Sentinel Homecare Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Sentinel Homecare provides a range of domiciliary care services to people throughout the Bradford area from an office close to the city centre. The agency provides care and support to a wide range of people including older people, people with a dementia related condition, and people with learning or physical disabilities. At the time of the inspection the service was providing care packages to approximately 230 people.

The inspection took place between 28 November and 2 December 2016 and was announced. At the previous inspection in May 2015 we identified two breaches of regulation and rated the provider as 'requires improvement.' At this inspection we found improvements had not been made and the service continued to be in breach of these two regulations, as well as an additional three.

A registered manager was 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.

Feedback about the service was mixed and had deteriorated since our previous inspection in 2015 with over half the people we spoke with raising significant concerns about late calls, calls cut short and a lack competency of some staff who delivered care and support. Although some people said staff were nice and friendly, other people said this was not consistently the case and they were not always treated with dignity and respect.

Most people said they received appropriate support with their medicines. However medicines were not managed in a safe or proper way as a complete record of the support provided to people was not kept.

People said they felt safe and comfortable around staff. We saw safeguarding procedures were in place and we saw evidence they had been followed and actions put in place to try and prevent incidents of this nature reoccurring.

Risks to people's health and safety were assessed and clear and person centred risk assessments put in place for staff to follow. Some people said that staff did not always follow or were unfamiliar with risk assessments.

There were not sufficient quantities of staff deployed to ensure a consistent and reliable service. Although we saw most people got calls at an appropriate time, this was not consistently the case and some visits were cut short. Safe recruitment procedures were in place, although some people complained about the quality of new staff.

Staff received regular training, support and supervision. Despite this being the case, a number of people

raised concerns about the lack of skill and competency of new care workers and lack of continuity of care workers.

The service was complaint with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's consent to care and treatment was sought and people told us they were given choices.

Overall, people received appropriate support to maintain good nutrition and hydration.

People's healthcare needs were assessed and plans of care put in place for staff to follow. However late and short visit times had the potential to impact on people's health.

We received mixed feedback about the attitude and behaviour of staff. Some people told us care workers were kind and considerate whereas others gave examples of staff not treating them appropriately. People said they were not always introduced to new care workers or informed if they were going to be late.

Information on people's likes and dislikes and preferences had been sought as part of a person centred approach to care planning.

The service had taken the time to listen to people and record their comments or concerns. We found whilst effort was taken to resolve complaints, complaints surrounding areas such call time and length and reliability had not been fully addressed due to staffing shortfalls.

People's care needs were assessed and clear and detailed care plans put in place. These were subject to review and people told us they felt involved in their care and support. In some instances we saw evidence care plans had been followed. However more than half of people told us care needs were not fully met. We saw call lengths were often shorter than agreed which in conjunction with the feedback we received led us to conclude staff had not always completed care and support tasks to the required standard.

People's feedback was regularly sought, and the management team analysed it to help inform areas for improvement. However systems to assess, monitor and improve the service were not sufficiently robust as the service had deteriorated since the last inspection in May 2015, where we raised concerns over a number of areas of care and support. Systems had not been operated effectively to prevent the breaches of regulation we identified during this inspection.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is

still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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.

Medicines were not managed safely as appropriate records of administration were not kept.

Most people told us they felt safe. Risk assessments were in place which assessed the risks to people's health and safety and provided advice to staff on how to provide appropriate care.

A system was in place to record, investigate and learn from incidents and adverse events.

Sufficient quantities of staff were not deployed to ensure people consistently received a reliable and high quality service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received a range of training, support and supervision. However a number of people raised concerns about staff skill, competency and lack of continuity of care workers.

The service was acting within the legal framework of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Overall, people received appropriate support with food and nutrition.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People provided mixed feedback about staff attitude and behaviour with some people praising staff whilst others saying there were a number of staff who did not treat them with compassion and kindness.

People told us they were not informed if staff were going to be late or introduced to a new care worker.

People's views and comments were listened to by the service.

Is the service responsive?

Inadequate

The service was not responsive.

People's care needs were assessed and clear and person centred care plans put in place. However people's care needs were not always met. Staff did not always arrive on time or stay the correct amount of time and a number of people said tasks were not completed correctly or to the required standard.

