Sevacare (UK) Limited

Sevacare - Washington

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

This inspection took place on 7 and 9 November 2016 and was announced. On 10 November 2016 we held telephone conversations with care staff.

Sevacare - Washington is a domiciliary care agency which provides personal care and support for people living in their own homes to meet their individual social care needs and circumstances. They mainly support people living in the Washington and Sunderland areas. At the time of the inspection there were 135 people using the service who received the regulated activity of personal care.

We last inspected Sevacare – Washington on 13, 14 and 20 April 2016 and found the provider had breached regulations we inspected against. Specifically the provider had breached Regulations 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The assessment of risks to the health and safety of service users was not effective. There was a failure to do all that was reasonably practicable to mitigate risks. Medicines were not managed or recorded safely. People were not fully protected from abuse and improper treatment. Systems and processes had not been operated effectively to prevent abuse. Incidents and complaints had not been assessed to identify potential abuse. Systems and processes were not operated effectively to investigate concerns. Safeguarding arrangements for the raising of concerns and alerts had not been followed. Systems and processes were not being operated effectively to ensure compliance.
The provider did not have an effective system to assess, monitor and improve the quality and safety of the service provided. There was a failure to maintain an accurate, complete and contemporaneous record in respect of each person's care and treatment. There was a failure to act on feedback, in the form of complaints.

During this inspection we found some improvements had been made to procedures for reporting and investigating safeguarding concerns. Audits had been introduced but further improvements were required to ensure regulations were met in relation to medicines management, care records and governance.

We have requested information be provided to us at regular intervals in order to monitor progress.

There had been significant periods of time over the past two years where managers of the service had not been registered with the Commission. A manager was in post at the time of the inspection and they had completed their application to become a registered manager with the Care Quality Commission was being progressed. They had been in post since June 2016.

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.

Risks to people had not always been identified and mitigated against. Some information noted in risk assessments had not been included in home care and support plans which left people vulnerable. Some care plans did not provide sufficient detail on how staff should deliver care in a safe and appropriate way.

Medicine administration records (MARs) contained gaps were medicines had not been signed for. Audits had identified this and action had been taken in terms of re-training staff and discussions in team meetings, however the required improvement had not been forthcoming and MARs continued to contain gaps.

Audits had been introduced which had led to some improvements but work was ongoing to identify and rectify the concerns noted during the inspection.

Safeguarding concerns, incidents, accidents and complaints were logged, reported and investigated. Action had been taken to address concerns.

Staffing levels were such that all visits to people could be met but some people and all staff were concerned that rotas were not being issued with a weeks' notice. A care co-ordinator described this as a 'blip' due to staffing issues but said it had been resolved and weekly rotas would be issued moving forward.

People told us, and records confirmed that staff training was up to date. An electronic system would not allow staff to be allocated work unless their training was up to date. The same system was used to ensure all appropriate recruitment checks had been completed before people started shadowing shifts with competent colleagues.

Supervision, appraisal, spot checks and carer (staff) assessments were completed and logged on the electronic system used by the provider.

People told us staff sought their permission before providing support. The manager and staff said they did not currently support anyone who lacked capacity to make decisions. The manager understood the process for assessing capacity and making decisions in people's best interest. They said staff were due to attend additional training to ensure they had an appropriate level of knowledge to assess capacity.

People were supported with meal preparation and care plans recorded this was to be a meal and drink of the person's choosing. People told us they had access to healthcare professionals and staff knew how to respond if people needed medical intervention.

People told us staff were kind, caring and patient. They said they felt respected by staff who maintained their dignity and did not rush them.

People had signed their home support care plans and risk management plans where capable, and where they hadn't been able to there was an explanation.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some risks to people had not been identified or mitigated against.

Gaps on medicine administration records had been identified and some action had been taken but improvements were not consistent.

People told us they felt safe with staff and recruitment procedures were appropriate.

Is the service effective?

Good

The service was effective.

People told us they thought staff were well trained. One person said, "They know what they are doing."

An electronic system was used to manage training, supervision and appraisal so staff could not be allocated to support people if their training was out of date.

Mental capacity was understood and additional training was planned to develop staff knowledge and skill in assessing capacity further.

Staff knew how to respond if people needed medical intervention.

Is the service caring?

Good

The service was caring.

People told us staff were patient, kind and caring and treated them with dignity and respect.

People knew about their care plans and that staff wrote in them on a daily basis.

