Care Quality Commission

# Sevacare (UK) Limited

# Sevacare - Haringey

## Inspection report

4th Floor Belmont House, 78-80 High Road, Wood Green, London, N22 6HE.
Tel: 020 8826 3270
Website: www.sevacare.org.uk

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## Ratings

| Overall rating for this service | Requires improvement |
|---|---|
| Is the service safe? | Inadequate |
| Is the service effective? | Requires improvement |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires improvement |

## Overall summary

Sevacare (UK) Limited is a national provider of care and support services to people in their own homes. 'Sevacare – Haringey' provides personal care to people of any age living in Haringey who need care due to ill health or disability.

We carried out a comprehensive inspection of this service on 14 and 15 December 2014. We found seven breaches of legal requirements, which put people using the service at significant risk of receiving inappropriate or unsafe care. You can read the report of this inspection, by selecting the 'all reports' link for this service on our website at www.cqc.org.uk

We took enforcement action against the registered persons, including cancelling the registration of the previous manager of the service, and proposing to remove the location 'Sevacare – Haringey' from the registration of the provider, Sevacare (UK) Limited.

We undertook this unannounced comprehensive inspection, of 24 and 30 June 2015, to check on the progress the provider had made to address our concerns from the previous inspection, and to check on the standard of care people using the service were receiving. At the time of this inspection the agency was providing a

# Summary of findings

care service to over 270 people in their own homes, which meant just under 4000 hours of service per week. Since our last inspection, the provider had moved its service for people in another local authority to a different location.

Whilst we found evidence to demonstrate that some of our concerns had been addressed, we found breaches of three legal requirements. This continued to put people using the service at unnecessary risk of receiving inappropriate or unsafe care.

We continued to find instances where people's scheduled visits did not occur as planned, because the visits were either missed or shorter than planned for. There was evidence of insufficient staff travel time in-between visits to people. Where people had electronic call-monitoring systems to check on the times of staff entering and leaving their home, these were not consistently used. People's care needs and preferences were not always met in these instances.

We continued to find that people were not being supported to manage their medicines safely. This was because medicine records had not been consistently filled in to demonstrate that people had been supported to take their medicines as prescribed.

There remained shortfalls in the effectiveness of the provider's governance of the service. Whilst a number of audit tools were now being used effectively to address potential service risks, weekly reports to senior managers continued to omit information on missed visits and safeguarding cases. Checks of care delivery records continued not to identify risks around medicines management. Where a person had requested a care worker to be excluded from visiting them, or a safeguarding case had recommended an exclusion, we found that systems to ensure this were not effective.

Records were now provided to us in full when we requested them. However, we still found some records were not accurate or up-to-date. This undermined, for example, explanations provided by the service into other concerns of ours, because there were sometimes no records to support what we were being told. Whilst there was evidence of complaints and safeguarding matters being attended to, records did not always demonstrate effective operation of these processes.

Staff now had up-to-date training, supervision and appraisal. However, we were not assured that these processes were being productively used to support staff to provide appropriate care for people, because, for example, some parts of the appraisal were not filled in. Most of the recorded content on care workers' supervision forms was similar, with little specific to each individual care worker's needs.

Staff were aware of the practical applications of the Mental Capacity Act 2005, however, this Act was inconsistently applied within care documentation.

However, a number of improvements had occurred since our last inspection. There was improved feedback about the approach of care workers. Most people using the service valued the relationships they had with staff and expressed satisfaction with the care they received. We found that people now received a consistent set of care workers with whom they developed positive, caring relationships.

There was no registered manager in post on the dates of the inspection visits. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. A new manager had been appointed since our last inspection, whom we met during this inspection. Their registration as manager was completed whilst this report was being drafted. There was positive feedback from people using the service and staff about the new manager's approach. Everyone had had a face-to-face review of their care needs, care plans were up-to-date, and there was improved feedback from people and their representatives about receiving personalised care.

People's formal complaints were now being responded to promptly, with apologies for service shortfalls where appropriate and action plans being communicated to complainants. Expressions of dissatisfaction were also being addressed.

The service was taking steps to protect people from the risk of abuse. Allegations of abuse were now being notified to us, and the service was alerting the local safeguarding authority about safeguarding concerns that care staff were raising, to help protect people.

Appropriate recruitment checks took place before new staff started work. Disciplinary processes were now being used to help ensure that established staff were suitable to work with people.

# Summary of findings

People received sufficient support with food and drink, and appropriate support to maintain good health, including through referrals to community healthcare professionals.

We found overall that people using the service continued to be at some risk of receiving inappropriate or unsafe care. We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Following this inspection we continued with our enforcement action. The action we took was to serve a notice proposing to remove the location 'Sevacare – Haringey' from the registration of the provider, Sevacare (UK) Limited.

Due process was followed which meant that the Care Quality Commission removed the location 'Sevacare – Haringey' from the registration of the provider, Sevacare (UK) Limited, on 4 April 2016.

# Summary of findings

## 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 remained unsafe. Whilst there was improved feedback from people using the service, and action had been taken to address some of our previous safety concerns, other safety matters had not been addressed.

We continued to find instances where people's scheduled visits did not occur as planned, because the visits were either missed or shorter than planned for. People's care needs and preferences were not always met in these instances.

We continued to find that people were not being supported to manage their medicines safely. This was because medicine records had not been consistently filled in to demonstrate that people had been supported to take their medicines as prescribed.

The service was taking steps to protect people from the risk of abuse. Allegations of abuse were now being notified to us, and the service was alerting the local safeguarding authority about safeguarding concerns that care staff were raising, to help protect people.

Appropriate recruitment checks took place before new staff started work. Disciplinary processes were now being used to help ensure that established staff were suitable to work with people.