Although the service made an effort to meet with people, discuss and/or respond to any concerns, because issues around staffing, and timeliness of calls had not been resolved, some people felt the service did not listen and act on their complaints.

Is the service well-led?

Inadequate

The service was not well led.

The service had not improved since our previous inspection in 2015 and feedback about the quality of the service had worsened.

Systems to assess and monitor the service were in place but these were not sufficiently robust to ensure a high quality service.

Staff told us morale was good, and they enjoyed working for the service.

Sentinel Homecare Limited

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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place between 28 November and 2 December 2016. The inspection team consisted of three adult social care inspectors 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 care service. On 29 November 2016 we visited the provider's office where we reviewed documentation and spoke with the registered manager and other office staff. Between 28 November and 2 December we made phone calls to people, their relatives and staff.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 16 people who used the service, 18 relatives, 15 care workers, the quality and complaints manager, the office manager and the registered manager. We looked at care records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the service. This included information from the provider, notifications and contacting the local authority safeguarding and commissioning team. We asked the provider to complete a provider information return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned to us in a prompt manner.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found medicine administration records were not returned to the office for audit purposes. At this inspection we still found they were not brought back in a timely manner and number of people who required medicine administration records (MAR's) did not have them in place.

The majority of people we spoke with managed their medicines either themselves or with the help of relatives. Most people who did receive medicines support said this aspect of care was appropriately managed. One person told us "she gives me my tablets twice a day and always watches me while I take them." Another person told us "They help with medicine and I generally get it on time but the odd time they are late because they have been held up. They make sure the tablets are on the plate and they make sure I take them." However one relative said that when staff were late this impacted on safe administration of medicines. They told us "relative had tried to take his own pills when the carer was late and spilled them on the floor."

In some care records details of the medicines people took, their side effects and when they took them was recorded within their care and support plan however others did not contain this information. This meant care was being planned, coordinated and delivered without the relevant supporting information.

Where staff supported people with medicines, we found that Medicine Administration Records (MAR's) were not always in place. For example where medicines were contained within dosette boxes, MAR charts were not used with the support provided only recorded within daily records. There were also no MAR charts for the application of topical medicines such as creams. This meant that there was no record of the exact medicines each person was supported with at each visit. One person was prescribed Alendronic acid to take once a week, however there was no MAR chart for this and therefore we could not confirm whether they had received their medicines as prescribed. Two relatives we spoke with also told us it was difficult to track whether their relatives had received their medicines as prescribed. One relative told us that they had they wondered if the carers were making sure their relative had their medicines but could not tell from the care records as they are not specific enough and another relative said that they could not decipher whether medicine support had been provided by the codes used in the daily records.

We saw some MAR charts were in place for medicines not contained in a dosette box and these were audited by the care manager. However, we saw MARs were returned to the office infrequently which meant mistakes and discrepancies were not noted within a reasonable time period.

We saw some medicines were given 'as required' (PRN). However, we saw no MAR charts were in place to support these and the service did not have a PRN policy.

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

Most people told us they felt safe in the company of staff. For example one person told us "I definitely feel

safe" and another said "Safe I have no problems with that." However some people told us they didn't always feel safe and this was down to carelessness and/or lack of training. Some relatives said that late calls put vulnerable people at risk because they tried to manage themselves." For example one relative told us their relative was supposed to get a "time specific" visit but instead they were "all over the place" and as a consequence their relative tended to try and get up and ready himself. They said "he is at risk of falling, he needs a reliable call." We saw in some cases calls were consistent from day to day, but our review of rotas, care records, complaints led us to conclude this was not consistently the case.

Staff we spoke with had an awareness of safeguarding issues and how to identify and report abuse. Where safeguarding incidents had occurred we saw these were investigated by the service and actions put in place to try and prevent a re-occurrence and keep people safe. These had been appropriately referred to the local authority and Care Quality Commission. We saw there were appropriate disciplinary procedures in place. For instance, we saw where a person who used the service had made a complaint about their care, the care workers were suspended whilst an investigation took place. Following the investigation, the care worker was retrained and placed under observation until the care manager was satisfied with their performance.

Following incidents we saw evidence of action taken to keep people safe. For example after an incident involving equipment we saw the occupational therapist had been contacted and changes made to the person's plan of care made.