People said they had been asked about their preferences for a

male or female staff member to support them and this was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Home care support plans continued to lack specific detail for staff to follow in relation to how to deliver support, for example in relation to diabetes management, personal care, and mobility. Some information was recorded in needs assessments and risk management plans but this was not included in the home care support plan.

Some home care support plans included information on maintaining people's independence. Some also included brief information on people's life history.

Complaints were logged, recorded and investigated with action taken to resolve them to the person's satisfaction.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A new manager had been in post since June 2016 and was proceeding with their application to be registered with CQC.

Statutory notifications had been submitted and the manager understood their responsibilities.

A governance system of audits had been introduced and had led to some improvements but further improvement was required to ensure regulations were met.

Sevacare - Washington

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 7, 9 and 10 November 2016 and was announced. We gave the service 48 hours' notice of the inspection because it provides personal care in people's own homes and we needed to be sure someone would be available in the office.

The inspection team was made up of one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We also contacted the local authority commissioning team, the clinical commissioning group (CCG) and the safeguarding adult's team. We also contacted healthcare professionals and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 14 people who used the service and three relatives. We also spoke with the manager, the area manager, two care co-ordinators, two team leaders, five care staff and one administrator.

We reviewed seven people's care records and 10 people's medicine records. We also viewed electronic records relating to recruitment, supervision and training information as well as information relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

During the last inspection we found the provider had breached regulations. We found medicines were not being managed in a safe way. The assessment of risks to the health and safety of people was not always effective and there was a failure to do all that was reasonably practicable to mitigate risks. People were not fully protected from abuse and improper treatment as systems and processes had not been operated effectively to prevent abuse. Incidents and complaints had not been assessed to identify potential abuse. Systems and processes had not been operated effectively to investigate concerns. Safeguarding arrangements for raising concerns and alerts had not been followed.

An action plan had been submitted by the provider which stated they would be compliant by 30 June 2016. During this inspection we found some improvements had been made to protect people from abuse and improper treatment.

We also found some continued concerns in relation to managing risk. One person had diabetes which was managed by insulin. Risk management plans identified risks as 'low sugar' and 'insulin not taken.' The management of the risks was for care staff to recognise confusion that the person may be low in sugar and ensure a glucose tablet or sugar was given or for care workers to look for signs of low sugar or no insulin taken and to give glucose immediately. There was no specific detail recorded as to additional risks associated with diabetes, such as hyperglycaemia (high blood sugar) or skin integrity. Control measures to mitigate the risks were not recorded nor was there information on how risks should be managed. The person was also registered blind and this had not been included in the risk assessment. We spoke with staff about this person's diabetes management and they were knowledgeable about the person's needs, but the lack of recorded detail left the person vulnerable.

We found some risks in relation to people's needs had not been identified. One person was living with epilepsy but there was no risk assessment or information in relation to how to support the person if they experienced a seizure. Another person told us they were at risk of aspiration (when food or fluid enters a person's airway) and choking. They were confident staff knew how to respond. We viewed the risk assessment which stated, 'carers to spoon feed [person]' and 'all meals are purified.' This should have read pureed. There was no assessment of risk in relation to choking or aspiration nor was there detailed information in the person's care plan.

These concerns had been raised during the previous inspection and audits had been developed and implemented to identify and address concerns. The concerns were raised with the area manager during day one of the inspection. On the second day of the inspection the manager said, "The area manager did a session yesterday on what should be in care records and the process now is that I will sign off all care records once complete."

An assessment of need was completed which included moving and handling assessments, lists of equipment used, general risk assessments and medicine risk assessments. We found the lists of equipment used did not include information on who was responsible for maintenance and servicing as prompted by

the document. One person we spoke to explained they had asked the provider to arrange for servicing of their bath chair but they said this hadn't happened.

We saw medicine administration records (MARs) had gaps where staff had not recorded whether medicines had been administered or not. The manager explained medicines audits were completed at the end of the month and due to the findings there had been discussions in team meetings, supervisions and re-training of staff.

MAR audits recorded the findings, the care staff involved, the action needed, the investigation process and the outcome. Investigations showed some gaps related to when people had cancelled their visits so staff were not present to prompt or administer medicines, but on many occasions there was no reason for the gap. This resulted in staff meetings being held to discuss medicine management and retraining.