**Is the service effective?**

**Requires improvement**

The service remained inconsistently effective. Action had been taken to address our previous concerns because staff support systems had been re-established. Staff now had up-to-date training, supervision and appraisal. However, we were not assured that these processes were being productively used to support staff to provide appropriate care for people.

Staff were aware of the practical applications of the Mental Capacity Act 2005, however, this Act was inconsistently applied within care documentation.

People received sufficient support with food and drink, and appropriate support to maintain good health, including through referrals to community healthcare professionals.

**Is the service caring?**

**Good**

The service was now caring. There was improved feedback about the approach of care workers. Most people using the service valued the relationships they had with staff and expressed satisfaction with the care they received.

We found that people received a consistent set of care workers with whom they developed positive, caring relationships.

# Summary of findings

**Is the service responsive?**

Good

The service was now responsive. Everyone had had a face-to-face review of their care needs, and there was improved feedback about receiving personalised care.

People's formal complaints were now being responded to promptly, with apologies for service shortfalls where appropriate and action plans being communicated to complainants. Expressions of dissatisfaction were also being addressed.

**Is the service well-led?**

Requires improvement

The service was not consistently well-led. The service had a new manager, and there was positive feedback from people using the service and staff about their approach.

We found that audit tools used to check on the management of the service were now accurate and up-to-date, and action was being taken when the tools identified risks to the welfare of people using the service and staff.

However, there remained shortfalls in the effectiveness of the provider's governance of the service. Weekly reports to senior managers continued to omit information on missed visits and safeguarding cases. Checks of care delivery records continued not to identify risks around medicines management. Systems to ensure specific staff were excluded from working with specific people were not effective.

Records were still not consistently accurate and up-to-date. This meant that some explanations to show that service shortfalls had not occurred, could not be backed by documented evidence.

# Sevacare - Haringey

**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 24 and 30 June 2015 and was unannounced. The inspection team consisted of four inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Their involvement was limited to phoning people, to ask about their experience of the care services provided.

Before the inspection visit we reviewed the information we held about the service including notifications, information from the local authority, any contact we had had with members of the public about this service, and other information the provider had sent us.

During this inspection we spoke with 30 people who use the service and six relatives to obtain their views on the service provision. This included visiting three people in their homes with their permission. We also spoke with 17 care workers.

During the inspection visits we spoke with the manager, the area manager, the regional director and eight staff members. We looked at the care records of 20 people using the service, 12 people's medicines administration records, and the personnel records of 12 care staff. We also looked at electronic care planning and delivery records, and various other records used for the purpose of managing the service. The manager provided us with further documents at our request after the inspection visits.

Inadequate

# Is the service safe?

## Our findings

At our previous inspection of 14 and 15 December 2014, we found instances where people's scheduled visits did not occur as planned, including very late visits or where only one of two planned care workers attended. People were not being supported to manage their medicines safely, and there were concerns with the provider's safeguarding processes. The provider's on-call team also relied on there being an accurate and up-to-date statement of each person's care needs on the provider's computer system, which was often not the case. This all failed to safeguard the health, safety and welfare of people using the service. This meant the provider was in breach of regulations 9, 10, 11, and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we looked at the actions taken by the provider in respect of addressing the breaches of regulations. We found that the provider had addressed the breaches of regulations 10 and 11. However, we found that there continued to be occasions where people's scheduled visits did not occur as planned. This continuing breach was now a breach of regulation 9 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 [The 2014 Regulations]. We also found that people were still not being supported to manage their medicines safely. This continuing breach was now a breach of regulation 12 of The 2014 Regulations.

Most people told us that they felt safe with their care workers, describing them as efficient, professional and well-trained. A typical comment was, "These carers are good at their job, they allow me independence but are also concerned for my safety and carefully supervise me when I take my medication." A relative told us they felt safe leaving their mother in the care of staff as "they know what they are doing."

Many people had no concerns about care workers' punctuality. For example, one person reported that they had two excellent care workers who came on time. "They look after me so well, leaving me feeling safe and sound, I would trust them with anything." However, several people told us that their care workers were sometimes delayed because they had too many people to visit in a small time-frame, especially at weekends. One person said, "They have lots … who won't work on Saturdays or Sundays….if you can't do much for yourself, you worry that they're not going to come at all when they're late." Typical delays people reported were about 30 minutes, though occasionally some had been delayed by an hour.

One person told us of a bad experience with their hoist as it needed two people to work it. They explained that one care worker waited three hours before another came to ensure the person was hoisted safely. "I would have recommended them, as my regulars are good, but now I am not so sure."

One person told us that staff, despite being very caring, often had to 'clip' their calls by five to ten minutes in order to get to the next person on time. Another person confirmed this, saying, "They have to do it, because they are not allowed travelling time, so this inevitably leads to either being late or leaving early." Both people were cross at losing time they are paying for, but understood that this upset the care workers too. They had both seen care worker's schedules and they felt these were not realistic in terms of getting to everyone on time and staying the full time.

Whilst many care workers told us of good support to get to people on time, a minority felt there was not enough travel time in-between visits to people. None of them were car users. Comments included, "Travel time in between jobs is terrible. The time in between is too short, because I have to get the bus. I have told the office and they just said I need to let the client know if I am going to be late."

When we checked a week of timesheets for four care workers, we found that travel time was too short in two cases. Internet mapping tools showed one care worker needed at least 15 minutes when they were assigned five minutes in-between their first three morning visits. Electronic visit records showed that they regularly worked 15 minutes less at their third visit, to keep on time. Another care worker was regularly assigned 15 minutes' travel time in-between evening visits. However, internet mapping tools showed they needed between 20 and 30 minutes in practice. Electronic visit records showed they regularly worked 10 minutes less than the 30 minutes allocated at one person's home, to keep on time. The organisation of care visits to people did not assure us that all reasonable steps to meet people's needs and preferences.