Comprehensive risk assessments were in place in people's care records to mitigate risks to people who used the service. These included moving and handling, environment, nutrition, medicines, health and lifestyle. We saw these risks were pertinent to people's needs and had been updated as changes occurred. For instance we saw one person whose care plan had recently been updated to include a risk of self -neglect and staff were requested to encourage this person with their personal hygiene, changing their clothing and having a wash. Daily records of care provided evidence that risk assessments had been followed.

A missed call log was in place and we saw evidence of action taken to investigate any missed calls and measures put in place to help prevent a reoccurrence. At the time of the inspection the service did not have a system in place which ensured staff had reached their destination on time and had to rely on people contacting them if staff did not arrive. We were concerned about this particularly given the size of the organisation as some people told us calls had been missed.

An on call system was in place which meant two staff were on call to receive calls and queries from staff in the event of an emergency. Staff were clear on what to do in the event of an emergency and following the non-response policy if people did not answer their door.

At the last inspection, we concluded there were insufficient staff deployed. At this inspection we found this was still the case. The registered manager told us the service was under pressure to accept packages from the local authority and this had stretched the ability of the service to cope with care and support demands. They said they had tried to hand some care packages back but the local authority was struggling to find another provider to accept these. The registered manager agreed that more staff were required and said that they had a number of people recruited who were due to start which would hopefully alleviate pressures. Six of the staff we talked to told us they thought the service needed more staff. Although most staff were happy with the service they said there was a lack of travel time and they could not always get where they needed to be at the required time. We saw some travel time was allocated on rota's however this was not always enough. For example we saw one staff member had five calls in a row with no travel time allocated and we calculated there was 44 minutes of travel time. Although the staff member had a 30 minute break after these five calls it would not be enough time to catch up given the travel time between houses meaning

visits would be have to be cut short. Other rota's showed some travel time but we concluded it was not always sufficient. A number of the people and relatives we spoke with said the service was not always reliable, staff were late and rushed and did not always complete the required tasks. Records we reviewed confirmed that staff often did not stay the allocated amount of time.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 regulations.

Recruitment records showed appropriate checks and references were taken up before staff members began work. These included checks of the records of the Disclosure and Barring Service, (which included criminal records checks) and proof of people's right to work in the UK. However we did identify that updated criminal record checks were not always undertaken in a timely way for existing staff. We raised this with the registered manager who showed us their plans to address. References from previous employers were requested and verified by office based staff. Applicants for posts were required to provide complete work histories and any gaps in employment had to be explained. Appointments to posts were confirmed when staff had successfully completed a nine month probationary period. However feedback we received was consistently that some staff particularly new staff did not have the correct skills to care for them. We concluded the recruitment and initial training process could be refined help improve people's experiences of new staff.

Requires Improvement

Is the service effective?

Our findings

The provider had spacious office premises with a designated training room which was used by staff for practical training sessions. For example, the room was equipped with a hospital bed, hoist, slings and Zimmer frames. Staff received induction training which covered topics which were essential for their work. These included safeguarding people from abuse, personal care, dementia care, documentation, health and safety, and moving and handling. Refresher training in all these areas was available to staff. The induction course was office based training over the course of five days. Part of this course was designed to help staff achieve the care certificate. The care certificate is a government backed training scheme for staff in social care. Existing staff were provided with training updates on a regular basis as well as through staff meetings. We saw staff were up-to-date with training. Staff all told us that they had received plenty of training and they found it was appropriate to their role.

People and relatives provided mixed feedback about the skill, knowledge and competency of staff. One person told us "They seem to know what to do" and another person said "Yes they do everything they empty the bin, make the bed and tidy up okay" However, a common theme amongst many people and relatives was that some carers were rushed, disinterested and didn't always know what they were doing, arrived with little or no knowledge about the people they were caring for or what their particular needs were. For example one relative told us "so many different girls, some arrive without a clue what to do, they ask me I tell them to look in the book." Further comments included; "The young carers couldn't care less and had not had any training," "The young ones are not as good as the more experienced ones I think they should be shadowed more I have to tell them what to do," "The new ones aren't good with the hoist I rang the company and they said they would speak to the seniors about it" and "The young ones didn't know how to deal with dementia and some of them said they didn't know how to use a microwave." A common complaint from people was that different carers came all the time so did not develop the required skill and knowledge. Records we reviewed saw that whilst there was some consistency this was not always the case, for example one complained to us about the high number of different carers for their morning visit, we looked at their records and saw they received 11 different carers within November 2016. Although staff received a range of training and support we concluded further training, competency and monitoring and more continuity of care workers was needed to ensure staff skill and competence was brought up to a consistent, acceptable standard.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Staff told us they felt well supported by the organisation. We saw staff met with managers for supervision, team meetings and annual appraisals. The registered manager told us they had identified a need for staff to have more opportunity to share their views about their role and had increased the number of supervisions held. Staff were given an annual appraisal so they could jointly assess their progress and development needs with senior managers.

