Sevacare (UK) Limited

Sevacare - Tower Hamlets

Inspection report

Room 103, Bow Business Centre
153-159 Bow Road
London
E3 2SE

Date of inspection visit:
12 April 2016
14 April 2016

Date of publication:
31 August 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 12 and 14 April 2016 as a result of concerning information we received about the service. At our last inspection in November 2015, we found a number of breaches of regulations in relation to safe care and treatment, person centred care, consent and good governance. The provider sent us an action plan stating what improvements they were going to make. During this inspection we found that the provider had not made adequate improvements in relation to consent, safe care and treatment and good governance. At the time of our inspection Sevacare Tower Hamlets was providing care to 348 people in their own homes in the London boroughs of Tower Hamlets and Haringey.

The service had a registered manager. 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.

We found that the provider had made improvements in their auditing processes since they were last inspected, however these had not been sufficient to pick up errors in care plans which did not always reflect the support that people actually received. We found that risk assessments did not adequately assess and manage the risks to people from ongoing health conditions and did not protect people from avoidable harm. There had been improvements in how medicines were managed, however we found that medicines given "as required" were not always appropriately recorded on medicines administration records and care plans. In some cases care plans did not document the support people received with their medicines appropriately.

There had been an improvement in the punctuality of visits, however lateness was still identified as a significant problem by many people who used the service and their relatives. Contributing to this was that rotas did not allow sufficient travel time between visits, and one of the teams did not have sufficient numbers of staff to provide the care that was required. In some instances, timesheets documented care that had not been provided.

The provider was not always following their own policies to ensure that safer recruitment processes were in place, and this may have posed a risk to people who used the service. Staff were checked and assessed for the quality of the care provided, however additional checks were not always carried out in response to concerns about staff members. Complaints were not always recorded and investigated appropriately in line with the provider's policies, and people told us that concerns reported to the office were not always responded to.

Although measures were in place to ensure that staff had the training they needed, we saw induction and shadowing of new staff was not fully completed. There was insufficient assessment of the competency of new staff to provide care effectively.

The provider was not meeting their responsibilities to assess the capacity of people to consent to their care plans and demonstrate that they were working in line with people's best interests, and managers did not always understand their responsibilities under the Mental Capacity Act 2005.

Most people we spoke with were happy with their care staff, and said that staff were kind and professional and respected their dignity and privacy. We saw that staff were reporting when they were concerned about people's welfare and that appropriate steps were taken in these cases. People were asked their views on the quality of their care, and care packages were reviewed regularly.

We found breaches of Regulations with regards to consent, safe care and treatment, complaints, safer recruitment, staffing, good governance and display of ratings. You can see some of the action we told the provider to take at the back of the full version of this report. We are considering what further action we are going to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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?

Inadequate

The service was not safe.

The provider did not carry out adequate risk assessments to manage the risks from people's health conditions. This meant that some people were at risk of avoidable harm.

Safer recruitment processes were not carried out and discrepancies identified in recruitment were not adequately explored to ensure that staff were suitable to work with people using the service. There were not enough staff to safely meet people's needs.

Despite improvements, safe procedures were not in place for managing people's medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Although measures were in place to ensure that staff had the training they needed, we saw induction and shadowing of new staff was not fully completed. There was insufficient assessment of the competency of new staff to provide care effectively.

The provider was not assessing people's mental capacity to consent to their care and treatment and, where appropriate, could not demonstrate that they were working in line with people's best interests and protecting people's rights.

We saw that staff worked with health professionals to meet people's needs and address changes in people's health.

Is the service caring?

Good

The service was caring.

People praised care staff as kind and caring. We saw that the provider regularly sought people's views on their care.

Staff demonstrated a good understanding of the importance of treating people with dignity, and people who used the service told us that staff spoke with them and treated them with respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People's care was regularly reviewed. However, care plans did not accurately reflect the care that people actually received, meaning that staff did not have access to up to date information on people's needs. Visits were regularly later than those on the care plan.

