Sevacare (UK) Limited

Sevacare - Birmingham Central

Inspection report

Suite 1, 2nd Floor, 40 Hagley Court
Vicarage Road
Birmingham
West Midlands
B15 3EZ

Tel: 01214556655

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 02 and 03 October 2018 and was announced. Sevacare Birmingham-Central are registered to provide the regulated activity of personal care. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults. There were 229 people using this service at the time of our inspection.

Not everyone using Sevacare Birmingham Central receives the regulated activity; the Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.
At the last inspection in February 2016, the service was rated Good but required improvement in the key question, 'Is the service Well-led?' We identified issues around arrangements to mitigate identified risks to people and a lack of oversight in the governance systems to monitor incidents, late calls and missed calls.

This inspection took place on 02 and 03 October 2018 to follow up on our previous findings. The inspection was prompted in part by increased statutory notifications from the registered provider. From those notifications we identified potential concerns about the management of people's care provision and the management of risk in the service. Some of these concerns were being investigated under safeguarding procedure both at the time of and following the inspection. One of the incidents we had been notified about may be subject to a criminal investigation. We were confident that the service had taken the appropriate action. The local authority and commissioning teams were also monitoring the service. At this inspection we found the service had not sustained the overall rating of good and found each key question now required improvement. Despite previous inspections identifying shortfalls in governance systems, we found that insufficient progress or improvement had not been made to the systems and processes to audit and monitor the quality of care provided at Sevacare Birmingham Central and to meet the Regulations. We are considering what further action to take.

There was a registered manager in post at the time of the inspection. 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.

People told us they did not always receive their care in an informed, consistent and timely manner that met their preferences and needs. Not all known risks to people were being identified, and the arrangements to mitigate these risks were not always robust enough in order to keep people safe. Incidents of late calls were not robustly reviewed, investigated and followed up to ensure lessons were learned for the future. The management of medicines was not consistently safe. Staff were recruited safely to protect people from the employment of unsuitable staff. Staff understood their responsibilities to protect people from abuse.

Improvements were needed to ensure all staff had the right training and observational competency checks

to carry out their roles in order to meet people's assessed needs and provide effective care. People told us that staff sought their permission before providing care and support. People received good support related to their eating and drinking, although guidance for staff could be clearer. People were supported to meet their health care needs, when necessary.

Whilst we received positive feedback about the care, kindness and compassion of most care staff, people did not always receive safe, respectful and responsive care because they were not always satisfied with the management of their call times and duration, how their concerns were managed, and risks to people's safety were not always identified and assessed. This meant the service was
not always caring.

People told us that the service were not consistently responsive to their needs. People told us they knew who to complain to. However, people told us their verbal complaints and concerns were not always taken on board, investigated thoroughly or had changed practice to improve their experience of the service. There was a system in place to identify, record and report on formal written complaints. Care was planned with people's involvement but we found care plans were not always up to date with people's changing needs. The staff we spoke with recognised the importance of people being able to observe and practice their religious, personal and cultural beliefs.

The provider had some systems in place to enable them to assess and monitor the quality of the service provided, but these systems were not being used effectively to manage all aspects of the service. The quality monitoring and assurance processes were not effective in ensuring that the risks to people's health and safety were appropriately assessed, monitored and mitigated. People expressed concerns about the management of the delivery of care, the response from office staff and the lack of effective or timely response to concerns. Staff felt well supported and valued in their roles.

We found that the provider was not meeting all of the requirements of the law. We found three breaches in regulations. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks associated with people's care were not always identified and managed.

A significant number of people told us they had experienced late calls and told us how this impacted on their lives.

Incidents of late calls were not robustly reviewed, investigated and followed up to ensure lessons were learned for the future.

People were protected from the risk of abuse, because staff understood how to identify, report and address safeguarding concerns.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to ensure all staff had the right skills, knowledge and experience to carry out their roles. Staff did not always receive the relevant training needed to support people effectively.

People were supported by staff who had developed a good understanding of their responsibilities when people did not have the capacity to make decisions.

People told us they were supported to eat and drink enough and staff supported them to access a variety of healthcare services to promote their day to day health and wellbeing.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Whilst we received positive feedback from people about the care, kindness and compassion of most care staff, people did not always receive safe, respectful and responsive care because they

were not always satisfied with the management of their call times and duration, how their concerns were managed, and risks to people's safety were not always identified and assessed.