We looked at MARs for October 2016 which had not yet been audited. Whilst there were some improvements MARs still contained gaps. The manager explained they needed to give staff the opportunity to improve before taking further action. They said, "The company has a MAR auditor in post but they haven't been here yet. The procedure to follow would be an identification of who is making consistent errors, they will receive an individual letter, re-training and if there is no improvement it will be addressed as a capability concern."

We noted hand written MARs had not been signed by the member of staff completing them, and another person had incorrect dosages of medicines recorded. These had not been identified during the audit process. This meant there was the risk of error as there was no clear line of accountability for changes which put people at risk of not receiving the correct medicines.

These findings were a continuing breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

One person said, "I feel safe in my home. Carers (staff) use a hoist, there's no concerns, there have been no accidents." Another person said, "Oh yes" when asked if they felt safe. A third person told us, "There have been no accidents. They are very safety minded. They won't do anything they shouldn't do. Everything is as it should be." They added, "They are honest and very good at the job."

We asked staff about safeguarding. One staff member said, "If I thought there was abuse I'd let the manager know or the team leader. I'd be looking for changes in character, behaviour, marking or bruises." Another staff member said, "If someone told me something in confidence I would be breaching it but I would have to tell the office, I'm confident the office staff would act on it."

A safeguarding policy was in place and available for staff to refer to. A log of concerns detailed the date it had been raised with the safeguarding team and the outcome of the alert and investigation. Action taken included speaking with staff about recording and reporting information, apologies being issued and disciplinary action being taken.

Accidents and incidents were logged and included information on the action taken such as referral to social workers or a staff member being removed from the visit.

A contingency plan was in place which included information on crises which may be associated with high levels of sickness, lack of senior management, inability to provide the service, inability to access information and other emergencies. Whilst there was no specific plan for each potential crisis, it stated that local management should use their 'best endeavours to contain the situation and take such emergency measures

as they deem appropriate and necessary.' There was information in relation to senior management on call and that the director of care services should be notified at the earliest practicable opportunity.

We received conflicting information when we asked about staffing. One person said, "My carers are reliable, come on time and do not have missed visits. I get a rota each week and they stick to it." They added that they had a consistent team of care staff. Another person said staff were reliable, came on time and they had never had any missed visits. Regarding continuity of staff they said, "I had one this morning and for the rest of the week I have the same one. They are very good."

One person said they did have some concerns regarding the organisation, not the staff. They told us, "Sometimes they are good, but other times they are absolutely hopeless." They went on to explain, "I don't know how long it is since I had a time sheet (rota)." Another person explained they were not happy with not getting a rota as it meant they did not know who was coming into their home and they did not get continuity of care staff which was very important to them due to their complex needs.

We spoke with the care co-ordinator about rotas and they said, "We have had a blip due to staffing but rotas were sent two or three days in advance and then amendments were sent if there were changes. Clients know the times of their visits but not necessarily who will be visiting but we do try and ring and let them know. Staff also have their availability as a template for when they will work. Full rotas are going to be sent out from now on." They confirmed this would be completed a week in advance and that printed rotas would also be sent out.

We asked if there were enough staff to cover the visits for all the people. The care co-ordinator said, "It is doable for staff and clients, calls always get covered. It would be nice to have two or three more staff on board, but it's manageable and it's safe." They added, "We cover about 1750 hours of calls with 70 to 80 staff but it's always fluctuating." Another care co-ordinator said, "We need more staff due to the location of care packages now. We always cover the calls but there have been some concerns about running late." One staff member said, "If a call runs over I would speak to on call or go to the backup staff, you can't leave if there's an emergency."

One staff member said, "The care staff are under pressure. There's lots of sickness but some staff will cover but it's all in the process of being managed." Another staff member said, "It was stressful due to covering sickness but things are better now, I love my job, love what I do. I see the same people on a regular basis unless extra help is needed due to sickness." A third staff member said, "Yes, there are enough staff unless there's sickness but personally I don't feel under any pressure."

One staff member said, "It is getting better, I don't like the rotas we are getting them daily so we don't know what we are working in advance." Another said, "Staff numbers are not good, and getting the rota day to day isn't good, we've had no explanation and it's impacting on clients they are getting irregular carers and some calls are even being missed. It's impacting personally as well as I don't know where I'm at. They email the rotas but sometimes we aren't aware it's been sent as we aren't told it's on its way." A third staff member said, "We always had rotas weekly and I don't know why it stopped, maybe they are trying to get on top of things but we get them at night for the next day or the next two days. Some clients don't get their rota either, some aren't that bothered but some are really not happy at all." Another said, "Not getting a weekly rota isn't good as we don't know where we will be. We've had people off on the sick so they need to cover jobs." They added, "Clients are lovely, I see the same people a lot of the time."