Complaints were not always recorded and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

Audits were completed, however these had failed to identify significant shortfalls in the service. The provider did not allow adequate travel time for staff between visits, resulting in late visits.

The service provided assessments of staff competency and undertook spot checks of staff. However, additional checks were not always put in place in response to concerns about individual staff.

Despite being registered as one location, the service still operated as two branches, with insufficient oversight from the Registered Manager.

Sevacare - Tower Hamlets

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 14 April 2016 and was unannounced on the first day. On subsequent days the provider knew that we would be visiting the service.

The inspection was carried out by five inspectors, a pharmacist inspector and three experts by experience, who made telephone calls to people who used the service and their relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to carrying out this inspection we reviewed information we held regarding the provider. This included notifications of events the provider is required to inform us of and the findings of recent inspections. In carrying out this inspection we looked at the care records of 21 people and other information relating to the delivery of their care, such as rotas. We spoke with 51 people who used the service or their relatives, including home visits to six people and their families. We offered to meet more people in their homes, however people told us that they had received visits from the Provider and local authority and did not wish to be visited further. We spoke with 19 staff and reviewed the staff and supervision files of 10 people.

Inadequate

Is the service safe?

Our findings

Most people we spoke with told us that they felt safe using the service. One person told us, "It's OK, I feel quite safe with them" and another said "I feel safe enough". However, a small number of people's relatives told us they had had concerns about their family member's safety. One relative told us, "I'm not going to say that they abuse [my family member] but the care quality is definitely not there."

At our previous inspection in November 2015, we found that documents could not evidence that risks to people were adequately assessed in order that they received a service that was appropriate and safe to meet their needs. At this inspection we found that the provider had not taken appropriate action to address our concerns. Risk assessments were in place and covered areas such as speech, hearing, skin integrity, issues with mobility and diagnosed medical conditions. We saw that the provider had procedures in place for ensuring that these were updated and reviewed regularly. However, we saw that risk assessments did not give adequate information on how people may be affected by their medical conditions. For example, for several people we saw that 'dementia' was stated as a possible risk, with no further information on the type and impact of the person's dementia and if there were risks associated with this. Where people were identified as being at risk of falls, there was limited information on how these were prevented. A relative of one person who used the service informed us their family member had equipment to prevent falls, but this was not mentioned on the risk assessment.

In another case, we saw that a person had diabetes, but this was not documented in the section which covered nutritional needs. The risk assessment did not document the need for regular care visits to ensure the person ate regularly, even though they could be at risk of hypoglycaemia if they did not do so. Although the person needed support from staff to prepare meals, some of their recent visits were as close together as two hours or as far apart as five. This put the person at risk of...

Risk assessments did not always have reasonable measures in place to manage risks to people. Where a person had diabetes, the risk management plan was for staff to be food hygiene trained, with no recognition of the need for regular visits to help prevent the risk of hypoglycaemia or for staff to have training on diabetes and healthy eating. Therefore we could not be assured that staff were provided with accurate, up to date information that protected people from avoidable harm.

The above issues constituted a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had detailed procedures in place to ensure that staff were suitable for their roles. For example, staff were required to give a detailed work history, two referees, provide identification and undertake a Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions. Records showed that the provider had carried out DBS checks on all active staff. However, we saw that the provider was failing to follow their procedures correctly. For example, when prospective staff had information on the DBS disclosure a risk assessment was undertaken to decide whether to employ the person which was signed off by the regional director. However,

these recorded decisions were not made before these staff members provided care to people in order to ensure that adequate measures were taken to protect people who were using the service. One staff member had convictions for theft and managers were unable to verify or demonstrate that the convictions had been discussed with the care worker as part of the recruitment process to ensure that they did not pose a risk to the people they would be supporting.

We also found discrepancies in recruitment records. For example, one staff member had a four year gap in their employment history, and another staff member had only one recent employment declared with no dates, neither of which was documented as adequately explored by the provider to ensure that these staff were suitable to work with people using the service. Another staff member's birth certificate had been altered which was not detected by the recruitment team, although their other forms of identification were valid.