People did not always know who would be coming to see them and sometimes people did not consistently receive care and support from the same care staff.

People told us staff respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People told us they did not feel their verbal concerns were always listened to or responded to by the service. Processes were in place to document, investigate and respond to formal written complaints.

People's care plans were person- centred. However, people told us that punctuality often affected the standard of their care and that the service was not consistently responsive to their needs.

People told us they were involved in the planning and reviewing of their care.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance processes, including ensuring the assessment of the risks to people's health and safely were not effective.

Feedback from people had been sought but had not been used to inform practice or drive up improvements.

The culture of the service was supportive and staff felt valued and included.

Sevacare - Birmingham Central

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on the 02 and 03 October 2018 and was announced. We gave the service 48 hours' notice of the inspection as we needed to ensure that staff were available to support the inspection. We made telephone calls to people and their relatives on the 01 and 02 October 2018 and we visited the office location on 02 and 03 October 2018. The inspection team consisted of two inspectors and two experts by experiences. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

As part of the inspection process we looked at information we already held about the provider. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and the improvements they plan to make. We took this information into account when we made the judgements in this report. We reviewed other information we held about the service to aid with our inspection planning. This included past inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also contacted other health and social care organisations such as representatives from the local authority commissioning team and Healthwatch to ask their views about the service provided. Their views helped us in the planning of our inspection and the judgements we made. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection visit, we spoke with 19 of the people who used the service. We spoke with 19 relatives of people to get their views. During our visit to the office we spoke with the regional manager, the registered

manager, two care co-ordinators and 18 care staff.

We sampled care documentation for ten people, medicines records, five staff files, staff supervision and training records. We also looked at other records relating to the management of the service including audits, quality monitoring systems and action plans; accident and incident records; surveys; meeting minutes and complaint records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in February 2017 we rated this key question as 'Good.' At this inspection the service had not sustained this rating. The service has now been rated 'Requires improvement' in this key question and is now in breach of regulations.

People who used the service told us they felt safe with the care and support provided. One person told us, "They [care workers] check the water and put the bath mat down when I am getting in the shower. I am frightened of falling and knowing they are there helps." However, this was in contrast to our findings. We found areas of concern regarding the safety of the service and the ability of the service to protect people from the risks associated with their care and support. The registered provider had not always taken the necessary steps to reduce the risk to people's safety by ensuring detailed risk assessments were in place where needed. We found examples where risks to people had not been documented as assessed or where they had been assessed, plans to mitigate the risks contained insufficient guidance to ensure people's safety. This included risks associated with diabetes, stoma care, catheter care, skin integrity, nutritional needs, and associated risks with Percutaneous endoscopic gastronomy (PEG).

One person's care plan identified that they had a PEG. There was no risk assessment in place to support staff how to use this piece of equipment safely. Daily notes we reviewed identified that staff were completing complex medical procedures that if undertaken incorrectly could have a serious, negative impact on the person's health and wellbeing.

Four people's care plans identified they had been assessed as being at risk of pressure sores. Whilst staff we spoke with demonstrated their knowledge about supporting people to reduce their risks of skin breakdown, there was no risk assessment in place to guide staff on the risks associated with this. Such detail contained within a risk assessment would enable staff to provide consistent support with people's skin integrity needs.

Another person's care plan identified they required pureed food and thickeners in their fluids. The person's care plan detailed conflicting advice for staff. The care plan identified, that they had porridge with thickener for their breakfast, in another part of the care plan it said, 'thickener in fluids.' We spoke with staff about this and they were unable to describe any records or guidance available to them to show when the thickener was to be used or that the fluid consistency information was available to all staff who supported the person. Staff told us this person had one scoop or more if they thought they needed it. We could not be certain that the services approach to assessing and managing risks to people was consistent.

Some people told us that they were happy with how they received their medicines. One person told us, "I need my medication with food and the staff will pop it into my hand directly as I can't see to get it myself." However, some care plans we sampled contained conflicting information about medicines a person required. For example, different medications were listed in different areas of the care plans. The registered manager was unable to tell us what people's current medicines were because their own records were conflicting.