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. In the case of Domiciliary Care, applications must be made to the Court of Protection. We found no people were currently subject to DoLS.

The provider had a policy and procedure to ensure they supported people in line with the Mental Capacity Act 2005 (MCA). The registered manager had a clear knowledge about their responsibilities under the MCA. They provided staff with guidance about their responsibilities of how to support people within the MCA. We saw best interest decisions had been recorded on behalf of people who lacked capacity which demonstrated the correct process had been followed under the MCA. We saw people were supported to access independent mental capacity advocates (IMCA) to represent their views where appropriate.

We saw evidence of consent in people's care records, including signing of the care record by the person or their relative, and consent to share information with relevant bodies. People told us that they had choice over their daily activities and carers asked them what they wanted to eat and wear. One person told us "they always ask before they do anything" and another person said "I choose if I want different clothes to wear."

Where the service was supporting people with their nutritional needs, we saw this was done to an acceptable level. Most people who had their meals cooked for them said they chose what they wanted, the food prepared was hot and nicely presented and staff cleaned up after themselves. One person told us "They cook what I have got in I buy it so I can decide what I want" and another person said "They ask me what I want for my breakfast and they make me a cup of tea." However we received some comments that new staff did not always know how to prepare meals in a competent manner. We saw information in people's care records about people's likes and dislikes and what they would like to eat for their meals, information about leaving fluids within easy reach and providing flasks of warm drinks before leaving the visit. The care records also contained detailed information of what the person liked to eat and drink and we saw in the daily records this was adhered to. For instance, we saw one person liked to drink a glass of diet coke with their breakfast and we saw in the daily records this was given.

People's care needs were assessed and appropriate support plans put in place. Care records we reviewed contained detailed information on people's healthcare needs. These provided clear information on how to meet people's individual needs. Staff we spoke with were clear of the action they would take if people felt unwell. We saw the service liaised with external health professionals such as district nurses and GP's if people's needs deteriorated. However we identified that staff rushing, cutting visits short and not arriving on time had the potential to impact on people's health.

Requires Improvement

Is the service caring?

Our findings

We saw care planning had considered the importance of treating people with dignity and respect and in a person centred way. However people and relatives provided mixed feedback about the attitude and nature of care workers. Some people said some of the carers were "very good", "very nice" and "kind". One person told us "They are very friendly, they are always nice kind and pleasant." Another person told us "They are willing to do anything for me like going shopping for extra milk to Asda." However other people and relatives told us there were some staff that did not treat them in a respectful manner. Some staff were described as "having a bad attitude", "disrespectful" and having an insensitive approach to the service and the needs of vulnerable people. One man described them as being "indifferent and couldn't care less." A relative told us that their call was hit and miss and the carers "cannot be relied on at all". Another relative said, "some are nice some are not." One relative said despite being told not to, the carers still banged the door when leaving her home causing it to need repairs.

People and relatives said that staff did not always stay the full call length, which demonstrated a lack of respect to some people. One person told us "Some stay the time some do not they will do the job quick and only stay 10 minutes when they should stay half an hour. I've spoke to the Office about it but I can't force them to stay." Records we reviewed confirmed that staff often did not stay the allocated amount of time with people. People also told us when carers were late they were not informed. For example one person told us "They are late because they are busy at other jobs and get held up. They don't ring me to let me know."