These failures to follow safer recruitment processes constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the Tower Hamlets care staff team had adequate levels of staffing to meet people's needs. However, by comparing numbers of staff to people's care plans, we found that the Haringey care staff team had a weekly shortfall equivalent to nearly 30 full time staff, representing a fifth of the total support provided, which may put people at risk due to late or short visits. Most people we spoke with had concerns about the lateness of visits from this team. One person told us, "There is not enough time to prepare a meal and they do not make sure I have enough to eat and drink they are rushing around so much." This constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in November 2015 we found the provider had failed to ensure the proper and safe management of medicines. At this inspection we found that the provider had made changes to how medicines were managed. For example, Medicines Record Charts (MRC) were now legible and typed for staff to complete and we were told that these were checked by the branch managers before being used, although this check was not documented. The provider told us that they now had a full time member of staff responsible for auditing some support logs and all medicines charts. There was evidence that when issues were noted during these audits, this was raised with care staff and appropriate action taken.

However, we noted issues with some of the MRC we looked at. Medicines or instructions on these were not accurate, which meant that the checking process was still not thorough enough. There was no written procedure for the creation and checking of MRC. Inaccurate medicines records place people at risk of not receiving their medicines correctly. We found care staff had recorded that a once weekly medicine had been administered on four consecutive days. Although three of these signatures had been crossed off, there was no explanation recorded for this. We were unable to verify whether an overdose had taken place. Some MRC did not contain supplementary information about how medicines should be taken, e.g. before or after food. The branch managers told us that this supplementary information was printed on the medicines labels, so care staff would know when to give these medicines.

There were inconsistencies between MRC charts and care records regarding medicines given as needed (PRN medicines). Daily communication logs or risk assessments for four people mentioned inhalers, creams and pain-relieving medicines, but these medicines were not listed on their MRC charts so it was not clear what involvement care staff had with these medicines. In one instance, a person's care plan stated that they were to be prompted with their medicine four times daily; however their medicine was prescribed only to be given daily. This put the person at risk of an overdose.

We saw that three people's MRC charts had been re-written, and that these charts had been the ones audited. The provider told us that these had been re-written by staff as a training exercise after discrepancies were identified, however this was not documented, and re-writing an original care record is poor practice.

A manager told us that care staff working in the Haringey team within the service were only allowed to administer or prompt medicines which had been supplied in a medicines dosing system (MDS). We were told that this instruction had come from the local authority. We saw that this instruction had caused potential issues for two people. A family member was adding one medicine to a pharmacy dispensed MDS, which care workers were then administering from the MDS to the person. This is unsafe practice. Another medicine had not been administered to a person as the pharmacy had been asked to provide a new MDS with the additional antibiotic, and the MDS then supplied was not used. We visited a family who told us that their relative had not received their antibiotics for this reason. Staff had instead supported the person to take a newly-prescribed cough syrup, although there was no documentation of that on the MAR and hence no confirmation of consistent support.

The above issues constitute a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding policy in place, and all staff had up to date training on safeguarding adults. Staff we spoke with were able to accurately describe the signs that abuse may be taking place, and told us they would report this to the office. However, the provider did not have a local safeguarding policy which outlined the reporting procedure to the relevant local authority when safeguarding alerts were raised. Most staff told us they felt confident raising concerns with the office when they thought somebody's safety or wellbeing was at risk. The provider had a whistleblowing procedure in place should staff find their concerns were not being acted on appropriately by managers, however most staff were not aware of how to do this. We saw that the provider had procedures in place to document when staff had handled money on behalf of people to minimise the risk of loss and abuse, and staff we spoke with understood these procedures. The provider had a procedure in place for staff to follow in the event they were unable to access a person's home. Staff we spoke with understood this procedure well, and we found no evidence that visits to people were missed.