One person's care plan identified that 'staff have no involvement with medicines.' However, the medicine risk assessment identified that care staff were to administer prescribed inhalers, and prescribed topical creams. The registered manager explored this following our inspection and confirmed staff were only administering prescribed topical creams. We found three conflicting body maps in place to guide staff about the safe use of applying the prescribed creams for one person. There was not a current medicine administration record (MAR's) available for us to review to determine what prescribed cream was needed or being applied. We found similar incidents for other people who were prescribed topical creams to support their skin integrity and prevent the risk of skin breakdown. In response to the above concerns the registered manager informed us after the inspection that they were addressing these shortfalls urgently and they would ensure that the review of these plans would not be signed off until they accurately reflected people's current needs and risks to their wellbeing.

A failure to ensure risks for people had been effectively assessed and plans developed to mitigate these risks, including the management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

Sufficient staff were not always deployed to meet people's needs. Most people who used the service told us that their care staff were late and many people informed us how this impacted on their lives. One person said, "The staff come in four times a day and if they are on time for my calls I get my meals at the correct time but if they are late for my breakfast call and early for my lunch, I am not hungry, it's a bit daft." Another person told us that they need to take their medicines with food and when staff are late they have to wait to eat and said, "My usual [member of staff] is usually on time in the week, so I don't understand why it is so different at the weekend." A relative informed us, "I worry about [name of relative] being safe when I have to start getting them sorted if the [staff] are very late because I struggle, but I can't leave them in a wet bed." Another relative told us, "The weekends can be rushed the staff arrive late and then want to go as soon as they are done to try and catch up the time…. I think it's the organisation, they seem to book a call at the same time as one just finished. They can't be in two places at once." A third relative was concerned about their relation not being able to have their insulin at the same time each day. They advised that call times were very irregular and that they had reported their concerns to the service but nothing had been done. We were concerned that lessons had not always been learnt where things had gone wrong, to ensure people received safe care. For example, some of these concerns had not been reported to the registered manager, therefore there was no prospect of the service putting improvements in place to prevent people from experiencing late calls.

People also shared concerns that they had experienced missed calls. One person told us they had been discharged from hospital and the care staff did not turn up for the calls. Whilst the person told us this had not had an impact on their well-being they were very upset about the incident. A relative also told us, "When the regular carer is off things don't always work. A few months back we had an occasion when no one turned up; my other relative phoned me as they were worried and although they apologised when I contacted them they didn't seem to be aware there was a problem."

Most of the staff we spoke with told us sufficient numbers of staff were planned in order to keep people safe and meet their needs, although last minute staff absence, less staff on weekends and travelling time sometimes impacted on the planned rota. We had received information prior and following our inspection that people had experienced late and missed calls. We spoke with the registered manager about the feedback we had received. The registered manager told us there were enough staff to meet people's needs. They advised this was based on the numbers of staff within each area. When new referrals were received, the registered manager would check the capacity of staff rotas before agreeing to accommodate the call. Whilst the registered manager told us that the recruitment of care staff was an ongoing challenge, they said they

had the current staffing capacity to meet people's needs safely. However, feedback from the local authority included that some people had raised concerns about the reliability, duration and timing of calls. Some staff we spoke with told us they did not always have enough travel time between visits. For those who tended to work in small geographical areas, this did not present as an issue most of the time. However, those whose calls took them over a wider area did find this a problem. One staff member said, "Sometimes we can't get from one home to another home in five minutes so obviously we run late a lot, I always do what I'm supposed to do for people though". The service had not ensured there were enough staff deployed in order to provide people with a consistent and reliable service.

Failing to provide staff in suitable numbers to meet the needs of people using the service is a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 18: Staffing.

People were protected from abuse because staff who supported them understood their responsibilities. One relative told us, "The regular carer knows what she is doing, and I believe keeps [name of relative] safe. If she spots anything like a bruise or scratch she would let us know about it." Staff were able to tell us about different types of abuse and what to look for and what steps to take to keep people safe. Some safeguarding concerns that had been notified to us were being investigated under safeguarding procedure both at the time of and following the inspection. One of the incidents we had been notified about may be subject to a criminal investigation. We were confident that the service had taken the appropriate action. The provider had a policy in place which was followed to ensure safe recruitment of staff. They carried out checks to ensure new staff were suitable to work with people before they started work and obtained work history and references. A check with the Disclosure and Barring Service (DBS) had to be in place before people started work. The DBS helps employers make safer recruitment decisions.

People told us that they felt safe receiving care from the service. One person told us, "I walk with a stick and no matter which carer comes in they stay near me when I am walking it makes me feel safe." Staff know what they are doing, and I am happy relative is safe". However, some people we spoke with told us that staff did not wear identification badges. One person told us they felt very uncomfortable when an identification badge was not visible on care staff's uniforms. We saw that this concern had also been previously raised by people who had completed the services customer survey. In response to this the registered manager had sent a reminder out to all staff that identification badges should be worn at all times.

