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Sensiway Care Services

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Sensiway Care Services is a domiciliary care service. It provides care for people living in their own houses and flats. People are supported in their own homes so that they can live as independently as possible. CQC regulates the personal care and support. There were two people who received personal care at the time of the inspection. 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

Care staff had not always had the required pre-employment checks completed when they had been appointed to work at Sensiway Care Services. There had not always been enough care staff to provide people's care as planned. Risks were not well managed, including for risks associated with infection and COVID-19. Systems to learn lessons when things go wrong were not robust.

Staff had not received adequate training to give them the skills and knowledge they needed to effectively manage and reduce risks from COVID-19. Not all staff listed on staff rotas were included on the provider's training matrix so we were not assured that all staff had received appropriate training. Staff supervision and appraisal meetings had not been recorded.

Systems and processes to assess, monitor and reduce risks and assess, monitor and improve the quality and safety of services were not effectively operated. Records were not always accurate, complete or contemporaneous. Business and management contingency planning was not effective.

Assessments of people's needs were available, however these had not always been reviewed regularly. Not all details of other professionals involved in people's care were included in their care plans. Evidence was not available to show how people, families, staff and other professionals had been asked for their views to improve the quality and safety of services.

Staffing shortages had impacted negatively on people and their families. A complaint that people had not always been treated well was under investigation by the provider. The complaints system did not always operate effectively.

Staff understood how to identify potential signs of abuse and knew what actions to take to help safeguard people. Staff understood people's dietary needs when they were involved in providing this care. People's preferences were known and respected. People were involved and able to make decisions over their care.

People's independence was promoted. People received personalised care and their communication needs were met. People were supported in ways to reduce the risk of social isolation. The provider had notified others when they were unable to provide the planned number of staff.

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

This service was registered with us on 10 June 2020 and this is the first inspection at this location. The service changed address and the last rating for the service under the previous address was requires improvement, published on 28 March 2020. The service has now been rated inadequate.

Why we inspected

This was a planned inspection based on the date of registration.

We have found evidence that the provider needs to make improvement. Please see the safe, effective, caring, 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 Sensiway Care Services 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 recruitment of staff, safe care and treatment and the management and governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this 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.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Sensiway Care Services

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 Care Act 2014.

Inspection team

This inspection was completed by one inspector.

Service and service type

Sensiway Care Service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing in Derby and Derbyshire. The provider is responsible for supervising day to day management of the service and there is no additional requirement to have a registered manager. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave the service two days' notice of the inspection. This was because the inspection was conducted during the COVID-19 pandemic and we wanted to speak with people, their relatives and care staff; we needed to be sure that the provider could make arrangements for us to access the office to support the inspection.

Inspection activity started on 6 July 2022 and ended on 14 July 2022. We visited the office location on 6 July 2022. Phone calls were made to people on 7 July 2022. We spoke with care staff on 8 and 11 July 2022. We continued to review evidence the provider sent us until 14 July 2022.

What we did before the inspection

We used information received about the service since the last inspection. We contacted local stakeholders to gather feedback on the care provided. This included the local authority commissioning team. The provider had completed a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they

plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We reviewed a range of records including the relevant sections of two people's care records and multiple medication records. We looked at three staff files in relation to recruitment. We reviewed other records related to the management of the service, including policies and audits.

We spoke with one person who used the service, four members of staff, including the provider, two care staff and one administrator.

What we did after the inspection

We continued to seek clarification from the provider to validate evidence found.

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- People had not always been protected and had been exposed to risk of potential harm. Required recruitment checks had not always been made on care staff working at the service. Disclosure and Barring (DBS) checks had not always been obtained by the provider. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions and this had not always been obtained by the provider.
- Gaps in staff members' employment history had not always been explored. References to help the provider understand how care staff performed in a previous role often contained identical and very similar wording. This led us to have concerns over the authenticity and originality of the references. These concerns had not been explored or risk assessed by the provider. People had been placed at risk of potential harm or exposed to potential harm as checks to help verify staff were suitable to work in the service had not been completed.

