

Sentricare Limited

SentriCare

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Sentricare is a domiciliary care service providing personal care to people living in their own homes. At the time of our inspection there were 72 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found

The provider's oversight of the service had not identified some of the shortfalls we found during the inspection process as part of their audits and checks.

There were systems in place for managing complaints, safeguarding concerns, accidents and incidents. However, feedback from people and relatives on how the provider dealt with complaints and concerns was mixed. The main complaint raised by people and their family members were late calls, the consistency of staff attending people's homes and poor communication with the office staff.

Most risks to people had been assessed. However, risk assessments were generic and had not always contained person-centred information to support staff with people's individual medical conditions.

People were protected from abuse because systems were in place to keep people safe. Staff were aware of their responsibilities to keep people safe.

There were enough staff members available to support people. People were supported by staff to take their medicines. Generally, staff followed infection control guidance and had access to personal protective equipment.

There were appropriate pre-employment checks in place to make sure newly recruited staff were suitable to carry out their role.

People's care and support was planned in partnership with them and persons close to them. Care plans were in place and had been reviewed. Staff received training and people told us they felt supported by the staff and considered they had the skills and knowledge to support them safely. Staff sought people's consent and encouraged people to make their own decisions. Where appropriate, staff supported people with nutritional and hydration needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported

this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was requires improvement (published 18 September 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected

The inspection was prompted in part due to concerns received about missed and late calls, staff not staying the correct length of time, client confidentiality and infection control practices. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make some improvements. Please see the safe, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sentricare on our website at www.cqc.org.uk.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the provider's governance and monitoring processes at this inspection.

Follow up

We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our effective findings below.

Good ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

SentriCare

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team

The inspection team comprised of one inspector and an Expert by Experience making telephone calls to people who used the service and their family members. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced on the first day of the site visit and announced for the second day on site.

Inspection activity started on 05 July 2022 and ended on 20 July 2022. We visited the location's office on 05 and 07 July 2022.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection activity

We spoke with three people who used the service and 10 relatives. We also spoke with five care staff, the care manager, the registered manager and a director of the service. We reviewed 11 care plans and a selection of medication records and risk assessments. We also used technology such as electronic file sharing to enable us to review documentation sent to us by the provider, following the site visits.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- At the last inspection we found risk assessments were not in place for all health conditions, or for people's known risks to enable staff to have the information they needed to meet their needs. At this inspection there had been some improvement however further improvement was required.
- Two people with a medical condition of epilepsy did not have a separate protocol in place to provide staff with information on what action to take if the person were to have an epileptic seizure. Speaking with staff, they said they would immediately call the emergency services if someone became unresponsive or ill while they were with them. We raised this with the provider post inspection and were told the appropriate protocols would be implemented immediately.
- Risk assessments we looked at, although generic in places, contained some personalised information for individual medical conditions. For example, diabetes.
- People and relatives we spoke with told us they felt staff followed the risk assessments and care plans to provide support. Staff we spoke with explained how they supported people safely.
- A risk assessment of the home environment was conducted to make sure care could be delivered safely to people in their own homes.

Staffing and recruitment

- At the last inspection we found there had been a high turnover of staff. People not knowing who to expect to visit on their calls which had impacted on the continuity of care. At this inspection this had remained an issue for some people. For example, two people mentioned they had to teach all new staff what and how to do what was needed. One relative told us, "One [staff member] is good but the other is a trainee. I have to teach them how to do it (care)." One person we spoke with said, "I have to explain to new carers what to do."
- Staff we spoke with told us they were given enough time between calls. The provider would try to assign them routes that were close to their homes and one staff member told us, "We try really hard to be on time and usually we are but sometimes someone is ill and that can make us late but we always phone the office or the family to let them know." However, only one of the 13 people and relatives we spoke with said they received a call to let them know when staff were running late. We raised this with the care manager who told us they would hold supervisions and staff meetings to reiterate the importance of letting the office know if they were running late.
- The provider had recruitment processes in place. These included pre-employment checks and a Disclosure and Barring Service (DBS) check was also completed. A DBS provides information about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