The staff we spoke with had received training in managing infection control in line with the provider's infection prevention and control policy. Staff were aware of their responsibilities in this regard and of its importance. People and their relatives told us staff used Personal Protective Equipment (PPE) to prevent the spread of infection except for one person who told us about one incident where a staff member had not followed hygienic practices.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in February 2017 we rated this key question as 'Good.' At this inspection the service had not sustained this rating. The service has now been rated 'Requires improvement' in this key question and is now in breach of regulations.

People felt staff had the necessary knowledge and skills to meet their needs effectively. One person told us, "I have never had any problem with staff not knowing what to do." One relative told us, "They [the staff] all know what they are doing and hoist my [relative] safely in and out of bed. When we first got the hoist we all tried it out to see what it felt like, even the carers." However, we found people received care and support from staff who did not have the necessary skills and competence to support them effectively.

Despite receiving this positive feedback whilst staff had received regular key training that the service had deemed as mandatory staff had not completed specialist training required to meet people's individual health and clinical needs. Staff were supporting a person with their PEG but had not received training to do so. The registered manager could not evidence that that clinical competency observations had taken place to determine that staff were competent in the safe use of PEG's. People could, therefore, not be assured that staff had the appropriate knowledge and skills in these specialised areas.

The registered provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet people's care and treatment needs. This was a breach of Regulation 18 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. Staffing.

Staff we spoke with told us that they felt supported in their roles and that the management team were approachable. Staff told us they had the opportunity to discuss any issues or personal development needs with the management team. Supervisions had not been completed for all staff although it was clearly organised and planned to take place.

One person we spoke with told us, "New staff don't seem to know what they are doing." However, staff told us they received an effective induction depending on their role and responsibilities. This included an induction into people's homes and shadowing of experienced staff. The registered provider had ensured their induction processes were in-line with the principles of the Care Certificate. The Care Certificate is the nationally recognised benchmark set as the induction standard for staff working in care settings.

Before people's care and support commenced, the registered manager or senior team staff met with them and their relatives, if necessary. Records we looked at confirmed these assessments took place, however, we found examples when people's individual needs had not been fully recognised.
People told us their nutrition and hydration needs were met and most were happy with the assistance staff provided in meal preparation at mealtimes. One person told us, "I am never left without a hot drink and access to a glass of water. I have everything I could possibly need." Another person said, "It is all my choice when they [the staff] get me my meal. I have microwave dinners and they will ask what I fancy. Sometimes they just make me a sandwich if I have been to the day centre as I will have eaten there." However, two

people that used the service shared less positive views about some staff's cooking skills. Staff had a good understanding of people's dietary needs, including their preferences, cultural and religious needs.

People told us they were supported to access health care in the community. One person told us, "The carer will report if I need anything like a flu jab and would ring the doctor for me if I needed her to. I had a fall and she found me in the morning she was brilliant she covered me up to warm me and sent for the ambulance." Staff worked well with their colleagues, other agencies and healthcare professionals to support people's health and well-being.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. During this inspection we reviewed if the registered provider was complying with the MCA. Staff we spoke with had a good understanding of the MCA and said, "The MCA is about deciding if people can make decisions or not and if some decisions have to be in people's best interests." Staff told us how they supported people to make decisions about their care and were clear they would not force a person to receive care and support. When deemed that people lacked capacity we saw that mental capacity assessments were completed However, we did identify that one person's care plan was conflicting around the person's level of capacity. We identified that their relative had given consent on their relations behalf to use bed-rails. Whilst it was good practice that the provider had consulted with people's relatives, records did not demonstrate why the person had not given consent themselves.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in February 2017 we rated this key question as 'Good.' At this inspection the service had not sustained this rating. The service has now been rated 'Requires improvement' in this key question.

Although we received positive feedback from people about the caring attitude and behaviours of individual staff we also found that the providers systems did not always support the service to be caring. This can be demonstrated by the concerns found in other areas of this report. For example; people told us they were not always satisfied with the management of their call times and duration, how their concerns were managed, and risks to people's safety were not always identified and assessed.