Electronic visit records for six people between 01 and 24 June 2015 showed that three people experienced a number of care visits that were half the planned visit length

# Is the service safe?

or less. This averaged at 10% of visits for the six people. This meant there was a risk that they were rushed during their care or did not receive the care that was planned. When we checked the total sum of visits times against the total planned, this averaged at 84% for the six people. This meant that people received on average five sixths of their scheduled visit time, equivalent to losing five minutes of every 30 minute visit. Whilst there could be good reason to stay a shorter time at individual visits, there could also be reason to sometimes stay longer, and so the average visit time should be a much closer match to the planned time to help demonstrate that people's care needs were met.

One person's electronic visit records showed that on 16% of occasions, at least one of the two care workers scheduled to attend at the same time stayed for 15 minutes or less of their planned 30 minute visits. The person received 81% of their total planned time from scheduled visits across June 2015. The person's records were manually-overridden in 20% of cases. The approach to this person did not demonstrate that their care needs were being met.

The electronic visit records for all six people had a number of manually-overridden entries, ranging between 10 and 50% of their scheduled visits and averaging at one in five visits. This meant those entries may not have been a true reflection of when, and for how long, care workers attended. A further three people's electronic visit records were almost entirely manually-overridden, for which the manager explained individual reasons why it was generally impossible for staff to use the system. However, manually-overridden entries did not demonstrate the time that care workers attended, and hence did not help demonstrate that people's care needs were met.

Records showed that a minority of people were experiencing missed visits. Out-of-office-hours on-call records for 21 and 22 June 2015 showed four instances of missed visits, two to people requiring one care worker, and two cases where only one of two planned care workers attended. Records showed that the consequences of this included a relative arranging dinner for their mother instead of the agency doing this, and another relative cancelling the visit as it was too late for them.

Electronic visit records for six people in June 2015 showed three instances when the second care worker attended after the first care worker left, for people assessed as needing two care workers to attend together to meet their needs. Twice, the first care worker stayed for 15 minutes or less of the allocated 30 minutes. The service had not identified these missed visits. A fourth instance occurred where a second care worker did not attend. The manager explained that the second care worker had phoned in sick, and that a second care worker was only needed for this person in case allegations of abuse were made. However, this compromised the safety of the person and the care worker who did attend.

We were made aware of five other missed visits occurring in May and June 2015, through the complaints record, one person's notes on the provider's computer system, weekly office staff meetings, and two notifications that the manager sent us. These did not meet people's care needs.

We saw some evidence of late visits occurring that did not meet people's needs. On-call records for late June 2015 showed that one person's husband helped in place of the second planned care worker in one instance, and that further lateness of the second care worker was covered by senior staff. As the person experienced care that did not meet their needs on two consecutive weekends, they raised a complaint. Records on the provider's computer system for June 2015 showed another person twice phoning to ask where their tea visit was. Electronic visit records showed that one care worker arrived over 90 minutes late. The other visit had been incorrectly scheduled for later in the evening, albeit the care worker arrived earlier than planned. People's care needs and preferences were not met in these instances.

The evidence above demonstrates a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received good support with managing their medicines and that care workers always checked to see if medicines had been taken. For example, one person told us, "My girls are very particular about my medicines. They never forget and they always write everything down in the book."

There was appropriate documentation of medicines support in the homes of the three people we visited. However, at the agency, when we compared 12 people's recent medication administration records (MAR) and care delivery records with their care plans and assessments, none of the MAR were appropriately completed. This indicated that medicines were not managed safely for the protection of people using the service.

Inadequate

# Is the service safe?

We found that one MAR had no-one's name, date or medicine name on, so the person could not be identified. People's medicines were recorded on 10 of the MAR as 'dossette box' or 'blister pack' without there being a list of medicines that people were taking. This meant that there was no record of the medicines that people had been given or supported to take.

One MAR had the names of medicines listed, however, when we compared that to the medicines listed on that person's assessment which had been completed during the month that the MAR related to, the list was incomplete. There were no doses recorded on the MAR for any of the medicines. In the assessment one medicine was recorded as being prescribed once a week, but the MAR was signed as if it had been administered daily. This did not assure us that the person was receiving safe support to have their medicines as prescribed.

One person's records showed that care workers 'prompted and monitored' the person with their medicines. Care delivery records showed that an additional 'two tablets for sickness' had been given on one occasion but these were not recorded on the MAR. One person's assessment recorded that they needed paracetamol when required for pain, but this was not recorded on their MAR. One person's MAR was signed for 'blister pack' three times a day for the month and as 'antibiotics' three times a day for two separate periods of six and four days. There was no record of what the antibiotics were or what the dose prescribed was on the MAR or the care delivery record. We were not assured that these people were receiving safe support to have their medicines as prescribed.

One person's care delivery record made intermittent reference to support with inhalers, and occasionally that the person was breathing heavily. Inhaler doses varied between one and two puffs. However, no inhaler name, dose or support was recorded on the MAR. The person's care plan did remind care workers to support them with an inhaler, however, the task prompts for the specific visits across the day did not. One care worker made a number of clear records of the support they had provided the person with two different inhalers. However, a second inhaler was not referred to on the person's care plan, other care delivery records or the MAR. We were not assured that the person was receiving safe support to have their inhalers as prescribed.

We saw that some people's assessments and communication sheets made reference to creams but none of these were recorded on the MAR or consistently recorded in the care delivery records. None of the creams were named or the required frequency of application recorded. We could not be assured that people were receiving their medicines as prescribed or were supported to take their medicines safely.