Requires Improvement

Is the service effective?

Our findings

Most people we spoke with told us that staff appeared well trained; one person said "They just get on and do it and know what they have to do", and a relative told us "They are very good, well-trained." Staff undertook regular mandatory training in areas such as safeguarding adults, infection control, catheter care, personal care and safe moving and handling so that they had the skills and knowledge to support people effectively. We saw that the provider maintained a record of training provided, and that when people's training was not in date, they were not able to undertake care without undergoing refresher training. Staff told us they felt they had sufficient training to undertake their roles.

We saw that the induction process included a section on the care of people who have diabetes, including symptoms of concern, guidance on healthier eating and noting that visits are time critical. Staff told us they felt confident meeting the needs of people with diabetes, which was covered as part of the induction process. Most staff we spoke with told us they had received training in meeting people's nutritional needs.

We saw that all staff undertook a three-day induction before starting work, however there were no induction records on file for the three staff we checked, which the provider told us were probably at head office. There was no evidence of staff completing the national Care Certificate programme which was advised as compulsory in the staff handbook. There were no records to demonstrate that two new staff had undertaken shadowing shifts as part of their induction, and this information was incomplete for a third person. The provider had failed to assess new staff member's competency in providing care to people and had failed to carry out spot checks on three out of four new staff, despite office staff telling us that this should take place within two to four weeks. None of the three new staff we saw had a company identity card confirmed on file. A fourth did but only after three spot checks where they were found not to have one.

This showed that the provider had failed to take reasonable precautions to ensure that new staff were adequately supported to carry out their duties. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that staff always asked their permission before supporting them, and care plans were routinely signed by people to indicate that they consented to their care. However, the provider was not meeting its responsibilities to work in line with the Mental Capacity Act (2005). The Act 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.

At our previous inspection in November 2015, we found that the provider's practice was not in keeping with the legal principles and requirements of the MCA, thereby failing to ensure people's rights were protected. The provider told us that managers would receive training on the MCA and then provide training for team leaders. We saw that managers had recently had training on the MCA, and had drafted a short document on the key principals of the Act for staff. However, of the care files we looked at, none had any information on

whether the person had the capacity to consent to their care and treatment. A manager told us "We can't assess mental capacity, that's for the social worker or GP." However, the provider must assess capacity when there is some reason to doubt that the person has capacity to make a specific decision. Staff must also do 'everything practicable' to enable people to make a decision for themselves.

Following the previous inspection, the provider told us that staff would no longer assume that a person did not have capacity to sign due to a condition such as dementia. However, we found that staff had documented that people were unable to sign consent for their proposed care plan, with the reason often documented as 'dementia' without any attempt to assess the person's mental capacity. We saw that if a person was unable to sign, the provider had asked a relative to sign as a 'best interests representative' even though there was no evidence that the relative had a Lasting Power of Attorney. In one instance, a care plan had been emailed to a relative to ask if it was correct without assessing the person's capacity to be able to do this themselves or following a best interests process. A relative of another person told us that it was doubtful their family member could consent to their care, but senior staff had not undertaken a capacity assessment of this, and the relative had not been invited to the person's review. Therefore there was no evidence that the provider was working in the person's best interests and ensuring that their rights were protected.

In another instance, a person was recorded as unable to communicate and was confined to bed with bed rails in place. The provider had not undertaken a capacity assessment with regards to the person's ability to consent to the care plan or to the use of bed rails.
The above issues constituted a continuing breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management team told us that the company was revising its policies and procedures to comply with MCA principles.

The majority of people we spoke with were happy with the care staff who assisted them at mealtimes. One person said "I am independent and like to remain that way. The carers always ask me if I would like a drink or if I would like to prepare the drink myself, they always give me a choice." Care plans included details of people's food preferences such as hot meals being delivered to the person's home or indicated where the family assisted with the meals. However, two people we spoke with said that staff often arrived late, which meant they did not always have their meals prepared.