The recruitment process remained safe. The administrator explained how they used a telephone conversation as a screening tool to assess people's motivation for wanting to work in care and to

understand an applicant's previous experience. It also gave an opportunity to explain the nature of work they would be required to complete and to ensure they were still interested. Following this applicants were invited for interview which included some scenario based work to the interview panel could assess people's responses to specific situations. If applicants were successful references and a disclosure and barring service (DBS) check were sought via head office. DBS checks are used to help employers ensure only suitable staff are employed to work with vulnerable people. The electronic system for rota planning would not allow staff to be allocated work until head office had authorised receipt of all satisfactory employment checks.

One person told us they had diabetes and that their medicine support was on time. They said this aspect of their care was, "Very good." Another person, who had sensory needs in relation to their sight also had support with diabetes management. They explained that staff checked they had drawn up the correct dose of insulin. They said, "Occasionally if staff are late for my 8am visit I take it myself but I can't see any units." The person explained they used a magnifying glass and would only do this in an emergency. We asked the care co-ordinator if there was any contingency for staff running late to time critical visits. They said, "The system logs time critical calls for medicine visits and won't let the time of the call be amended, this is also flagged on the rota. If there was a late call or a staff member wasn't available at that time a team leader or care co-ordinator would go out and do the call."

We saw body maps had been introduced for people who received support with the application of creams. Body maps included an indication of where the cream should be applied and administration of creams was recorded on the MARs.

Good

Is the service effective?

Our findings

We asked people if they thought staff had the skills and knowledge to support them. One person told us they thought staff were well trained. Another person said, "The majority are well trained, and they pick things up as they go along. If a new one starts maybe the first time, they come here they will ask if they are doing it right." This person said they felt able to tell care staff how they liked to be cared for. Another person told us, "They know exactly what they are doing."

We asked if any additional training had been completed since the last inspection. A care co-ordinator said, "Care staff have done a medicines refresher workbook and some re-did their induction as a refresher. Care co-ordinators have had informal risk assessment training and we are clearer about expectations." Another care co-ordinator said, "We've done medicines training, team meetings, dementia care, mental capacity, safeguarding update and moving and handling." A care staff member said, "I did dementia care in my induction, we did hoist training, medication, safeguarding."

The provider used an electronic system to monitor the induction, training, supervision, appraisal and spot checks of staff. The induction was linked to the care certificate and included safeguarding, food safety mental capacity, medicines, safer people handling, personal care, catheter care and pressure sore care. At the point where staff were required to attended refresher training this was flagged by the system and staff would be booked to attend the required training. If staff did not attend the training within the required time the electronic system would block them so they could not be allocated to provide care and support to people. The care co-ordinator also explained that staff were required to complete workbooks as part of their refresher training. The workbook included sections on safeguarding, emergencies, safer people handling, personal care, pressure care, dementia, medicines and mental capacity. The workbook was assessed by care co-ordinators and then scanned onto the internal system for authorisation from head office and the area manager. Once assessed as compliant the information was updated onto the electronic system. This meant only staff with the required training were able to support people.

The same system was also used to monitor the frequency of supervisions, spot checks and 'carer (staff) assessments. Supervisions were held every three months and were up to date other than for staff who were on leave or absent due to sickness or maternity. Appraisals were completed annually by the manager and we noted they were on track to complete each staff member's appraisal as required.

Spot checks and staff assessments were completed six monthly by the team leaders. One team leader said, "A spot check is of performance in the field, are they courteous, wearing the uniform and name badge, did they read the care plan. It also includes a medicine observation." They went on to explain the staff assessment included, "A check of the training, is the person happy with them, it's an assessment of care delivery and a discussion around anything that could be affecting that." They also told us if they saw unsafe practice they would stop the staff member and take over asking them to observe. They would discuss what they had done wrong and explain why. They would then add onto the system that further assessments and spot checks were needed to ensure they were supporting the person appropriately and safely. We found these were up to date other than for a few which were planned to take place.

Another team leader said, "I have a mentor and the area manager is offering support, I'm doing lots of shadowing and waiting for risk assessment training. I'm meeting new clients and looking at risk assessments and care plans, arranging occupational therapy assessments if people need equipment that sort of thing."