- At the last inspection improvement was required to monitoring the administration of medicines. At this inspection there had been some improvement. The provider had introduced an electronic monitoring system that recorded the time medication was administered and the staff member supporting that person.
- However, the system was not always effective. Staff we spoke with shared their frustration when they were unable to add the information to the electronic record because there was a signal issue with their mobile telephones, or the system was not working properly. The care manager explained to us the reasons why the system did not always work and the measures they were taking to address this and assured us the information was captured on the daily notes. We checked the daily notes against 11 people and found this information was being recorded.
- On reviewing care records we found additional information for staff was required for people using paraffin based creams to mitigate the risk of burns and for people who needed oxygen. Protocols for staff were also required for people using 'as required' creams. We raised this with the provider who took immediate action and implemented the protocols immediately post inspection.
- Most people who staff supported with their prescribed medicines were happy with how this was managed. However, one relative told us they had to give the medication to their family member because calls were sometimes late. We found one person had not always received their medicines at a consistent time. For example, every four hours, which was due to some calls taking place at later times than scheduled. This included medicines for Parkinson's and pain relief. We checked the medication records and found the medication had been administered between a four and six hour window. We did not find that anyone had sustained harm. This was discussed with the care manager at the time of the inspection.
- Staff had completed medication training and their competencies assessed through supervisions and spot checks.

Systems and processes to safeguard people from the risk of abuse

- At the last inspection we identified the processes for reporting abuse were not robust. At this inspection there had been an improvement. Staff we spoke with were aware of their duty to report any concerns to the management team. Appropriate processes were in place to monitor and report any allegations of abuse.
- We had received concerns about late and missed calls. The care manager demonstrated to us how their monitoring system worked and while the current system did not immediately alert if a call was late or missed, it did allow for staff to monitor calls in real time.
- Most people and relatives we spoke with told us staff would arrive close to the correct time and stayed for the allotted time.
- People and relative's main concerns were the consistency of staff. One relative told us, "I have told them [the provider] keep the same carers but I get different carers. They change like the weather." An inconsistent approach means, at times, it places people's safety, health or well-being at potential risk of avoidable harm. We discussed at length with the care manager about the consistency of staff attending calls. We were told they tried very hard but it had become difficult during the past few weeks in particular with staff members reporting positive lateral flow tests (LFTs). LFT is an instant test which shows if a person has an infection or not.
- Most people and relatives we spoke with felt the service was safe. One relative told us, "I had three issues recently with them [staff]. The key safe is not managed properly and there is a risk of [person] being locked inside in case of fire or emergency." Another relative told us, "Yes I do think the service is safe. I've met the carers and they are friendly and interact with [person]. They are looked after very safely, washed and changed, no bed sores and they [staff] check back and feet regularly."

Preventing and controlling infection

- We had received concerns staff were not following safe infection control practices. Overall, we found staff

adhered to infection control practices. One staff member had been wearing their own clothes rather than their uniform and some staff had disposed of their used personal protective equipment (PPE) in people's own rubbish bins. We shared this information with the care manager and they told us they would discuss with the staff at supervision and team meetings the importance of wearing their uniforms and disposing of their PPE safely.

- The provider had infection control policies and procedures in place and staff had received training in how to prevent and control infection.
- PPE was available for staff to use.
- Staff carried out COVID-19 tests to help mitigate the spread of infection.
- People and relatives confirmed staff wore their PPE appropriately when delivering care.