We were told that all care staff completed medication induction and refresher training. We looked at the training assessment and the example MAR that was part of the training pack. None of the MAR we saw in practice were completed to the standard expected in the training. The medication policy for the service stated, 'A medication record list will also be kept in the service user's home. This will be a clear and current record, signed and dated and accessible to other care providers.' We saw no evidence that this was being followed and staff we spoke with could not confirm that it was.

Each member of staff had a recently completed care worker assessment on record, for senior staff to observe aspects of the care being given. Whilst most care workers had responsibility for medicines, none of the 12 assessments we saw included medicines observation, despite there being facility on the form to do so. This failed to help ensure that people received their medicines safely.

Medication administration records and care delivery records were returned to the office monthly for audit. The completed audit sheets we saw did not pick up on any of the medicines issues that we found.

The evidence above demonstrates a breach of regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff could tell us of signs of abuse to look out for, and how they would record and report all incidences of possible abuse. One care worker told us of reporting an allegation to the office and how the matter had been dealt with by staff there. "They were very good at following it up, they jumped right to it." Another told us of their experience of writing a statement for the police as a result of the concerns they raised. Staff were also aware of the provider's whistleblowing procedure. One care worker showed us that

# Is the service safe?

they had the provider's whistleblowing number in their phone. We raised a dummy alert using the provider's whistleblowing procedure one evening, and found that it was responded to later that night.

Since our last report, the provider had reviewed processes to ensure that we were promptly notified of any allegations of abuse. A designated safeguarding file was being kept to document all safeguarding cases. It showed that the agency was making safeguarding alerts to the local authority where appropriate, regardless of whether the agency was implicated or not.

A relative told us, "I do feel all the carers are professionally competent, but not all have the appropriate temperament for the job." However, they added that the agency "seem to have a way of keeping the good staff, and losing the others." Records and feedback from the manager demonstrated that staff capability and good character was kept under review. We saw that disciplinary cases included where staff failed to report abuse. Disciplinary records were kept on staff files where appropriate, and we saw that one staff member had been dismissed through these processes.

Appropriate recruitment checks took place before staff started work. Staff personnel files included an identifying photograph, completed application forms which included full employment histories, two written references including for previous care work, and relevant qualification certificates. We found no unexplained gaps in employment. We saw evidence of staff members' right to work, including copies of visas and work permits.

There was a record on each staff member's file at the time of recruitment that their criminal record check had been returned as clear. We asked to see evidence of up-to-date criminal record checks, as those we saw were up to 12 years old. The regional director told us that the provider had no specific guidance on this and therefore, these checks had not been updated. He later informed us that the provider had decided to renew criminal record checks for staff where the checks were older than three years.

People were involved in decisions about risks associated with their care as much as they were able. People's care files showed that family members had been involved in discussions about people's safety and needs where appropriate. Risk assessments had been completed and recently reviewed, including for environmental factors, manual handling, food hygiene, and the person's welfare. Plans were put in place to lower risks where appropriate.

Requires improvement

# Is the service effective?

## Our findings

At our previous inspection of 14 and 15 December 2014, we found that care workers were inconsistently trained, supervised and supported. Oversight of these processes was not accurate and so staff were not supported to deliver care to people safely and to an appropriate standard. This meant the provider was in breach of regulations 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we found that the provider had addressed the breach of regulations, although we could not always be assured that the quality of the support provided to staff was productive. We also found that the Mental Capacity Act 2005 was inconsistently applied within care documentation, despite staff having awareness of practical applications of it.

Most people said they felt staff were well-trained. We were told that new care workers normally accompanied a more experienced care worker, especially to people who required two staff for their care needs. However, a few people were concerned with the current standard of training. One person told us, "Training does not seem to be as 'in-depth' as years ago." Another person said, "My principal carers are very good, but some don't know what they are doing. This makes me feel insecure. Weekends can be a nightmare. Some have no experience of ordinary things."

Most staff we spoke with told us they had refresher training recently. One care worker told us, "The office regulate it and call me when I am due for a refresher." We saw systems in the office for ensuring this, which presented as accurate and showed that training was up-to-date across the service. Office staff also demonstrated that the provider's computer systems prevented staff with out-of-date training from being allocated additional visits outside of their usual schedule, which helped to focus staff on ensuring they took opportunities to keep their training up-to-date.

Staff files showed they had completed training recently which the provider considered mandatory. This included for dementia awareness, safeguarding adults, health and safety, moving and handling, fire safety, safe food handling, and infection control.

Care workers told us they had had a supervision meeting within the last three months. They said it was confidential, on an individual basis, and they signed the notes afterwards. Most told us it was a useful process, for example, "It is useful to be able to discuss clients with a manager" and "We get told about changes to procedures, it is good to be kept up-to-date." Some care workers mentioned, however, that they did not receive a record of the supervision meeting.

Records confirmed what care workers told us. However, most of the recorded content on each supervision form was similar, and there was very little input specific to the individual care worker's needs. Many sections were pre-populated with the same information, for example, the same response was recorded in 'Health and Safety issues relating to Working Practices', 'Time keeping', 'Communication log' and 'MARs Charts and Medication' for each care worker. We saw records showing that the manager had provided office staff with further guidance in this area, and we were shown a new supervision form that helped address our concerns.

Each staff member had a recently completed appraisal and development plan. We found that these records, whilst supportive, did not have much content recorded to reflect the discussion which had taken place. There was a section for training and development needs, which was left blank on ten of the 12 forms we looked at. It was completed for one care worker during May 2015 where 'further medication training' was written. However, records showed their medication training was updated in March 2015. There was nothing to indicate what additional medication training was now required. There was a section entitled 'Targets (professional and organisational)', which was not completed on any of the records we looked at. This did not assure us that these processes were being productively used to support staff to provide appropriate care for people.