Meetings had taken place with both the office staff and care staff and minutes were available for staff to read if they had been unable to attend the meetings. A schedule of future meetings up to June 2017 was in place. Discussions included medicine management, communication, CQC and governance, safeguarding, respect and dignity and complaints. The staff we spoke with said the meetings were informative and supportive. The office meetings had included discussions around health and safety, rotas, staffing and sickness, concerns and risk, audits and file updates.

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.

We checked whether the service was working within the principles of the MCA and whether any applications had been made to the Court of Protection.

We spoke with the manager and found that no applications to restrict the rights of people had been made to the Court of Protection. They went on to say, "If staff feel someone lacks capacity it would go back to the social worker to assess capacity. I have spoken to the staff and we feel people have capacity to agree to day to day decisions and things like manual handling. If not we would involve the family." They added, "We are down to attend training as we aren't appropriately trained to do it yet (assess capacity)." They also explained capacity included best interest meetings, they said, "We would give people time and information to assess understanding, we would speak with the people they know which would lead to a best interest decision." This meant the manager had a good understanding of MCA but was keen to ensure their knowledge was up to date and current.

We asked if anyone was being restricted by the care and support they needed. One staff member said, "Some people have got the capacity to consent to cot sides, they are used because of a physical impairment rather than dementia."

Several people had support plans which included staff support to prepare or warm meals. One person said, "Usually at tea time they cook me a ready meal and bits like that, they are all very good." Another person explained they had specific dietary needs, they said, "A diabetes nurse, a dietician is involved and SALT (speech and language therapy)." They added that they were supported with their health needs by the local nursing team.

We asked staff how they would respond if someone they visited was poorly. One staff member said, "If someone was unresponsive I would ring 999 then while I waited for the ambulance I would ring the office so they could contact the next of kin. If it was a cold I'd arrange a general practitioner (GP) visit, or for a pressure sore the district nurse." Another staff member said, "If someone was poorly I would ring the office and I guess they would contact the next of kin. I did visit one person who was on the floor but they had already got help so I waited while the ambulance was there and sorted the medicines out."

Good

Is the service caring?

Our findings

People told us they thought staff were patient, kind, caring and treated them with dignity and respect. Other people added that they had good relationships with care staff and they felt listened to and were not rushed.

One person said, "The staff who come out to the houses they are very good." Another person said, "The girls I've got are wonderful." A third person said, "Ah yes, they are very good. We have a laugh and they know what moods I am in and go with that feeling."

One relative said, "[Family member] is treated with dignity." Another person said of their care staff, "They are very caring and very nice, I've no complaints at all." They added that they had good conversations with care staff. Another person told us, "If I'm feeling a bit down I can talk to the carers (staff)." They added, "Oh, they're nice." Another person explained they were able to confide in their staff. They added, "Oh yes I am happy with the care."

All except one person we asked told us they had been given a choice over whether they would prefer male or female care staff and that their choice had been respected. We noted people's preferences in relation to the gender of care staff was recorded in their care records. One person said, "I did at the beginning, I told them no way and I never get one (a male carer)." They added, "They are very caring."

People also told us that care staff asked permission before offering any support and that staff supported them to maintain their independence.

The majority of people we spoke with told us they would recommend the agency to others. One person said, "The carers (staff) are marvellous." Another said, "Oh yes, they are very good, I am quite happy." Another person agreed and commented, "Oh yes, the care is good. Its great I can't complain."

People were aware of their care plans and knew that care staff wrote in them on a daily basis at each visit. One person explained their care plan had been recently re-written but said it had been done by a new care staff member who did not know them well. We viewed this person's care plan and noted they had signed to give agreement. Other people we spoke with said they were involved in decision making about their care and support.

We saw home care support plans and risk management plans included the signatures of the person who was receiving care and support. If there was a reason why people were unable to sign this was recorded and there was a record of the person's representative or next of kin.

We asked if people had an advocate and were told that people either made their own decisions or had the support of their family.

One staff member said, "The best thing is the team, so proud. All the girls and boys do it because they care, I can't fault them, blood, sweat and tears go into it. It feels like a family, we all pull together and will get there

eventually."

A log of compliments were kept and recorded in a compliments book. Comments included, 'grateful for the support [staff member] has given to parents and myself over recent years and that he has shown more support in that short time than others have over the years.' Others read, 'good carers (staff) always friendly and chatty and aware of [family member's] specific preferences,' and 'fantastic team, they always work together, delivering a great standard of care.'