People did not always feel their preferences and decisions were respected by the service in relation to the times of their calls and consistency of staff. People told us they would be happier if they knew who was providing their care and support. Not all people we spoke with had regular care staff assigned to them. Although some people received a rota regularly to advise them of which staff would be supporting them it frequently changed and people told us they had not been informed by the service. Some people we spoke with told us they were happy with their care workers. Comments included, "I usually get the same carers and we have got to know one another." and "I usually get the same regular care worker [who] knows me, and we get on well together, [they're] a lovely [care worker], genuine and caring." However, one person told us, "I have the same carers Monday to Friday and it works well but the weekends can vary, and I don't know who is coming." Another person told us, "I do have a regular one [care worker], but it is different on a Tuesday as apparently [they have] another client that day. I don't like them swapping and changing as you get used to one another. You get to know them and have a laugh and life would be miserable without a laugh." A relative said, "We don't seem to be getting the same carers despite my asking to make sure at least one of them knows [relative's name]. The weekends are the worst, I have brought it up with them, but it hasn't really improved." Another relative told us, "The problem I have is that you get the same carers for a time and get used to them then they change them without reason, so you have to start all over again. It is very frustrating." We shared this feedback with the registered provider.

People told us that staff were kind and caring. One person told us, "They [the staff] are all good but one in particular [name of care staff] is wonderful, really good, [they] help me to help myself. I have a nice relationship with them all." A relative told us, "The carer is lovely with [relative] and will do anything we ask her to do .. We leave little notes for one another and [they] will let me know if we are running out of anything like shower gel. The carer is kind and caring and will do things like plait [relatives] hair and spend time chatting…." People told us that when they received support from regular care workers the staff knew them well. Staff could describe people's individual preferences and life histories. Staff spoke with kindness and compassion about the people they supported. One member of staff said, "I feel really good, I've made my client's [person who uses the service] smiley face." Another member of staff told us how they enjoyed speaking with people about their past and said, "[name of person] used to bake all the family cakes."

People told us they were involved with decisions made about their care and felt staff respected and acted on their wishes. One person told us, "I think they [the staff] know what they are doing, well my carers do.

They are good at keeping me warm by using towels and helping me dress. They don't take over but are there if I need them." Staff described how they developed positive relationships with people by asking them questions and building a rapport. One member of staff told us how they asked people about their likes and dislikes and stated, "People like to talk about their past and it's important for us to listen and get to understand their needs."

People told us they were treated with dignity and respect. One person told us, "The staff always close the blind in the bathroom and while I am getting dried they cover me up with another towel my dignity is respected at all times." A family member said, "They [staff] will use a towel to cover [relative] when moving [relative]to make sure they maintain their modesty." People's independence was supported and encouraged by staff. One person said "They [staff] help me stay as independent as possible I couldn't do without them. I am very happy." A relative said, "They [the staff] are very respectful and kind while encouraging [relative] to do as much as they can for themselves." Staff we spoke with shared examples of how they promoted people's dignity and how they supported people to maintain their independence. People's right to confidentiality was respected and protected appropriately in accordance with GDPR (General Data Protection Regulation) guidelines. For example, people's care plans were securely stored and information held on computers and mobile phones were password protected.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2017 we rated this key question as 'Good.' At this inspection the service had not sustained this rating. The service has now been rated 'Requires improvement' in this key question.

People we spoke with did not always feel their verbal concerns were listened and responded to by the office staff. One person told us, "When I have brought issues up they [office staff] say they will sort them, but I am not convinced they do, and they never really apologise about whatever it is that has gone wrong. It does make you feel like they haven't listened." Another person said, "I have brought the issues regarding the changes of staff and the late calls up with [name of registered manager] and she doesn't seem to know what has gone on, she tells me she will get back to me then doesn't. This all adds to my frustration and I end up shouting which I know isn't good." A relative informed us, "What's the point of complaining nothing ever changes there isn't enough staff to cover all the clients." The majority of people we spoke with told us their verbal concerns had not been responded to their satisfaction.

We spoke to the registered manager about how people's complaints and concerns were managed. We were told that complaints submitted in writing were considered formal complaints. Records showed these were logged, investigated and monitored for completion in line with the provider's policy. We looked at some of the records of verbal complaints and concerns which were recorded into people's notes on the office system. There was no management oversight of verbal complaints and concerns unless they were brought to the registered managers attention. For example, the majority of people we spoke with shared their concerns in relation to experiencing late and missed calls. Whilst we saw some of these verbal complaints and concerns had been recorded there was a lack of follow up and monitoring. This meant trends and patterns had not been identified and feedback gathered from people had not been used to inform improvements in the service people received. In addition, the service had not checked that verbal complaints and concerns had been resolved to people's satisfaction.

