did not always pick up on inaccurate records or gaps in signatures, and there were no follow up records to show if people had received their medicines as they needed in those instances and what action was taken to address shortfalls with staff.

The above evidence demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Quality monitoring of the service was not always timely or robust enough to check and improve the quality and effectiveness of the service.

Staff files in both areas showed that unannounced 'spot-checks' were carried out by senior staff and managers. These focused on punctuality, interactions with people, presentation and skills of staff, their interaction with people and completion of tasks. Staff felt these were helpful and gave examples of changing their practice, using different words when talking to a person for example, as a result. However they did not include areas of good practice or actions to help develop staff.

Most people who used the service said they thought the service was managed well and they were asked for their views. For example, one person told us, "A lady comes over to see if everything is okay once per month and asks me if I'm satisfied with the support I get."

Each Tower Hamlets service file we checked contained quality monitoring forms, where all those people had been visited or called to ask for their views about the service. These mostly showed a high level of satisfaction with the overall service. However, where people said they were less satisfied with the service in their service monitoring reviews, we saw no actions recorded, for example, after one person said the service was 'inconsistent,' giving reasons why, despite being signed off by the registered manager. The registered manager we spoke with was confident the issue had been addressed but accepted that there was no recorded evidence and said this was an area for improvement.

The majority of staff gave positive feedback about management support. We received comments including, "I feel completely satisfied with the support I get. I can always talk to a manager if I have a problem" and "They're brilliant. If I have a problem, they sort it out straight away." Staff told us there was an emphasis on support, fairness and transparency, an open culture, and concerns were dealt quickly with by managers. One staff member said, "It's like a family." Staff said they were fully engaged with the provider's set of values that included involvement, compassion, independence, dignity, equality and safety.

Office staff in both areas had designated roles, newly assigned in Haringey, to help with the oversight and auditing of service delivery. This included checking use of the electronic visit-monitoring system, including follow-up where there was evidence of staff being late or visits not corresponding with scheduled times. We were shown records indicating more consistent use of the system in people's homes, albeit only 19 people on the Haringey side were using the electronic service at that stage. This helped to monitor which staff were attending to those people and for how long.

Separate audits had started in Haringey of the care delivery records, accuracy and completeness of medicines records and financial transaction records that had been moved from people's homes into the office. We saw that specific action was recorded in audits, which was transferred to an oversight tool for wider monitoring, for example, to see if the involved staff member was repeating errors. This provided a clearer audit process. The Haringey manager told us that she was going to be holding medicines workshops for identified staff members imminently, following on from support that was provided at recent staff meetings, as she recognised that further improvements were needed in relation to some staff members' medicines management skills.

We saw there was good communication between both areas and the local authorities they worked with, who they kept informed about, for example, use of the electronic visit-monitoring system by staff, review meetings that had occurred, and details of phone calls to people to check on the quality of services. The latest contract monitoring report from one of the local authorities in the Tower

Requires improvement

Is the service well-led?

Hamlets led service did not identify any issues. Before this, the service had met some actions from a similar local authority report, including life histories in support plans, for example.

In both areas managers dealt with professional issues in meetings with staff, including the importance of adhering to policies and procedures regarding care, safeguarding and filling in medicine charts correctly. It was evident that the provider pursued its disciplinary processes to help keep people receiving services safe where staff did not follow procedures.

The provider sent surveys to 100 people using the Haringey service in August 2015. The surveys showed the majority of people gave positive feedback and there was some analysis of results including areas for improvement, however there was no overall action plan included to address these.

Whilst we were clear about the shortfalls, there was a positive approach demonstrated from new senior management to address the concerns going forward, for which there were already improvement plans in place. The newly recruited local area director had themselves identified and accepted the areas requiring improvement and told us of their improvement plans. They told us of changes they had already initiated, such as running the out-of-hours on-call system locally during one recent weekend, instead of through the provider's national dedicated team, to see how that affected care delivery. This was being formally analysed, but initial results suggested staff sickness levels reduced in consequence. We felt confident that the area director had taken a positive, open and proactive approach to the concerns we raised about the safety, effectiveness and quality of the service during the inspection. We saw they had a good oversight of the issues and where improvements were needed to the quality and safety of the service for people who use it.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of services users was not always appropriate and meet their needs. Regulation 9 (1)(a)(b)

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not done all that was reasonably practicable to assess and mitigate risks to service users. Regulation 12(2)(a)(b) The registered person had not ensured the proper and safe management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not always acted in accordance with the Mental Capacity Act 2005 to ensure that care and treatment of service users was only provided with the consent of the relevant person. Regulation 11(1)(3)

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not operated effectively systems to assess monitor and improve the quality and safety of services provided or maintain an accurate, complete and contemporaneous records in respect of each service user, including decisions taken in relation to the care and treatment provided. Regulation 17(1)(2)(a)(b)(c))