Although we saw systems were in place to monitor respect and dignity and that management took these complaints seriously, the sentiment from people showed that these systems had not been effective in resolving the problems people had experienced.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Some people told us staff engaged them in conversation and positive relationships had developed. One person told us "First and foremost I get on very well with them and another person said "They talk as they do the job and before they go will ask me if I want anything else doing." However people also told us that there was a lack of continuity of care workers and this was a barrier to the development of positive relationships. People said that they were not always introduced to new care workers. One person told us "Most of the time I get the same people but sometimes there are different ones who turn up. No I haven't been introduced to them" and another person said "We have the same lady in the evening but in a morning they are all different and they are not introduced to us they just turn up."

Most people told us staff respected their privacy. For example one person told us "When they help me they will cover me up" and another person told us "They cover her up and shut the doors. If I go to the toilet they will shut the door and wait for me until I have finished." However one relative told us that on two occasions she had to tell the carers about sitting on the sofa watching their relative use the commode.

People's independence was encouraged where possible. For instance, we saw care records indicated where people could wash themselves in the morning and where they needed assistance.
People confirmed to us that staff helped maintain their independence stating "I try to do as much as I can but I have problems with my back and legs" and "If I can't manage to do something they will help me but I try to do as much as I can."

Information about people and their preferences was present within care and support records. However a number of people did not appear to know what their particular time slots were. Comments included, "they come out of the blue at weekends", "all over the place" and "I don't know when to expect them." Although we saw people initially people had agreed to call times when the package commenced, this information was not updated during care reviews of if people had additional calls added. This meant that there was not a clear agreed timeframe for some people which would help manage people's expectations and provide a well-defined target for staff.

Care plans contained information on how to ensure effective communication with people. People told us that staff talked to them during care and support interventions whilst stating that staff were rushed. Some staff could speak other languages and efforts were made to ensure these staff visited people who shared these languages to ensure effective communication. Cultural and religious needs were taken into account during care and support planning.

Inadequate

Is the service responsive?

Our findings

We received mixed feedback about whether people's needs were met by the service with most people raising concerns over the care and support provided. For example 17 out of the 32 people we spoke with told us they had concerns about care needs being met with reliability and quality of carers the main themes. Other people were happier, for example one person told us "all my needs are catered for." Some people told us that the service was poor but had improved recently, for example one person told us "It's a bit better now but they were late a lot" and "A lot better now I have the same two girls, on time unless they have an emergency and then I ring the office." However the majority of people raised concerns with us about the timeliness of calls and the length of time staff stayed. One relative said "It should be 9-9.30 but we've had them at 10.30 and 12". Another person told us "The timing is intermittent and they don't phone to let us know so I ring if it gets to an hour late" A relative described the service as "higgledy-piggledy" and that visits have been up to two hours late. On reviewing daily records of care, overall we found that most calls took place close to the required time although this was not consistently the case. In some records we looked at we found discrepancies for example teatime calls taking place anytime between 3.00 and 5.45. This variability led to gaps between calls sometimes being inconsistent and not appropriate. We saw evidence that where people had appointments such as day-care appointment, staff had not always arrived on time.

Most people told us visits were cut short which meant their needs were not always met by the service. One relative told us they had been "very disappointed" in the standard of care their relative, had received in the two weeks since they started with Sentinel.

However the main concern we identified was that staff did not stay the required amount of time, which was confirmed by people we spoke with. One relative told us that although staff were on time, "they didn't stay 2 minutes" so the person had left the company. People told us that care needs were not met as the required jobs were not always undertaken. For example one relative told us "They are supposed to change his bed every 3 days but don't. They ask him a couple of times if he can turn over then just push him, I can't turn him myself." Another relative told us "they will go after 15 minutes in the morning and they will record the full half hour…They will say they don't know how to shave and put down they have shaved him and say they have done the bed and they haven't."