Care workers told us they had spot checks, a process of auditing the quality of the care visit, from a senior staff member on a regular basis. Comments about these included, "You never know when they are, but that is not a problem, they prove that I am doing a good job" and "Spot checks are needed to make sure we are keeping on track." There were spot checks in each of the care worker files we looked at.

Whilst care workers we spoke with were not all familiar with the terminology of the Mental Capacity Act 2005 (MCA), they were all able to tell us about consent and how they would not force a person to do something against their will. They

# Is the service effective?

also understood the need to obtain consent before performing care tasks. For example, one care workers aid, "My client will often refuse to be washed and that's ok. I chat and make a cup of tea and then go back to the idea of a wash, which usually works. If not, I let the office know and try again the next day."

Care delivery records gave some indication that people were asked about the care to be provided and what their preferences were. People's decisions to refuse care were respected, but we saw evidence of senior staff being contacted where care workers had cause for concern about these decisions. Care plans showed that people's consent was obtained, where possible, about decisions on how the care and support was to be provided. Where this was not possible, best interests representatives were asked to be involved by signing assessments and care plans. However, care assessments included very little about people's choices and preferences, and we found no evidence in people's files about capacity assessments taking place where care assessments and plans were signed by best interests representatives. The area manager told us that care forms were being reviewed to better demonstrate compliance with the MCA.

Most people were happy with the standard of personal care provided. One person told us that their skin was prone to tears and bruising. She praised the care workers' patience in drying her carefully, and using three different creams to protect and moisturise her skin. She told us, "They are very good on skins. I'm grateful for that as my skin breaks down very easily. They will always notice if my skin needs extra care." A relative felt the staff were competent and "excellent at strip washing, showing great concern."

The agency supported people to maintain good health. Several people told us that because they received the same care workers, any changes in their health were quickly noticed. One person said, "They will notice if I am having a bad day. Often they'll be aware before I am." Another person told us that if they did too much their speech become slurry, which staff noticed and advised them to rest more. Most people told us they felt the agency supported their health needs. For example, one person said, "When I had a very bad back the carers contacted the GP for me, very helpful."

Records and feedback showed that staff had received training on skin integrity. Staff we spoke with explained how they monitored pressure areas and how they might alert the district nursing service if appropriate. People's care delivery records included instances where care workers documented concerns about their health. On some occasions, the records showed that health matters had been referred to senior staff or directly to healthcare professionals, so that further support could be acquired.

Those who had meals provided for them by their care workers, told us that this was done to their satisfaction, and wherever possible, choice was offered to them. One person said, "I have the same for breakfast every day, my choice, but they do me a cold tray for tea with lots of choices available. It's presented nicely, so that it looks appetising." Another person told us, "They help me with my food and see that I eat well." We were told that staff always encouraged people to drink regularly, with some commenting on care workers increasing the levels of drinks available because of the recent hot temperatures.

Staff we spoke with about dietary needs showed a good awareness of the importance of reporting issues such as weight loss. Care delivery records usually included, where relevant, exactly what food and drink the person had had, and often stated that a drink had been left within reach of the person before the care worker left. Care plans reminded staff of the support they were to provide in respect of food and drink. These were backed by assessment of need and risk in these areas. The area manager told us of working with the local authority to access further training for staff on nutritional awareness.

Good

# Is the service caring?

## Our findings

At our previous inspection of 14 and 15 December 2014, people had mixed views about how caring staff were, and we found that some people did not receive a consistent set of care workers who got to know their individual care needs and preferences. We concluded that people were not always treated in a caring way that met their individual needs. This meant the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we found that the provider had addressed the breach of regulations. There was improved feedback about the caring nature of staff. We found that people received a consistent set of care workers with whom they developed positive, caring relationships.

Most people referred to their regular care workers in glowing terms, telling us that they were extremely caring and understanding. One person said, "They're all as good as gold. Even when our regular is off, they still send someone in who is just as good and kind." A relative praised the support care workers provided their husband who has dementia. "They are patient and caring, and laugh at his jokes." One person explained how their care workers helped them feel good about themselves, adding that their personal care was "expertly managed."

A relative told us, "They work their socks off, and they do it admirably. They are beyond good." They added that a regular care worker had just returned from holiday abroad "so today my husband is wearing a beautiful tunic from Ghana brought back by her. That sums up how they go over and above what is expected of them."

We were told that, despite care workers being busy, people did not feel rushed, especially if they were feeling unwell. One person told us, "I know how busy they are, but I also know they'd stay longer if they felt I needed more help one morning," which gave them peace of mind. We checked care visit records and saw cases where care workers had stayed longer than scheduled due to people's health needs which they additionally reported to senior staff.

However, one relative told us of an uncaring and neglectful approach to their father. We raised this as a safeguarding alert with the local authority. At the time of drafting this report, the investigation had not been concluded but the agency was cooperating with the investigation.

Most people told us of having regular, long-serving care workers which led to a helpful level of understanding about their physical and emotional conditions. One person said, "It's not like a carer, it's like having a friend come to see me. She looks after me, but we also have a real laugh together, which is just as important." Another person commented, "I've had the same group of carers for years, they do an amazing job, and I've grown very fond of them all."

Our checks of people's electronic visit records confirmed that most people received smaller groups of staff across each week to attend to their care and support needs. The manager told us that work had taken place to ensure the provider's computer system had a standard set of staff who were automatically assigned to each person each week. We saw records confirming this work. Improvements were therefore evident for helping to ensure people were visited by consistent care workers who knew their needs and preferences.

People told us that staff listened to them, and provided care in ways they preferred. One person said they had been receiving care for six months, adding, "At the beginning I was absolutely dreading it, but they give me choice in everything they do, and never take over in my home."