Requires Improvement

Is the service responsive?

Our findings

During the last inspection we found the provider had breached regulations. We found inconsistencies between the identified risks and the support plans. Some support plans were found to be inaccurate and others did not provide sufficient detail to enable staff to provide consistent, safe and person centred care.

We found some improvements had been made to ensure all the necessary documentation was in place. Further work was needed to ensure improvements were made to the quality and detail of recorded information.

We found some care plans lacked detail for staff to follow in relation to how support should be delivered to meet people's needs. Care plans made statements like, 'requires assistance with all aspects of personal care' and 'assist out of bed and into the bathroom.' There was no detail in relation to the specific support needed with personal care, or support to get out of bed.

One person who was living with insulin dependent diabetes had a care plan which stated staff were to ensure insulin was checked for air bubbles, to ensure the correct amount of insulin had been drawn up and to give a glucose tablet if sugar levels were low. There was no detail as to the action staff should take if air bubbles were present, how they knew what the correct amount of insulin was or how to test if the person's sugar levels were low, or what a low sugar level was for the person. We spoke to a team leader who wrote the care plan and they were able to explain that the person independently checked their blood and calculated the insulin they needed; staff just did a visual check. It was noted that this person had additional sensory needs in relation to their sight so it was vital staff understood how to deliver safe care in relation to supporting the person to manage their diabetes. This information was not in the care plan and therefore placed them at potential risk of harm due to a lack of detail for staff to follow.

Another person who was living with diabetes and had been assessed as high risk was supported at meal times. The care plan stated, 'offer [person] a choice for breakfast and prepare it along with a drink of [person's] choice.' There was no information to guide staff as to healthy options for a person assessed as being 'high risk diabetic.'

Another person had a moving and handling assessment which included that they experienced seizures however this was not noted in the care plan, nor had it been risk assessed. This left the person at risk of harm as there was no detail for staff to follow in the event that the person experienced a seizure, nor had there been any mitigation of the risk. It was noted that the person used a bath seat and zimmer frame but this was not detailed in the care plan.

We also found some relevant information had been recorded in a needs assessment, or risk management plan but this had not been included in care plans. Examples of this included one person who was registered blind and one person who wore hearing aids. For another person there was a moving and handling assessment which stated staff were to assist with all transfers. It was recorded that the person used a slide sheet and banana board but there was no detail in the care plan as to how to support the person's mobility

or how to support with transfers.

Another person had a moving and handling assessment which included that they experienced seizures however this was not noted in the care plan, nor had it been risk assessed. Again it was noted that the person used a bath seat and zimmer frame but this was not detailed in the care plan.
We also found gaps in details for other people in relation to transfers and the use of hoisting equipment and the specific detail on how to support people who needed physical assistance to eat a meal. A risk management plan for one person stated staff were to, 'use appropriate equipment (hoist, shower, chair)' but there was no information on the equipment used or how staff should support the person to use it in the care plan. This meant there was a lack of guidance for staff to follow.

These findings were a continuing breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

All home care support plans included an introduction which gave a summary of the person's needs. Some introductions included brief information on people's life history and past, such as where they used to work, or that they had spent their whole life living in the same area. Other support plans included detail on why people were unable to sign their support plan due to things such as poor eye sight.

There was information in some records on the areas where people did not need staff support so there was acknowledgement of people's independence and an aim to maintain this. One person's support plan included the impact if the person was feeling more tired or stressed than usual and how this should be managed.

People told us they had had a review of their care and support. One person said they had a review once a year. Another person said they had reviews and the care staff completed care plan records at each visit. One staff member said, "Communication is good if service users' needs change."

One person had a recorded telephone monitoring call which stated there were no changes needed to their care plan or risk assessment, it stated, '[person] happy with carers (staff), says they are doing a fantastic job but doesn't like new carers (staff).' Other people had recorded meetings titled 'service monitoring and review' which assessed the person's view of their satisfaction with the care they received. This included a review of the service, the attitude of staff, staff proficiency and competency, call times and support plan outcomes.

Staff said they supported some people with companionship visits were they would support people to follow their interests and take part in activities.

One staff member said, "We do work with people with dementia, if you bring a smile to their face it's extra special as it's harder to get a response at times. One person responds really well if I sing, so I sing all the time I'm with them."

We asked people if they knew how to raise any concerns or complaints. One person explained they had concerns about the consistency of staff and the number of new staff who were being introduced to them. They had shared their concerns with the manager. We saw this had been logged as a complaint and investigated with the actions being agreed to by the complainant.