Recruitment practices did not promote safety as required checks were not completed. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There had not always been enough staff to meet people's needs. One person needed two care staff to provide their care. The day prior to our inspection, sufficient staff had not been available to provide two care staff to attend to this person's needs on all their required care calls. We made a safeguarding referral to the local authority, so they were aware. The provider gave notice to stop providing this person's care as they had insufficient staff to meet this person's care needs.
- The provider told us they had tried unsuccessfully to recruit to care staff vacancies. They told us they would continue to try and recruit care staff and only take on a limited number of new people. They told us they currently were not able to provide care where people required support from two members of care staff at a time.

How well are people protected by the prevention and control of infection?

- People had been exposed to the risk of harm from potential infection such as COVID-19. Care staff were not wearing face masks or testing for COVID-19 in line with the latest government guidance. This meant there was an increased risk people were being exposed to contracting and transmitting COVID-19.
- Infection risk assessments were not in place. This meant there was no guidance for staff to follow on how to reduce the risks of infection, including from COVID-19. People had been placed at risk of harm as staff did not take steps to reduce the risks of infection transmission.

- We were not assured that the provider's infection prevention and control policy was effective. The provider failed to ensure relevant information on the risks around COVID-19 and other infections were available to staff. This meant staff did not know what safe practice was and people were exposed to the risk of harm from COVID-19 and other infections.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Risk assessments had not been kept under review. This meant staff did not have current information on how to identify, monitor or manage people's health conditions and needs. For example, the risk assessment for one person at risk of falls had last been updated in 2021. This person was at risk of unexpected collapse. There were no details as to how staff should safely manage this if it occurred whilst the person was walking. There was no review of whether the person's mobility aid continued to be suitable or if alternative equipment offered more protection. This meant the person may have been exposed to the unnecessary risk of harm.
- Risks were not always assessed and well managed. One person's care plan stated at certain times they were more at risk of choking. There was limited guidance available to staff around what to do to safely support the person, for example there was no risk assessment. This meant the person was exposed to the unnecessary risk of harm.
- Another person's care plan stated plastic aprons were not to be used. We asked the provider about this and they told us staff were now wearing plastic aprons. Their care plan had not been updated to reflect this. People were at risk of inconsistent care as care plans and risk assessments were not always up to date. This placed people at risk of harm.

Using medicines safely

- Medicines administration record (MAR) charts were not available. Care staff aided one person to help them manage their medicines and applied their skin creams. Recent MAR charts were not available for us to check medicines had been given as prescribed. Older MAR charts had not always been filled in to say medicines had been offered. The provider told us care staff would not fill this in if the medicine was not needed. This meant people were at risk of not having their medicines as prescribed.
- Care staff told us when they aided people with their skin creams, they did not always record this on the MAR chart. One person's care plan stated where a person required a skin cream. Care staff we spoke with told us they did not apply the skin cream on this area and the person did not require it. People were at risk of not receiving the medicines care they needed.

The provider had failed to ensure risks to people's health and safety had been assessed and done all that is practical to mitigate those risks. The provider had failed to ensure the proper and safe management of medicines. The provider had failed to assess and mitigate the risk of infection. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and process to safeguard people from the risk of abuse: learning lessons when things go wrong.

- Records did not provide enough detail to help identify learning when things went wrong. For example, we reviewed daily records for a person whose behaviour could cause harm to themselves or others. There was not enough detail to analyse what had occurred and why, to enable lessons to be learnt.
- People told us they felt safe. Staff told us they had been trained in safeguarding and understood how to identify signs of potential abuse and how to report these.
- Safeguarding policies were in place. These provided guidance on how to raise concerns to help keep people safe.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Care staff had not been trained to have the skills and experience to reduce risks from COVID-19. The provider told us staff had not had training in COVID-19 other than being sent a booklet on it.
- We asked to see what training staff employed at the service had completed. We were not assured the provider sent details for all staff employed, as some care staff names appeared on recent staff rotas but we were not sent their training details. We were therefore not assured all staff had been provided with sufficient training and skills to meet people's needs.
- The provider sent us a completed competency assessment for one staff member. Competency assessments were not recorded on the staff training matrix and so we were not assured they were in place for all staff.
- We asked the provider what appraisal and supervision meetings were held with staff. The provider told us they asked if staff were okay when they worked with them and also, they said, "I'm tight of time so sometimes it's over the phone." They told us supervision meetings were not written down. Supervision provides staff members with the opportunity to reflect and learn from their practice, receive personal support and professional development. We were not assured staff received support and development to have the training and skills to meet people's needs, as appraisal and supervision records were not available.