A number of relatives told us that continence needs were not met because staff were rushing. One relative told us that staff rushed and did not always change their relatives incontinence pad so they were left to do it. Another relative we spoke with said when staff changed their relatives incontinence pad they didn't always clean the person properly which have caused them to get sore. When we reviewed this person's care records we saw visit times were often less than the agreed time for example between 5 and 10 minutes instead of 15 when a range of care and support tasks were required. Another relative told us carers had not been washing their relative properly. We looked at this person's care records which showed carers regularly did not stay the full time for example 15 minutes instead of 30 in the morning on occasions which meant there was not enough time to complete the tasks. We reviewed a number of other call records and saw these were in keeping with people's concerns. For example, we saw one person had received a care visit of

11 minutes on one day and 15 minutes another day when both should have been for 30 minutes duration. We saw another person had received seven minute care visits instead of 15 minutes on two consecutive days where the duties included assisting with medicines, assisting with night clothes, applying creams, checking they were wearing their alert pendant and documenting the call. These issues were also the subject of recent complaints recorded in the complaints file and people's care reviews. The registered manager told us they were planning to introduce an electronic call monitoring system to ensure staff stayed for the appropriate length of time and calls were not missed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

We saw care records were detailed and person specific. Information included risk assessments, care plans, daily records, quality assurance and reviews. We saw people's preferences were included in the planning of their care, such as what type of soap they preferred, the choice they liked for their breakfast and how they liked their drinks prepared. For instance, we saw one person's care plan detailed how they liked to have Horlicks in the evening and how staff were to prepare this. We saw evidence in the daily records this was followed. We saw a detailed routine for each care visit was contained in each person's care record. This provided staff with clear information about what tasks to perform at each visit and contained relevant information such as, '[Person] is able to wash [person's] feet and top half', and, 'Please assist [person's name] out of bed and onto the commode.' We saw one person's daily routine involved alternating their breakfast menu and this was seen to be followed by the information in the daily notes.

We found people and relatives were involved in the creation and review of their care and support plans. People had the opportunity to discuss with senior staff what their needs were and this information was included in their assessments, from which care plans were written. People were provided with a copy of their plan and had the chance to review it at scheduled reviews or in response to changes in the person's condition or needs. One person told us "I had a review a few weeks ago and the lady came from the office and looked at everything and the log book is filled in every day."

We saw staff completed daily records of care and support given. However, these were in a numbered format, according to the allocated care tasks for the visit, rather than looking at a more person centred approach to the documentation.

We saw evidence complaints were taken seriously by the service, and saw meetings had been held with relevant parties and actions put in place to try and resolve where possible. People knew how to make complaints and raise concerns about the service they received. They received written information about the complaints procedure when they began to use the service. We saw 38 records of complaints received in 2016. The registered manager made enquiries into the circumstances of the concerns raised and provided the person with written response which included an apology if they had experienced care which fell below acceptable standards. However we noted that 17 of the 38 complaints received were in reference to timings of staff or missed calls. We mentioned this to the registered manager who told us they were aware of the concerns and were currently recruiting to fill staff vacancies. However as this problem had not been fully resolved, people and relatives felt that these complaints had not been effectively dealt with. One person told me "what's the use I have given up" another said, "complain, it's a waste of time!" Some people had better experiences and said complaints had been resolved. For example one person told us "At the beginning timing was bad but my son rang the office and it's got a bit better."

Inadequate

Is the service well-led?

Our findings

People provided mixed feedback about the overall quality of the service with 19 out of 34 people raising concerns about the timeliness of calls, staff rushing, not completing all required care tasks and the competency, skill and attitude of some care workers. Feedback from people had worsened since our last inspection in May 2015 with these complaints now more prominent. We concluded that the service had not ensured appropriate improvement following our previous inspection as it had not fully addressed risks associated with insufficient staffing levels, staff skill and competency and medicines management. During this inspection we identified breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities 2014) which should have been prevented from occurring through the operation of robust systems to assess, monitor and improve the service.

Care documentation such as medication records, daily records of care were not brought back to the office in a timely way. We also identified this as a concern at the previous inspection. For example we saw one person's MAR chart from February 2016 had not been audited until November 2016 which meant that any discrepancies or shortfalls were not identified within a useful timeframe to take action to protect the person. Daily records of care were also not always brought back to the office in a prompt way for review to ensure people had received the required care. We were particularly concerned given the size of the service that there was no system to monitor in a timely fashion whether people had received care calls. Our experience of speaking with people, staff, reviewing records and complaints showed that a large number of concerns regarding call times were received on a regular basis. Whilst the service was trying to take action to address these concerns on an individual, reactive basis, these problems were only discovered after people complained. This led us to conclude there were likely unknown quality issues associated with calls to those who lacked the mental capacity to complain. The provider's PIR stated that electronic call monitoring would be introduced within 2017 and that this will ensure they become more proactive dealing with incidents rather than dealing with issues reactively.