Another person said, "The carers, I have no complaints about at all, they are good. However the timekeeping is poor." They also told us consistency with care staff varied and some weeks they had regular staff and

other weeks they didn't. Another person said they had concerns regarding the lack of rotas and poor communication to inform them of any changes in care visits. Another person said, "The only complaint I have ever had was the office, and that's damped down a bit. They ring up and tell me if they are going to be late." They said they thought the agency had vastly improved. They said they had raised concerns in the past and there had been improvements made.

One person said, "I've no concerns or complaints. They're great." Another said they had no concerns at all, even about time keeping. They said, "They are very good at the moment, I've no complaints they are quite nice." Other people explained that they did not have any concerns but if they did have they would be confident to raise them and speak to someone.

A complaints log was in place and we saw a dissatisfaction report was completed which detailed the complaint or concern, the investigation, outcome, improvements made and whether the complainant was satisfied by the outcome. Actions taken included new rotas being introduced, follow up checks and evaluations of rotas to ensure they were effective and appropriate to meet people's needs. Team meeting discussions had also been held alongside increased sport checks, assessments and supervision.

Requires Improvement

Is the service well-led?

Our findings

During the last inspection we found the provider had breached regulations. There had been significant periods of time where there was no registered manager in post. The provider had failed to ensure audit and governance systems were effective. Systems and processes had not been established or operated to ensure compliance. Systems had not been implemented to assess, monitor and improve the quality and safety of the service. Systems had not been implemented to assess, monitor and mitigate risks. The governance systems were not effective in ensuing accurate, complete and contemporaneous records of care and treatment were maintained.

We found some improvements had been made to governance procedures to include regular audits of medicines management, communication records and care records. The audits had resulted in some improvements but further improvement was required as identified during this inspection.

A new manager had been recruited and had been in post since June 2016. At the time of the inspection they were attending a fit person's interview with the Commission in order to progress their application to become the registered manager for Sevacare - Washington.

Following the last inspection the provider submitted an action plan with an expected compliance date of 30 June 2016. During the inspection the manager also shared an action plan which they had been working towards. Whilst some actions had been completed sufficient improvement had not been made over a sustained period of time to ensure compliance with current regulations.

The manager explained they had an action plan to improve quality monitoring and other aspects of the service. We noted this included reassessment of all support plans and risk assessments to be completed by 30 June 2016.

Audits of care records had been completed which had led to improvements in relation to ensuring people had a full set of documentation in place. However, concerns were noted during the inspection in relation to the lack of detail in some home care support plans and the failure to identify and assess some risks. These concerns had not been noted during audits however the manager said the next step in the process was to improve the quality of the content of care records.

Audits of medicine administration records had been completed. Areas for improvement had been identified and some action taken. However there remained gaps in the recording of medicine administration which meant there were still concerns about the safe administration and recording of medicines.

Due to the findings of our inspection in respect of unsafe administration of medicines and inaccuracies within care records we cannot say that the overall effectiveness of the audit process is satisfactory and will serve to drive improvements across the service. Further work is required from the provider to demonstrate that these systems

We spoke with the manager about improvements that had been made since the last inspection. They said, "We've audited all the files, staff morale has improved, there's a change in the culture, it's a needs led service. I have a full complement of staff in the office. We can fully cover all the work we have and are recruiting additional staff for any new work." They explained there were ongoing areas for improvements such as people's care records and medicines management. The findings of the inspection confirmed this.

The people we spoke with and their relatives had mixed views about whether the service was well-managed. Some people said they did not know the manager and did not consider the service to be well led. They said, "It could do better." This was in relation to communication. Another person also said, "Communication is the biggest let down." They added, "They employ good girls." A third person told us they didn't think they had met the manager. They told us they thought the staff seem to be caring and well trained. When asked if there were any improvements needed they said, "Not a lot just the management side."

These findings were a continuing breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

Other people said it was well managed. One person said, "They seem to put the patient first." They added, "I never had to ask for something twice. There are no improvements for me everything is fine." Another said, "As far as I am concerned I am attended to and manage okay. I think more or less the girls are nine out of ten. I am quite satisfied with all I get." Someone else told us they had met the manager who occasionally helped out which they thought was very good. They said they had no suggestions for improvements and commented, "I am quite happy with it thank you. No concerns at all."