Care records demonstrated that there was involvement with healthcare professionals. For example, one person had involvement with the community stroke team and a speech and language therapist (SALT) visited the person as part of their rehabilitation. One person's assessment showed that they had difficulty swallowing, and that a SALT assessment needed to be undertaken. Staff we spoke with told us that if they noticed a change in a person's health condition or if they were concerned about their eating and drinking they would report this to the office. We saw examples on care notes of concerns being reported and followed up appropriately, such as health concerns being reported to the GP or District Nurses.

Good

Is the service caring?

Our findings

People we spoke with were positive about their regular staff. One person told us "She looks after me like I'm her own grandmother." Another person said "My carer is just brilliant, really good."

The branch manager gave us examples of caring approaches by staff. The branch manager told us that they would be visiting a person for a review whose first language was not English. They were therefore making sure a staff member who could speak that language would be present. This helped ensure that the person was enabled to express their views.

The provider had measures in place to ensure consistency of staffing. This took the form of analysing how much each person had the same staff assigned automatically each week, and was measured across all branches. Managers told us that they were among the best performing branches nationwide for consistency. "This means all of our service users are getting a regular care worker in which they build a good rapport and makes for a happier work force who have their regular service users." Most templates of a person's standard week were filled out with a small number of staff, which automatically assigned these staff each week if they were available to work. People told us that they tended to get the same care staff regularly. One person said "Now we are settled with a regular team we have no problems at all." One person added, "Not all the others are as good, I suppose they don't know me and know what to say to me."

People we spoke with described care staff as kind and polite. One person said "They are usually very nice, have a bit of a chat and treat you properly." A relative said "She chats to her really nicely."

There were personalised descriptions for some people of the support provided, for example tools described people's interests and hobbies such as reading, and another care plan described how the person liked to spend time with their family and loved music. We saw two care plans which provided a description of the person's sense of humour, this supported staff to build positive relationships with people. However, we found that the majority of care plans lacked this information. A manager told us "We have a compassionate and caring team who really know their service users and relatives' wishes."

We saw that most people were routinely asked for their views on the service. As part of the twice-yearly review, people were asked which care workers they liked and who they didn't like as much, and what was and wasn't working about their care. We saw that people's answers to these questions were noted, and in some instances the care workers were changed as a result or people were asked if they were happy with particular care workers if other changes were made. A relative told us "Six or nine months ago two people did turn up at my [family member's] to ask her opinion; she did tell them a lot of the stuff she was not happy with."

We observed kind and friendly interactions between people and care staff. Staff told us that they treated people with dignity and respect and always knocked on the door before entering the home or called the person's name to let them know they had entered the home. Staff talked of the importance of explaining what they were doing and providing people with the opportunity to carry out tasks like washing by

themselves. All care staff we spoke with explained how they ensured people's dignity was respected, for example by closing doors and drawing blinds whilst carrying out personal care. All but one of the relatives we spoke with said their family member was treated with respect. One person said "They talk nicely and treat me with respect, I couldn't do their job."

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not always match the care that they required or received which put them at risk of their individual needs not being met. For example, a person's care plan stated that they were to be supported to change into day clothes in the morning and night clothes in the evening. Support logs did not show that this was taking place. One care plan was dated February 2015 and full details of the visit times were not documented. The manager printed out the current care plan and told us that this had been updated on the person's file. However, on visiting the person's home we found that this plan was not available for staff there either. For another person we saw that care staff were prompting a person to take their medicines and assist the person with personal care and toileting, however this was not listed on the care plan. This meant that the care staff who visited would not have the correct information in place to provide support appropriate to people's needs.

We found inaccuracies in people's call times and care logs. For example, one person's care plan stated that they were to receive support for 45 minutes from two staff, however on six occasions they had left the person's home after 30 minutes. We found timesheets signed by the person stated that staff had stayed for the full time. The manager showed us a telephone questionnaire that stated this person will at times ask staff to leave early. However, there was no information that the local authority had been informed of this, or that the care package had been reviewed.