People reported support with maintaining their independence. One person said they were by nature very independent, and that they valued staff understanding this. When showering, or getting dressed, they were encouraged to do as much as they could, but care workers "pick up the slack" and assisted as needed. Another person told us that, following a recent fall, they needed more support which care workers were providing well. They added that their independence was encouraged when appropriate, which they appreciated.

All care workers we spoke with demonstrated a good understanding of how to respect a person's dignity and told us how they did this whilst supporting them with personal care. This included ensuring all doors and curtains were closed and exposing only those parts of the body which were being washed. One care worker told us, "You must listen to how they want to be washed, for example, by using different flannels for different parts of the body."

Good

# Is the service caring?

The manager told us that staff were being encouraged to sign up to the Dignity Champions program, which helped raise awareness of treating people respectfully and reporting abuse. It had been a prominent part of recent staff meetings.

The manager told us of reintroducing the care worker of the month award. The first care worker to receive this was because they reported their concerns for the health and welfare of a person they supported. The service was therefore able to offer better support, for example, with the cleanliness of the person's home. The manager also told us the care worker had a patient approach to the person that enabled the person to accept support despite initial reluctance.

Good

# Is the service responsive?

## Our findings

At our previous inspection of 14 and 15 December 2014, we found that some people's care plans and care delivery records showed that their individual needs were not being responded to. We also found that people's complaints were not identified and addressed. This all failed to demonstrate a responsive service. This meant the provider was in breach of regulations 9 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we found that the provider had addressed the breaches of regulations. Everyone had had a face-to-face review of their care needs, and there was improved feedback about receiving personalised care. People's concerns and complaints were also now being responded to promptly.

Most people found the agency to be responsive. Some people spoke of being kept informed if care workers were running late. We were told that changes to visit times could be accommodated if people had to be out early for hospital appointments or social events. Records confirmed that this took place where possible.

Several people told us they felt more able to make their views known in recent months. They gave examples of changes that had been implemented because of their feedback. A relative told us of there having been too many different care workers. "I have recently raised this with the office, and I'm confident that they're going to change things – they do listen to us more now."

Another relative told us they had complained recently about a care worker who seemed lazy and spoke about inappropriate matters that caused embarrassment. "They listened, the care worker has never been back since, and I think they've let her go. Our girls were grateful that I complained because they found her difficult to work with too."

One person said that staff always took their problems seriously, and tried to resolve them to their satisfaction. For example, a weekend care worker had been booked for a 10:00 visit rather than the usual time of 07:30. They told us, "I was cross as I have to leave at 10:30 to go to church." They said they received an apology, confirmed that it had only happened once, and that they felt it would not be repeated.

We checked the scheduling for someone else who attended a place of worship at the weekend. At our last inspection, despite repeated complaints, care workers were being scheduled to visit whilst they were out. We found that they were now regularly receiving care workers just after their return, and there were recent records of the person being satisfied with the times of visits and the overall care provided.

A number of people told us about the service's recent annual review of their care, which they felt had been helpful. They all felt that the staff who came out to visit them in their home had listened to their views, had genuinely wanted to improve their service, and had made sure that it was meeting current needs. Records demonstrated that people had received one of these reviews since the new manager started working, or a shorter quality monitoring visit. Where appropriate, action had taken place to improve on the service provided to specific people.

Care records we looked at contained assessments of people's individual needs. There were up-to-date care plans in place arising from these, showing how the care was to be provided. We saw that care plans and emergency contact details were in place in people's homes.

There were six complaints recorded in the agency's complaints file since the new manager started in early April. These showed that investigations produced a range of outcomes but indicated that the agency accepted where service shortfalls had occurred. For example, a recent complaint about the approach of a care worker had resulted in a disciplinary record on the care worker's file with clear instruction of expected standards. There was a record of a phone call to the complainant about actions taken, and a letter of actions taken. We found that complaint resolutions were sufficiently prompt, the longest being 16 days.

There was other evidence of people expressing dissatisfaction with the service in the last few months, for which action had been taken to resolve matters. For example, records showed that a relative of one person phoned the agency to express dissatisfaction with the lack of support from care workers to wash their relative and change clothing. Care delivery records showed that a senior staff member visited the person the next day, and

Good

# Is the service responsive?

put in place further instruction about the person's care for staff to follow. Care delivery records showed care workers recording in more detail to show they had actioned the instructions.

Complaints about care raised with the provider's out-of-office-hours on-call team were actioned through weekly office staff meetings. Records of these showed, for example, that following a healthcare professional raising concerns about the approach of an unnamed care worker, a memo had been sent to all staff reminding them of appropriate behaviour. Where someone had complained about a care worker not staying long enough, an unannounced spot-check of the care worker had taken place to ensure they knew how to meet the person's needs. The manager had also notified us of actions taken to address a missed visit they had identified through a follow-up phone call to someone who had expressed some concerns about their care package in a review meeting. This all helped to demonstrate that the service was now routinely listening to, and learning from, people's experiences, concerns and complaints.

Requires improvement

# Is the service well-led?

## Our findings

At our previous inspection of 14 and 15 December 2014, we found that audit tools used to check on the management of the service were not always accurate and up-to-date, and action was not taken when the tools identified risks to the welfare of people using the service and staff. Missed care visits were not investigated or routinely reported to senior managers, so that action could be taken to prevent reoccurrence. Records were not always accurate and up-to-date, and they were not always provided to us in full when we requested them. This all undermined our confidence in the transparency and management of the service, and meant the provider was in breach of regulations 10 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection, we looked at the actions taken by the provider to address the breaches of regulations. We found that audit tools used to check on the management of the service were now accurate and up-to-date, and action was being taken when the tools identified risks to the welfare of people using the service and staff. Records were now provided to us in full when we requested them. However, whilst action was taken to investigate missed visits that were identified, weekly reports to senior managers continued to omit information on missed visits. Records were still not consistently accurate and up-to-date, and checks of care delivery records continued not to identify risks around medicines management. This meant that there remained shortfalls in the effectiveness of the provider's governance of the service. This continuing breach was now a breach of regulation 17 of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new manager had been appointed since our last inspection, following our cancelling of the previously-registered manager's registration. The new manager informed us they had started working at the service on 07 April 2015. Information from the new manager assured us that they had applied for registration as manager of the service.