Learning lessons when things go wrong

● At the last inspection we found processes in place to monitor and learn from incidents and accidents were not always robust. At this inspection we found there had been some improvement. We were shown how incidents had been investigated, what the outcome had been and the action taken. The records did not always show what had been put in place to mitigate reoccurrence or identify potential trends.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last comprehensive inspection in February 2019 when we last rated this key question good. At this inspection the rating has remained good. This meant people's outcomes were good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People and relatives told us they were involved in the initial assessments completed by the provider before starting to use the service. One relative told us, "The care plan has been reviewed and a re-assessment is being done. Sentricare will attend the meeting."
- Staff told us the care plans were in people's homes and on the provider's computerised system. We found staff we spoke with were knowledgeable about people's support needs and how to deliver their care.

Staff support: induction, training, skills and experience

- The care manager told us all staff completed a comprehensive training programme on an annual basis. We reviewed the programme and found it covered 64 on-line training modules. The staff we spoke with all told us they had completed the modules. One staff member shared they had received assistance from a family member. They told us, "[Relative] helped me and explained (the training)." However another staff member told us they would ask the care manager for assistance when they needed any guidance.
- The care manager explained how they checked staff were competent in their training. We saw evidence staff were assessed through spot checks, supervision and team meetings.
- Most of the people and relatives we spoke with were satisfied with the level of skill demonstrated by the staff. There were some issues with staff having to be shown by people and relatives how to use equipment or provide support, but once shown, they were satisfied with the care and how it was provided. One relative told us, "They [staff] are very careful of [person]. They [staff] know what they are doing. The carers use the hoist and are competent."
- Staff told us when they first started working at the service, they received a three day induction. This included shadowing other staff members and face to face training in the office. One staff member told us, "They [the provider] gave us all the training before we go out to people, so we get used to everything." Another staff member said, "I had training with [care manager], it is the most important thing for us (as carers) and the client."
- Spot checks and competency assessments were carried out to ensure staff were applying their skills and knowledge in the right way. The care manager completed care calls themselves and worked alongside staff to identify and share if there were any areas for development needed.

Supporting people to eat and drink enough to maintain a balanced diet

- Not all people we spoke with required support with meal preparation or assistance to eat. Where this support was offered generally people felt staff supported them well. Some people did tell us that some staff

needed further support. For example, not all the staff knew how to use a toaster. One person told us, "One day the toast was burned and the next day it wasn't cooked."

- People's dietary needs were considered and assessed. Staff knew how to support people with specific nutritional needs. For example, the amount of thickening agent put into fluids to make sure the person did not choke.
- Staff always ensured people had access to drinks and snacks before they left.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The provider and staff worked in partnership with people, their relatives and health and social care professionals.
- Staff knew what to do if they had concerns about a person's health or if there was a medical emergency.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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.

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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

- Staff we spoke with gave us examples of how they gained consent before supporting people with their care.
- People and relatives confirmed staff always sought consent before providing care and support.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last comprehensive inspection in February 2019 when we rated this key question good. At this inspection the rating has remained good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported by kind and caring staff. One person told us, "It is a very good service, the staff are lovely and I have no complaints."
- Staff spoke about people respectfully and shared examples of how they had got to know people and their individual preferences.
- The care manager told us they were confident people were supported by caring staff as this was discussed in reviews with people and their relatives.

Supporting people to express their views and be involved in making decisions about their care

- A member of the management team had regular discussions with people using the service and their relatives to make sure people were able to express their views and be involved with the support they received. One relative told us, "One or two of the managers will come to see [person] and chat to see if anything needs changing."
- People and relatives told us they were involved in planning their care.

Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us that privacy and dignity was promoted. Staff would ensure privacy when personal care support was given.
- Staff told us how they supported people to do as much for themselves as they were able to help them maintain some independence.
- Staff we spoke with understood peoples' support needs.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last comprehensive inspection in February 2019 we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider's information return (PIR) stated. 'Our service always starts new care packages with a care needs and risk assessment. Part of the reason for this is to identify protected and other characteristics under the Equality Act which makes it necessary to remove barriers.'
- However, on speaking with people and relatives we found this was not always the case and people had not been offered their care plans in an alternative format. For example, one relative told us, "[Person] cannot speak or read English. There was no discussion on having a care plan in Punjabi." Another relative told us, "[Person] has not been asked for feedback and no assessment was done of their communication needs due to their blindness so, [person] can't fill forms in." We did not find that anyone had sustained any harm.