Staff did not have the competence and skills to provide care safely. Staff had not received appropriate training, supervision and appraisal to carry out the duties they were employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Assessments of people's risks and care needs were not always reviewed regularly.
- One person was at risk of strokes. However, their care plan lacked details on how this was managed and what actions staff should take.

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

- There was limited information on the involvement of other healthcare professionals involved in people's care. For example, advice from speech and language professionals was included for one person, but there were no details of other professionals involved in helping to manage people's other health care needs. For example, regarding the risk of strokes and falls. The provider told us care plans were under review and this information was available.

- Despite limited information in people's care plans on other healthcare professionals involved in their care, care staff told us people did receive healthcare support from other professionals. For example, care staff knew when a person had last seen their consultant and told us nurses came in to check on them. People accessed healthcare support however, this was not reflected in their care plans.

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

- Where people received care with their nutrition, they told us this worked well. One person told us, "[Care staff] do understand what I can and can't eat." Care plans detailed any dietary preferences people had.
- Care plans referenced advice given from speech and language professionals and dietitians. This helped staff support people's nutritional needs effectively.

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

- Where people were assessed as lacking capacity to understand and make their own decisions, these were considered for them in line with the Mental Capacity Act. This meant decisions were taken in their best interests and involved any appropriate representatives.
- Where people had capacity to understand their care their choices were respected. One person told us their choices were respected.

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- Whilst people we spoke with told us staff treated them well, a complaint that staff had not always treated people well had been received by the service and was being investigated.
- Staffing issues had impacted on one person and their family and this meant people had not always been well treated and supported.
- People's care plans reflected their preferences to receive care from female or male care staff. People's emotional well-being was considered in care plans and care staff provided reassurance if people were anxious.
- Care staff spoke warmly of the people they supported, and they knew people's preferences. For example, they used a person's preferred name.

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

- People we spoke with told us they had not seen their care plan. Care plans had people's names typed as a signature; however, these were not verified to explain the care plan had been discussed with the person and dated. The provider told us care plans were always discussed with people and their families and they were given a copy.
- People we spoke with told us their views were respected and they were involved and able to make decisions over their care.

Respecting and promoting people's privacy, dignity and independence

- One person told us, "I try to be as independent as I can, [staff] are there if I need them." Care plans included what people were able to do themselves to help promote their independence.
- Care staff understood how to promote people's privacy and dignity. Care staff told us how they made sure they had towels ready to help cover people when they gave personal care, and that doors were kept closed.

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- On our inspection we were told a family member had raised recent concerns. The covering staff member told us the person had not put their complaint in writing and they had not made a record of the family member's verbal complaint for us to be able to review.
- Following our inspection, the provider sent through a report of the concern and a plan of what actions they had taken or were still to take. It stated the family member had not, 'Filed the appropriate paperwork for complaints procedure and the complaint had only been registered by the telephone.' We were concerned that the provider's report contained these comments as requiring a complaint to be in writing is unnecessary for complaints management and handling.
- The provider told us they had not received any complaints prior to the above concern. Complaints were not entered into any 'complaints file or log' with timescales identified for response times. There was no system to record concerns and complaints and monitor them to ensure the provider's complaints policy was followed and effectively operating. The provider told us complaints were entered into communication books in people's homes.

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

- Staff told us how they supported people's choices. For example, care staff knew what times people usually liked to get up and go to bed, and what they liked to drink before bedtime.
- People's care plans reflected their personal choices and daily routines. This helped people receive care in line with their choices.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care plans identified if people required any communication aids, such as glasses and hearing aids.
- Information had been provided to people so they could understand about the AIS in the service user guide. This helped ensure people knew they could receive information in alternative formats to aid their understanding.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People told us staff spent time talking with them. Care staff told us they enjoyed spending time with

people. One care staff told us about the person they cared for, they said, "We have so many things to talk about and laugh about."