A number of people told us that they felt the service had improved in recent months, and would continue to do so. One person said, "The new manager is far more available than the old one. The new one is happy to discuss any issues with you."

We looked at the tools used by the manager and provider to oversee that different aspects of the service were being appropriately provided to people. These showed that most people had had a care review meeting or equivalent within the last three months, to help ensure that the care package met their needs and preferences. Staffing tools showed that most staff had had supervision in the same period, and that they were up-to-date with core training requirements.

The manager showed us reports that were prepared weekly for oversight of the services provided. These considered, for example, complaints, supervisions, and reviews of people's care packages. They did not, however, prompt for information on safeguarding cases or missed visits that had occurred, as per our previous inspection. There was additionally no summary of the safeguarding cases in the safeguarding file. The manager told us that missed visits were added to the safeguarding file, as per the provider's missed visits policy. However, we identified a number of missed visits that were not part of the file. We were therefore not assured that there was appropriate oversight of safeguarding cases and missed visits, including that key information about these matters was being passed onto senior managers so that they could ensure that the matters were being appropriately managed. The provider's governance systems were not being used effectively to identify, assess and manage risks in relation to the health, safety and welfare of people using the service arising from safeguarding cases and missed visits.

There were separate audits of the care delivery records, medicines records and financial transactions that had been moved from people's homes into the office. However, these continued to be ineffective at capturing concerns. Three of the five we checked failed to identify that medicines records had not been completed in full. Whilst we found that many care delivery records showed that medicines support had been provided at the time of the gaps on the medicines record, this was not always the case, meaning there was no record of the person being supported to take their medicines as prescribed. One of these audits failed to identify that where the medicines record for one day twice recorded 'X' (meaning the person refused the medicines), there was no care delivery record of any support being provided at that time. Whilst electronic visit records confirmed that staff had attended, the audit failed to identify the risk of both a missed visit and a failure to

# Is the service well-led?

provide medicines support. These audit processes were not being used effectively to identify, assess and manage risks in relation to the health, safety and welfare of people using the service.

The 'missed visit' policy stated that each missed visit, clarified in the policy as not visited in accordance with the person's care plan, would be investigated, with reports placed onto the file of the affected person, that person's entry on the provider's computer system, and a separate designated file by which to help audit. However, we found no investigation records on people's files, incomplete investigation records on computer entries, and the manager told us she was only just starting to capture missed visit occurrences in a separate file. This was despite there being evidence of a small amount of missed visits from on-call records supplied to the service. Electronic visit records also showed a small amount of instances when the second care worker attended to someone after the first care worker had left, where two care workers were required to work together to meet the person's needs. These were not identified in on-call records, and we found no records of investigation of these. Whilst weekly office meeting minutes showed that action was being taken to investigate missed visits advised by the on-call team, nothing was provided to us on request to show how electronic visit records were checked for missed visits except for live monitoring by an office staff member when in the office. The approach to identifying, assessing and managing risks to people's health and safety as a result of people's scheduled visits not occurring in a manner that met their needs was not effective.

We found four cases where the agency had not ensured that specific care workers had been excluded from being sent to provide care to someone in circumstances where they should have been excluded. For example, an inconclusive safeguarding case from earlier in the year included an outcome that the involved care worker would not be working with the person using the service again. However, we found that the care worker was not blocked from being assigned to working with that person on the provider's computer systems. A recent quality review meeting in May 2015 for one person asked for another care worker to be removed from their care as they were "not doing what is needed." There was no follow-up action recorded on the review form, and we found that the care worker had been assigned to work with the person for each weekend in June 2015.

When we checked for appropriate oversight of hoists used in people's homes, there was no specific check of the hoist for one person within the latest assessment of risk. This failed to establish whether the hoist was in need of servicing. Subsequent records on the provider's computer system for this person found that the hoist had recently stopped working mid-use. Whilst no harm was reported, the failure to document a check that this hoist was appropriately serviced was not effective monitoring of risks to the person relating to use of the hoist.

The area manager told us the provider's quality auditing team was last at the agency in December 2014, before our previous inspection. This meant that despite the concerns highlighted in our last inspection report, including the lack of concerns found by the provider's quality team, the provider had not asked that team to make further checks at the agency. This was not effective governance of the service, particularly as we found at this visit that some of our concerns had not been addressed.

The manager sent us a copy of the action plan that she had set up with the area manager in response to our previous inspection along with updates to show what had been completed. The plan addressed a number of our concerns from the previous inspection, and we saw evidence corroborating aspects that that had been signed off as addressed. However, the plan did not reference some of our concerns from the last inspection, for example, to address missed visits and the auditing of these, and to eradicate instances of people receiving much shorter visits than planned. At this inspection, we found that these issues were still occurring. Additionally, there was little progress at this inspection with addressing the concerns we previously found with medicines management. This meant that the action taken to address the concerns we identified at our last inspection was not fully effective.

People told us that care workers always recorded the support they provided at the end of each visit. Most records confirmed this to be the case. Some records made by care workers provided good detail on the support provided, for example, on what the person had eaten, if anybody else was visiting at the time of the care visit, and any concerns about the person's health.