Improving care quality in response to complaints or concerns

- The provider's PIR stated, 'We have a robust complaints procedure. The complaints that we have received are to do with carers running late for care calls.' We saw there was a complaints process in place, and we could see where complaints had been raised, they had been investigated and responded to. However, conversations we had with most people and their relatives highlighted there were still issues with staff running late for calls and not being notified.
- People and relatives told us they were able to raise complaints with the service but not everyone was confident the issues would be dealt with. One person told us, "I've given up phoning the office as no-one gets back to you."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The care plans we looked at were generic in places but contained some person-centred information about the person's life history. They were reviewed annually or as people's needs changed. Staff we spoke with told us any changes in people's care was communicated to them.
- Overall, people felt the care and support was responsive to their needs.
- Staff told us and we saw from care records they recognised when a person was unwell and required additional support.

End of life care and support

- There were no people requiring end of life support at the time of this inspection. However, the provider had completed end of life planning which included people's wishes in the event of them becoming unwell.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating remained requires improvement. This meant the service management and leadership was inconsistent.

At our last inspection the provider had failed to put in place robust processes to monitor the quality of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

While there had been some improvement on the issues identified from the last inspection, the provider's processes had not identified some of the new issues found at this inspection. Therefore, the service remains in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- At the last inspection audits and monitoring of the service had failed to identify notifiable incidents to CQC had not been submitted. We also found the provider had failed to act in response to accidents and incidents and implement risk assessments for specific medical conditions.
- There had been some improvement to care records and risk assessments to personalise them, but they still required more detail to ensure information was clear and up to date for staff to refer to. The provider's processes had not identified these shortfalls. This included; missing protocols for people using oxygen, paraffin based creams, 'as and when' creams and people at risk of epileptic seizures. The lack of an effective system in place to monitor and mitigate risk continued to place people at risk of harm.
- The provider's monitoring processes had not always identified people's preferred communication means and providing information in an accessible format. This meant people were at the potential risk of not receiving their care and support in a way that meet their needs.
- Monitoring of missed and late calls had improved through the use of electronic call recording system. However, feedback from people and relatives identified the issues remained around staff being late and people not being informed. The care manager was aware of the issue with late calls and was trying to address it.
- The provider's processes for reviewing staff knowledge against the completed training modules required some improvement. This was to ensure checks were in place to monitor staff completed the modules themselves and their level of understanding of the individual modules robustly assessed.

We found no evidence that people had been harmed however, systems and processes in place to assess and monitor the service were not consistently effective at driving and maintaining improvements. This was a continued breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had completed investigations into allegations of abuse and poor care and had implemented action plans to mitigate risk of reoccurrence.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People and their relatives told us they were involved in the care provided. However, there were some mixed views on whether they felt their views were listened to.
- People and relatives told us trying to contact the office was difficult and they did not always receive a call back when promised.
- People and relatives confirmed the provider sought feedback about the quality of the service through telephone calls and visits to people's homes.
- Staff told us they felt positive about the service and the management team encouraged communication and feedback. One staff member said, "Sentricare are a good employer they are co-operative with hours and they manage their time (rotas) if I need cover; they're very good at helping us [staff], I'm very happy here."
- The service worked closely with other health and social care professionals to ensure people received appropriate care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider was sending statutory notifications to CQC. Registered service providers and their registered managers are required to notify CQC about certain incidents, events and changes through statutory notifications.
- The provider displayed their current CQC rating in the service on their website.

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 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to assess and monitor the service were not consistently effective at driving and maintaining improvements. This was a continued breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have issued a Warning Notice to the provider with a timescale to improve their governance processes to ensure the service can monitor quality, safety and continue to make improvements to their service.