People told us that on the occasions they received care and support by staff who knew them they were happy. One person told us, "The carer helps me to do the things I can't do for myself. I need someone in the bathroom to make sure I don't fall. I have a grab bar in the bath and she makes sure I have hold of it, she will wrap me up in a big towel and put my slippers on." Staff described their understanding of person centred care and were able to describe people's likes, dislikes and interests and how people liked care to be delivered. Staff that we spoke with described how one person was not able to communicate verbally and said, "Thumbs up for yes, thumbs down not happy and little finger for the toilet."

Each person had a care plan which was personalised to them. However, care records were not consistently fully completed, accurate and kept up to date. We found care plans lacked sufficient detail to determine what peoples' specific needs were in relation to key areas including mobility, pressure care, nutrition and equipment. We found examples where important information was not included in care plans and risk assessments or where these documents had not been reviewed and updated despite changes occurring. This meant staff were not always provided with the information they required to deliver personalised care.

We also found that the providers systems did not always support the service to be fully responsive. For example, they did not always receive their care calls at their preferred time or at the agreed time and / or had experienced missed calls. One person told us, "I sometimes feel they [care staff] come to put me to bed early, my proper time is any time after 9-30pm but sometimes, this is usually on a weekend the staff can come just after 6-30pm its really to early but what can I do." Another person told us that if staff arrive too late they missed their church service on a Sunday. Some people shared with us that not all staff read their care plans. Comments included, "New staff don't read the care plan and reply on me to tell them what needs doing. It is very frustrating." and "When the staff come they book in, but they don't read the care plan, so I have to tell them everything." Other people told us that the service had been responsive to their requests. One family member said, "If I needed to change anything for example, if (my relative) has a hospital appointment and we need an early call, there is never a problem."

Most people told us they were involved in the planning and reviewing of their care plan. One person told us, "Someone from the office came to talk to me with the social worker and filled in my care plan. I understood everything that was put in it and I signed to agree it was accurate." Another person said, "Someone comes quite often, about every three months to check the care plan and check my tablets haven't changed and such like. They will also ask me if I am happy with things."

We were told that there was a multi-cultural staff team available from a variety of cultures and with a variety of linguistic skills to reflect the needs of the community. The registered manager told us that they matched people, where possible, with staff who understood their faith and were able to communicate in the person's preferred community language. However, people expressed mixed views about communication with the staff who supported them. One relative said, "Some of the staff speak [relative's] language…… they all seem to communicate well." Some people told us they were not matched with staff who communicated in their chosen first language. One person told us, "Sometimes there can be language difficulties but on the whole, we get by." A relative said, "All the staff treat my relative with respect and I believe care for [them]. However, I think some of them need to better understand my relative's needs, [they] can't communicate as others do but there are signs that we can use."

People's religious beliefs, cultural and spiritual needs were discussed with them when they commenced using the service. The staff we spoke with recognised the importance of people being able to observe and practice their religious, personal and cultural beliefs. One member of staff described how they supported a person with their religious preferences whilst undertaking personal care. Staff told us they had received training around equality, diversity and human rights and it was expected that they would not discriminate against anyone. They understood how to protect people from any form of discrimination and were knowledgeable about equality and diversity with regard to protected characteristics. One member of staff told us," We treat people equally despite their disability, sexuality, religion and culture."

From April 2016 all organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand, so that they can communicate effectively. The service had looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS) which affirmed their commitment to ensure people were provided with information about the service in a format which met their needs. This included for example, providing information to people in large print or alternative languages.

The registered manager confirmed that no one using the service had the need for, or was in receipt of, support with end of life care. Information about people's preferences and choices for their end of life care

was not evident in the files we looked at. This did not show that the people had been involved in planning, managing or making decisions about their end of life care. This information would assist staff, if the need arose, to know how best to support people to have a comfortable, dignified and pain free death.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in February 2017 we rated the registered provider as 'Requires improvement' in this key question. We identified on-going concerns regarding good governance of the service. At this inspection in October 2018 we found the service's quality assurance systems to monitor the delivery of the service continued to be ineffective. We found that further improvements were needed in all key domains and we have judged the registered provider to be in breach of regulations.