However, we found that accurate records were not consistently maintained in respect of people using the service and the management of the service, which failed to support the effective governance of the service.

Requires improvement

# Is the service well-led?

When we asked the manager to explain why only one care worker was scheduled to attend a particular visit for someone who was assessed as needing two care workers to meet their needs, we were told that the second care worker was planned in case allegations were made. However, this was not recorded on the person's care plan, and there was no record on the provider's computer system explaining reasons why it had been decided that one care worker could attend in that instance. There was similarly no record of decision for another person when only one of two planned care workers attended, when the explanation we were told was that the first care worker had phoned the office to say that the person had said the second care worker was not needed on that occasion. Explanations for a third person's altered care visit was similarly not documented.

We asked for explanation of two short visits to one person, and instances of another person being recorded as refusing their medicines twice in one day. Whilst electronic visit records showed the attendance of the care workers, the manager established that the care workers had not recorded the care delivery in the file at the people's homes on those occasions.

When we asked for evidence of weekly visits to someone by a senior staff member, which was an action point on a complaint resolution letter for that person, the manager told us these were occurring but had not been recorded.

We asked for explanations of why staff seldom used the electronic logging system at two people's homes. Whilst explanations were given, there was nothing formalised on these people's care plans indicating the likely difficulties for care worker with using the system.

We found that the safeguarding file lacked sufficient records. Whilst there was an entry for each safeguarding case, two recent alerts to the local authority had no other information on actions taken except for the alert. Where the agency had investigated matters, we saw records of supervisions and disciplinary processes but no investigation reports to explain the process and outcome of the investigation. We checked the care files of three people as office staff told us the investigation records would be there, which matched the provider's safeguarding policy. However, we only found records of safeguarding cases from before 2015. Whilst there was evidence of safeguarding matters being attended to, records did not always demonstrate effective operation of safeguarding processes.

We found evidence of people expressing dissatisfaction with the service in the last few months that were not recorded within the agency's complaints file, contrary to the expectations of the provider's complaints policy. For example, records showed that a relative of one person phoned the agency to express dissatisfaction with the lack of support from care workers to wash their relative and change clothing. Whilst this was a prompt response to the matter, it had not been recorded in the agency's complaints file. Weekly office staff meetings showed action being taken in response to expressions of dissatisfaction that were evident within on-call records or notes on the provider's computer system, but without these being added to the complaints file.

Many of the above cases were additionally not referenced within the weekly reports sent by the manager to senior managers. This meant the complaints system was not being used effectively to assess, monitor and mitigate the risks to people's health, safety and welfare.

The evidence above demonstrates a breach of regulation 17(1)(2)(b)(c)(d)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager showed us various ways in which she had promoted a positive and open culture. She showed us various letters sent to people using the service, including introducing herself, and making people aware of our last report along with some actions being taken to address matters.

One person said that the manager was in the process of setting up a 'forum' for people to come in and discuss the quality of the service. They explained, "I'm quite opinionated, and if they don't do a good job I'm on their back, but the manager says she wants me there. That's a good sign I think."

Some care workers told us that they had been to a recent team meeting with the new manager, for introductions and to help improve standards and morale. Staff fedback positively about this, for example, "It made me feel that things are going in the right direction."

Many care workers fedback positively about how well office staff supported them. One care worker told us, "They guide me, for example, make suggestions about what alternatives to offer if a client refuses to eat their lunch." We

Requires improvement

# Is the service well-led?

were told of how office staff directed someone to a new person's home when they got lost, and how another care worker was always rung back when they left a message seeking advice.

Most care workers told us that the provider's out-of-office-hours on-call service was supportive. Comments included, "They always answer the phone promptly or they call back if busy" and "You feel you have the support at all times." The manager told us that whilst this was a national service for all of the provider's agencies, senior staff worked a concurrent back-up roster for the on-call service to get local knowledge and advice from when needed.

Records and feedback from the manager demonstrated that staff sickness levels and reasons were being monitored, with staff being called into the office for further discussion where considered appropriate.

The manager demonstrated that she took action in response to our findings. For example, after we showed various medicines support records that had not been appropriately recorded on, a memo was sent to all staff about expectations around recording practices in people's homes.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>The registered persons did not ensure that the care of service users was appropriate and met their needs, by means of ensuring that care visits always took place as planned.<br><br>Regulation 9(1)(a)(b) |

**The enforcement action we took:**
The Care Quality Commission served a notice proposing to remove the location 'Sevacare – Haringey' from the registration of the provider, Sevacare (UK) Limited. Due process was followed which meant that the Care Quality Commission removed the location 'Sevacare – Haringey' from the registration of the provider, Sevacare (UK) Limited, on 4 April 2016.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The registered persons did not ensure that the care of service users was provided in a safe way, by means of the proper and safe management of service users' medicines.<br><br>Regulation 12(1)(2)(g) |

**The enforcement action we took:**
The Care Quality Commission served a notice proposing to remove the location 'Sevacare – Haringey' from the registration of the provider, Sevacare (UK) Limited. Due process was followed which meant that the Care Quality Commission removed the location 'Sevacare – Haringey' from the registration of the provider, Sevacare (UK) Limited, on 4 April 2016.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Systems were not effectively operated to ensure compliance with the Fundamental Standards. This included failure to:<br><br>assess, monitor and improve the quality and safety of the services provided; |

This section is primarily information for the provider

# Enforcement actions

assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others.

Regulation 17(1)(2)(a)(b)

**The enforcement action we took:**

The Care Quality Commission served a notice proposing to remove the location 'Sevacare – Haringey' from the registration of the provider, Sevacare (UK) Limited. Due process was followed which meant that the Care Quality Commission removed the location 'Sevacare – Haringey' from the registration of the provider, Sevacare (UK) Limited, on 4 April 2016.