A large number of people we spoke with told us that staff were often late, and at times this could cause them problems. One person said "They're with me 8-9 and [another person] 9-10, that can't happen unless they have wings." Another person told us that they were not getting their morning visits in good time, with care workers arriving up to 90 minutes late, which caused the person difficulties in attending regular appointments. We saw a care plan for a person who needed regular support with meals due to diabetes, however their regular visit time was scheduled on the rota system for over an hour earlier than that stated on the care plan. One person said "My care plan has gone out of the window. It has been altered but I was not informed about this."

Care plans had records of a person's medical history, but did not always contain personal information about the person and did not always describe people's likes, dislikes and interests.

Therefore people did not always receive safe care as they care was not always provided at the times that they required it. These issues represented a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had measures in place to ensure that people's care was regularly reviewed. Reviews were carried out twice-yearly where people's views were sought on the service they received and whether changes were needed. In most, but not all cases, changes were made as a result of these reviews. Forms for carrying out people's reviews contained a space for the person's goals and wishes, however we found that these were usually left blank.

We saw that the provider had a complaints policy in place, and indicated that complaints would be responded to within 28 working days. Managers had undertaken training in managing complaints. Of the four complaints recorded since the last inspection, we saw that the appropriate actions had been taken within the timescales. The guide for people who used the service contained information on how to make a complaint. People we spoke with said that they knew who to contact if they had a complaint. However, we noted that the provider's website did not contain information on who to contact in the event of a complaint.

When people had complained about the service, most people said that the provider had responded appropriately to their complaint. However, four people we spoke with were not satisfied with the provider's response to their concerns. One person said "If you ring up the office they don't do much." One person said "I haven't complained about the late arrivals, I don't want to cause the carers any trouble as it's not their fault."

We found that on two occasions people had reported concerns to the office, however these had not been recorded as complaints. One relative complained that staff were not able to access spare keys to their family member's flat in an emergency. The relative told us that they had complained to the on-call team, however this was not logged as a complaint. On another occasion a person had complained about the lateness of a staff member, and had asked that this person not work with their family member any more. This had been agreed by the provider, and subsequently the person's relative had provided more positive feedback about the service they received. However, this was also not logged as a complaint, even though the provider's policy states that 'A complaint is defined as any expression of dissatisfaction whether or not identified as a complaint by the person expressing dissatisfaction.' The provider was unable to demonstrate that all complaints were recorded and addressed to the complainant's satisfaction.

This constituted a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The provider had taken steps to improve the quality of audits. However, these audits were not effective as they had not identified significant shortfalls that we identified during this inspection that put people at risk of potential harm.

The provider's policy stated that staff were due to receive supervision twice yearly, and the provider kept a detailed audit of the frequency of supervision. Supervisions covered work schedules, training completed, incidents, issues around people's care and working difficulties. More than three-quarters of staff had supervision in line with this policy. Care staff assessments were due to be carried out annually, assessing staff for competency in areas such as moving and handling, supporting people with toileting, preparation of food and, medicines and how respectful the staff member was. This was audited by staff at the branches, who were carrying out these assessments in a timely manner in most cases.

Spot checks were also carried out annually on staff in people's homes, in order to check that staff were providing appropriate care. Branch audits showed that the provider was carrying this out in most cases. However, where concerns had been noted against staff, spot checks were not being carried out in a timely manner, which meant that some issues were not detected. For example, a staff member had received a warning last year for failing to record two visits. No spot check had taken place since this time, and subsequently further concerns were noted against this staff member. There had been concerns about another staff member failing to complete records appropriately in February. No further spot checks had been carried out on this person, who was later investigated on another matter. Carrying out appropriate checks may have detected some of these issues at an earlier stage. In another situation, an internal investigation was carried out into recent allegations of poor care. We noted a significant inaccuracy when compared to a disciplinary investigation on one staff member's file. The internal report investigated an allegation about a late care visit and concluded that this was not as severe as alleged. However, other records demonstrated that managers had investigated the wrong care visit date. If the investigation had been carried out correctly it would have found that the allegation was as severe as described.