The registered manager and manager carried out quality audits on paperwork and the service provided. They told us they were currently in the process of completing care plan audits but had only done about 18 of 230 so far. Senior staff carried out a series of checks and audits to monitor the quality of the service. They carried out unannounced spot checks and assessed the quality of care people were receiving and asked their opinion of the service. However we concluded this system was not sufficiently robust as it had not ensured the service and staff operated to a consistent high standard.

A number of people told us that their comments and suggestions had not been acted on by the service around the timeliness of calls and care workers. We saw evidence of this in records we reviewed. For example we looked at one person's care records which showed they had received a quality visit in March 2016 which stated they were not happy with call times. When we contacted them during the inspection we found these same concerns still remained.

People were aware of their care plans and the care logs which the carers were seen completing. However a number of people said these were not always helpful or explanatory and it was difficult to be able to work

out exactly what care and support had been completed. Recording was very task based with a lack of clear records a lack of information on of the social aspect of the support provided. We found a lack of records demonstrating the support people had received with their medicines with some relatives telling us they were worried they could not confirm whether their relatives had received their medicines.

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

Other quality assurance checks assessed the frequency of staff assessments, supervisions, staff appraisals and training. We looked at the quality checks for financial transactions. We noted that audits for the financial transactions had checked people's money in and money out against receipts and taken action to address any discrepancies. Databases were in place to keep an oversight of audits and systems in place.

Audits of rota's were undertaken to inform staffing deployment and capacity. We saw some audits had picked up the requirement for extra travel time to be added and this had been actioned. However some staff told us that when changes were suggested these were not always actioned by management. We also saw some rotas were poorly organised with a lack of appropriate travel time between clients.

A registered manager was in place. We found the required statutory notifications had been submitted to us. Management staff were employed to specifically undertake audits, deal with complaints and ensure face to face contact for people. People told us they were able to get through to the office when needed. For example one person told us "They are okay on the phone I always get through". Some people told us they knew who the registered manager but others did not. Most people were aware of senior care workers they could contact if there was a problem. The registered manager told us the service had expanded since our last inspection and were aware improvements needed to be made to aspects of the service. We found them open to ways to improve the service.

Staff told us that they enjoyed working for Sentinel homecare, that they felt well supported and that morale was good. The main concern staff raised was about the organisation of rota's , extra calls being added and lack of communication on issues from the office such as if people did not require a call. A number of people also commented that they thought communication could be improved by the service.

We saw the service completed regular postal and telephone questionnaires with people who used the service. We saw evidence actions were taken where required and results were discussed at staff meetings. We saw evidence further information gathering by the service had taken place. For example between July and December 2016, we saw some people were telephoned for their views. A summary of complaints and safeguarding's had taken place in order to identify themes and areas of improvement.

Staff and management meetings were held regularly and these were seen as an opportunity to discuss concerns, raise issues and share best practice. We saw each meeting had a specific policy discussion such as health and safety or communication, and a quiz was incorporated into the meetings to assess staff knowledge of various subjects and policies such as infection control, catheter management and adult protection. We also saw results from quality assurance visits, telephone calls and spot checks were discussed at these meetings, highlighting areas required for improvement as well as what had been seen to have been done well.

We concluded that whilst there were established mechanisms in place which aimed to lead the service these had not been fully effective to drive the necessary improvement to the service and required further refinement in order to ensure the service provided an acceptable standard of service to people.

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 10 HSCA RA Regulations 2014 Dignity and respect (1) Service users were not always treated with dignity and respect

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1) (2g) Medicines were not managed in a safe or proper way

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 9 HSCA RA Regulations 2014 Person-centred care (1) Care was not always appropriate, did not always meet people's needs or preferences.

The enforcement action we took:

We issued a warning notice requesting the provider to take action by 31 January 2017.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1) (2a) Systems and processes were not operated effectively to ensure compliance with the regulations in this part. Systems to assess, monitor and improve the service were not sufficiently robust.

The enforcement action we took:

We issued a warning notice requesting the provider to take action by 17 February 2017

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not employed to ensure people's needs were met.

The enforcement action we took:

We issued a warning notice requesting the provider to take action by 31 January 2017.