- Care staff told us what people's favourite past-times were and at what time of day they liked to do things. Care staff told us they would enjoy sharing conversation about people's favourite television programmes. People's care plans reflected people's involvement with their families, for example when they usually spoke over the telephone. These actions helped people to avoid social isolation.

End of life care and support

- No-one required any end of life care at the time of the inspection. The staff training matrix recorded staff had been trained in this area of care should it be required.

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There were significant shortfalls in how the service was managed. The provider had not effectively understood and ensured implementation of government guidance on wearing face masks in people's homes and COVID-19 testing. The provider had failed to establish effective processes for the oversight and management of the quality and safety of the service. This put people at risk of harm from COVID-19.
- The provider had not effectively operated recruitment processes so all the required checks to verify staff were suitable to work at the service had been completed. The provider had not always ensured there were sufficient staff available to deliver care as planned. This placed people at risk due to poor recruitment practices and lack of staff contingency plans.
- Resources to run the service in the provider's absence were not available. The provider had not ensured there was an effective contingency plan in place for when they were absent. The provider was unable to provide us with the records we required on inspection as they had not given the covering member of staff permission to access electronic and written records. The covering staff member had not been trained in safeguarding or how to provide care. There was no clearly defined role that provided cover for the provider in their absence.
- The provider had no business contingency plan in place to deal with such matters as IT failures or staff absence. There was no effective system in place to ensure the service operated effectively in the event of foreseeable adverse events.
- The provider had not operated an effective system to ensure people's care records, including those for their medicines administration were accurate, complete and contemporaneous. There were significant shortfalls in the management of the service as policies and procedures were not being followed.
- Staff were not adequately supervised. The provider had not followed their own 'governance processes.' This stated, 'Sensiway Care Services have practice-based supervision discussions with home care workers at least every three months.' There was no evidence care staff had supervision every three months. This meant staff development was not recorded and tracked. This placed people at risk of harm as staff were not supervised and appraised appropriately.
- The provider's systems and processes to assess, monitor, improve safety and quality and reduce risks were not effective. Audits designed to check on the quality and safety of services had not identified the shortfalls identified in this report.

Systems and processes were not effective at identifying and reducing risk and assessing, monitoring and improving the service. Records were not accurate, complete and contemporaneous. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

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

- People told us they would speak to the provider if they wanted to give any feedback. They told us the provider visited them occasionally and they would also speak with care staff. The provider told us they gave out feedback forms to people and their relatives but had not had any returned for the people receiving care at the time of our inspection. However, there were no records of any verbal feedback given by people to show the provider had used people's views to review and improve the service.
- Staff told us they saw the provider regularly and felt able to give feedback and told us they felt listened to and involved. However, there were no records of staff meetings, supervisions or appraisals to show how staff views were collected, reviewed and used to improve the service.

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; Working in partnership with others

- The provider had responded to the local authority when they requested information on when they were unable to provide staff as planned. People's family members were identified in people's care plans when they were involved in people's care. However, not all details of other health and social care professionals involved in people's care were included in their care plan. Therefore, there was limited information to show how the service worked in partnership with others.
- The provider had a policy in place for the duty of candour. One complaint had not been fully concluded at the time of this inspection. The provider had notified commissioners when they were not able to provide the required number of staff to provide a person's planned care.

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 18 HSCA RA Regulations 2014 Staffing Staff had not the competence to provide safe care. (1) Staff had not received appropriate training, supervision and appraisal as necessary to carry out the duties they were employed to perform. (2)(a)

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Not all steps were taken to assess and reduce risks, including those for infection and medicines. Medicines were not managed safely. Infection prevention and control measures were not operated effectively. Staff did not have the competence to provide care safely. (a)(b)(c)(g)(h)</p>

The enforcement action we took:

We issued a warning notice against the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems and processes were not operated effectively to assess, monitor, reduce risk and improve the quality and safety of services. Records were not always accessible, complete, contemporaneous, and accurate. (a)(b)(c)(d)</p>

The enforcement action we took:

We issued a warning notice against the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>Recruitment procedures were not established and operated effectively to ensure person's employed met the conditions and required recruitment checks. (2)</p>

The enforcement action we took:

We issued a warning notice against the provider.