We found that the provider had systems for governance in place. Audits were carried out of staff, care files and of the overall performance of the branch as measured against other branches managed by the same provider. These audits had identified some problems, but overall had rated the provider as among the best performing of their branches. However, we found that governance systems had failed to address shortcomings which compromised the quality of the care people received, with regards to capacity and consent, risk management, safer recruitment and the support of staff.

The staff team, including the branch manager of the Haringey branch had joined the Tower Hamlets branch in October 2015, and were now operating together under the registration of 'Sevacare - Tower Hamlets'. This meant a single registered manager, the manager of the Tower Hamlets branch, was responsible for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, as with our inspection in November 2015, the registered manager told us that he had no involvement with the management and oversight of the Haringey team and did not appreciate that he was

accountable for the service as a whole as Registered Manager for the Tower Hamlets location. Care for people who lived in the London Borough of Haringey was managed by the Haringey branch manager. These issues represented a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Just under half of people we spoke with in the Tower Hamlets branch identified staff lateness as a significant problem. Many staff told us that they did not have sufficient time to travel between visits. We looked at rotas for staff who provided care in the London borough of Tower Hamlets. Nine out of these 11 rotas were not realistic for staff to follow. A fifth of visits from these rotas were back to back, where no travel time had been allowed between visits. Out of these, more than half the visits would have resulted in more than 10 minutes' lateness, and 5% would have resulted in more than 20 minutes' lateness. One person told us "She does her best…she does her [visit] here and is then supposed to start her next job [straight away]." The person's care worker confirmed that this was the case. Therefore we found that the leadership of the service was ineffective in ensuring that staff were organised in a way that enabled them to carry out their duties effectively.

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

We observed that the Sevacare website stated that the Haringey team were operating as a separate branch from a different address which was inaccurate as the Haringey branch had been deregistered following our enforcement action to remove the location from the providers registration. Providers are required to display ratings from their most recent inspection from the Care Quality Commission on their websites, if applicable. However, there was a link on the Sevacare website to the most recent inspection for the service but the rating for the service was not displayed.

This represented a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there was now a full-time member of staff who was responsible for checking medicines records and support logs. The quality of care records had improved since the last visit, and staff were more likely to be accurately recording the care that was delivered. A month before our inspection, the provider's quality team had audited a number of files for people using the service in one borough. They concluded that there were improvements in the accuracy of records and timeliness of care reviews. However, we found that these improvements were still not sufficient to ensure that people's care was safely delivered.

We saw records that showed the electronic call monitoring system had been used to identify a short visit and that this had been followed up by staff. We also saw that where staff had not been using the system effectively, this had been followed up by managers. The majority of people using the service were not on this call monitoring system, and in the Tower Hamlets team a system was only in its pilot phases. Where the system was being used, the monitoring of this had been effective at reducing care delivery risks.

The branch manager told us they always attended staff meetings that were held every few months, to enable care staff to discuss any concerns they may have with their working arrangements. Minutes confirmed that the meetings included reminders on signs of abuse and how to use whistleblowing procedures if staff were concerned about working practices. Staff were familiar with the signs of abuse and how to report safeguarding concerns, but most staff we spoke with did not understand the whistleblowing procedure.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person was not operating effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments There was not shown on a website maintained by or on behalf of the Provider the most recent rating by the Commission of the Provider's overall performance. 20A (2)(c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not assessed the risks to the health and safety of service users of receiving the care or treatment 12(2)(a) Medicines were not managed in a proper and safe way 12(2)(g)

The enforcement action we took:

A Warning Notice was served

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to meet people's care and treatment needs. 18(1) Staff did not receive appropriate support and supervision to enable them to carry out the duties they were employed to perform 18(2)(a)

The enforcement action we took:

A Warning Notice was served