The manager was aware of their responsibilities to CQC and had submitted notifications appropriately. They said they were well supported by the area manager. They said, "[Area manager] is on the end of the phone and we have supervision. I will say if I'm not happy with a certain procedure. I got support when auditing the files; they now need to be done in more depth now they are all in place (care plans and records). We will be revisiting all the care plans and risk assessments to add detail."

In order to keep up to date with best practice the manager said they attended, "Commissioning meetings, which includes a presentation of quality, monitoring of visits, complaints. I also go to the providers forum which is picking up pace and we have topics to discuss. There's also Sevacare area meetings that I attend."

During a commissioning review meeting in August 2016 discussions included safeguarding alerts and complaints and compliments. Three missed calls and 20 late calls had been noted during the quarter which had been investigated and were due to high levels of sickness which had resulted in the late calls, and being unable to gain access on three occasions. Staff told us the procedure to follow if they could not gain access to someone's home at the time of a visit was to contact the office and they would try and speak with the person or the next of kin. One person told us this had caused some anxiety as they had contacted the office to cancel a visit but this had not been communicated so their next of kin who lived a considerable distance away had been contacted. This had led to some worry due to the person being otherwise engaged and not contactable.

We spoke with a care co-ordinator who said, "Things are getting better, there's been lots of hard work and we dropped before we improved, it's been all hands on deck. Priorities have been rotas and continuity of care. Some staff left which affected [the rota] but we are making good progress and improving." They went on to explain other priorities had been staff supervisions and staff morale.

An administrator said, "I've lots of confidence in [manager]. They've shown me how to audit communication

notes, they are supportive, it is hard with staff issues but there is light at the end of the tunnel. We are being led the right way by someone who knows." Audits were completed of communication notes by the administrator. We asked what they were looking for when auditing. They said, "Gaps between notes, the staff name, time of arrival and departure, the users name and the number on the pages. We had a meeting with carers (staff) at the end of August and I've seen improvements in September." They went on to say, "There's a pattern coming through of who does forget and who does descriptive notes. We need to keep any eye on it and we issued staff with the recording policy. The pattern will be monitored which will lead to individual discussions and action taken if there's no improvements."
We noted one compliment had been recorded from a care worker to the office staff which read, 'thank you to the office staff who are doing a great job. There have been vast improvements in the last few months. Communication has improved, messages are being passed on and it is great to feel appreciated. The atmosphere in the office is lovely.'

We spoke with staff about the culture of the location. A care co-ordinator said, "Morale is fantastic, [manager] is the best thing that's happened. They are supportive and honest, will say if something needs done, they are encouraging. I feel valued." They added, "I can't fault them, I'm more confident in my role and I know my manager will support me in my decision making and following processes and procedures." They also explained, "[Manager] keeps on top of us, if we are given a task they ask for feedback on how it's going. We are still working on everything, we are more flexible to people's needs, we've done a lot of work on everything, we are working on the action plan, it won't be perfect but we have audited all the files and the medicines. I have no major concerns."

Another care co-ordinator said, "It's good, [manager] has been fantastic, everything has a plan and we are working together, it's more positive, there's been lots of hard work. 100% better morale, good team, good relationships with carers. I'm very well supported." They added, "The regional trainer has done training days, we help each other out and all chip in and help, it's a good atmosphere now. [Manager] has made a huge change." They went on to say, "We are getting there, things are a lot better, we've a stronger manager, she's got our back, the area manager is really supportive, we've a good team and we look after each other."

One staff member said, "We've had a difficult few months, but the team work well. We have a great bunch of people (staff) who dedicate their life to it." They went on to say, "There are definite improvements, new management who are firm but fair, they are there for you, we didn't feel supported previously but [manager] knows her stuff and gets it done." They also added, "I feel I'm being heard, listened to, I feel welcome in the office, personal and professional support, [manager] acts on what they say, there's more team work, there's a big morale difference."

The administrator said, "Morale is up and down but it's getting better, we have someone who knows and who isn't floundering. There's lots of hard work. We are appreciated for it."

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The assessment of risks to the health and safety of service users was not effective. There was a failure to do all that was reasonably practicable to mitigate risks. Medicines were not managed or recorded safely. Regulation 12(1); 12(2)(a); 12(2)(b); 12(2)(g).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes had no been established and operated effectively to ensure compliance. There was a failure to ensure accurate, complete and contemporaneous records in respect of each service user. Regulation 17(1); 17(2)(c)