Governance systems were not always reliable and robust. Systems in place for identifying, capturing and managing risks and issues were ineffective. Care planning and risk assessment documentation was either not in place, or, if they were, did not contain sufficient relevant information to reduce the risk to people's safety. People who had known risks associated with their health and medical conditions, had not had their needs appropriately assessed to ensure staff could support them safely and effectively. Other care planning documentation was also not in place or conflicting and did not reflect people's current needs in key areas such as medicines, nutrition and skin integrity. The registered provider had not ensured that copies of people's records stored within their office accurately reflected the records kept in people's homes. This placed people at risk of receiving care and support that was not appropriate for their needs. Accurate and contemporaneous records were not kept for each service user.

The registered manager advised us that medicine records and food and fluid charts were audited on their return to the office. However, these had not been consistently monitored by a senior member of staff. For example, we were presented with a selection of food and fluid charts for one person and saw none had been audited. The food and fluid chart was in place to monitor the consumption on a daily basis. We found individual nutritional intake was not quantified and fluid intake was not calculated on a daily basis to ensure nutrition and fluid intake was adequate to maintain people's health. We found that the failure to monitor and the lack of oversight identified that possible risks would not be easily identified.

A system was in place to monitor call timings. However, these had not been used robustly. People had made their concerns known to the service, but there had been no management oversight of these. The system in place had not addressed or helped to improve people's experiences of late calls.

Systems to ensure that care staff were carrying out their roles effectively were not always operated effectively. For example, the service had not ensured staff had received specialist training and observational competencies in order to meet people's medical and health conditions. In addition, the system in place to identify when staff required observational competency assessments to ensure they had the appropriate knowledge and skills to administer medicines safely were not effective. We found a number of staff were overdue for their assessments. In addition, systems in place to monitor the progress of staff inductions to the service had not identified that some staff had not fully completed their induction process

The failure to effectively assess, monitor and improve the quality and safety of the services provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives expressed mixed views about the service. People expressed concerns about the management of the delivery of care, the response from office staff and the lack of effective or timely response to concerns. Whilst some people made positive comments about the care staff who directly supported people, a number of negative comments were also made. One person told us, "I am quite happy with the service and would recommend." A family member said, "I would certainly recommend the one carer [name of care staff] they are great, but I don't know about the organisation of the company. Weekends can be really bad although they are better at the minute as we have [name of care staff]."

People and their relatives we spoke with could not consistently recall if they had been asked to express their views and experiences on the quality of the service provided for them within their own homes. One person told us, "They [office staff] do ring now and again to ask for feedback, but I don't think we've had a questionnaire." It was clear from the feedback we received from people and from the service's own quality surveys that people were not consistently happy with the quality of the care provided. We reviewed the analysis and results from the service's quality surveys that were completed in April 2018. The feedback we received from people we spoke with during our inspection reflected the feedback the service had received in April 2018. Although in response to the quality survey results the service had developed an action plan, this had not been effective to address and resolve people's experiences of the service to their satisfaction.

The registered manager had a clear vision of the culture they wanted to promote within the service. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the registered manager both during and following our inspection to be open, transparent and highlighted their own errors and areas which needed to improve. The registered manager understood their responsibilities in relation to the service and with their registration with CQC. Organisations registered with the Care Quality Commission (CQC) have a legal responsibility to notify us about certain events that have taken place. We received regular updates with notifications and other information which meant there was evidence of transparency. In addition, we saw that the service had on display in the reception area of the service and their website their latest CQC rating where people could see it.

We received positive feedback from most staff about the leadership of the service. Staff comments included, "[name of registered manager] is approachable and fair" and "I would recommend Sevacare for my mum or dad; staff go above and beyond to help people." Staff told us and records confirmed they attended meetings and were kept updated regarding changes within the service and had the opportunity to share their views.

The registered manager told us, and records confirmed, that the service worked in partnership with other key agencies and organisations such as funding authorities and external health care professionals to support care provision, service development and joined-up care in an open and positive way. Where required, staff also shared information with relevant people and agencies for the benefit of the people who used 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 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to monitor the quality of the service. The provider did not have effective systems in place to assess and monitor risks relating to the health, safety and welfare of people using the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet people's care and treatment needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment A failure to ensure risks for people had been effectively assessed and plans developed to mitigate these risks, including the management of medicines

The enforcement action we took:

We issued a warning notice that requires the provider to be compliant with regulation 12: safe care and treatment by a given date.