Sevacare (UK) Limited

Sevacare – Sheffield

Inspection report

Omega Court
356 Cemetery Road
Sheffield
South Yorkshire
S11 8FT
Tel: 01142663570

Date of inspection visit: 4 and 9 December 2014
Date of publication: 24/03/2015

Ratings

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

Overall summary

As the result of concerns raised by the local authority and by people contacting the Care Quality Commission we undertook an announced inspection of Sevacare - Sheffield on the 4 December 2014 and the 9 December 2014. We told the provider two days before our visit that we would be coming so that we were able to access the office and records of the service.

Staff from Sevacare - Sheffield provide personal care services to people in their own homes. At the time of our inspection 174 people were receiving a personal care service.

This was first time the service has been inspected by the Care Quality Commission. The service was registered with the Care Quality Commission on the 4 February 2014.

The registered manager for this service was not based at the service. We contacted the registered manager by telephone and they informed us they did not have any involvement in the management of the service. They were not present during the inspection. A registered

Summary of findings

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.

One of the provider's supporting managers was managing the service at the time of the inspection. They informed us that a new manager had been recruited for the service and was due to start working at the service at the beginning of January 2015.

Out of the thirty three people spoken with, nine people were fully satisfied with the service being provided by Sevacare - Sheffield. People made very positive comments about staff and the care they received if they had regular care workers providing all or some of their care. However, people told us they want regular call times and regular care workers who were properly trained. We found the service had not made sure there were sufficient staff with the right knowledge and experience to support people to an appropriate standard.

Most people told us they felt "safe". A few people told us they didn't feel safe being supported by strangers and/or inexperienced staff who need more training. Most of the relatives spoken with felt their family member was safe but also expressed concerns about the training new staff had received.

Staff had received training in safeguarding vulnerable adults as part of their induction training. Our discussions with staff told us they were aware of how to raise any safeguarding concerns. However, we found some staff did not demonstrate a good understanding of the provider's whistleblowing procedures.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

The service had not completed regular care plan reviews with people using the service. Individual risk assessments were completed for people so that identifiable risks were managed but these were not being regularly reviewed to ensure they reflecting people's changing needs.

Some people's nutritional and hydration needs were not being met because they were not experiencing regular calls during the day. This meant they were not being supported to have regular drinks and meals during the day.

Staff were able to demonstrate an understanding of the Mental Capacity Act 2005 (MCA). Staff were able to describe how they respected people's privacy and treated people with dignity and respect. We received mixed views about the staff. Some people made very positive comments about the staff and described them as caring and that they were treated with dignity and respect. However, some people felt they were not treated with consideration and respect by staff.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work. However, a few people expressed concerns regarding the standard of English of a few staff recruited from the European Union.

Staff received induction training for their roles. However, people and relatives were concerned that new staff had not been properly trained to enable them to deliver care to an appropriate standard. We found that staff competency had not been checked prior to them supporting people on their own to ensure people's needs were met by competent staff. Staff had not received regular supervisions which meant their performance was not formally monitored and areas for improvement may not have been identified. This meant the service did not ensure staff received appropriate training, professional development, supervision and appraisal.

The provider had a complaint's process in place. However, the provider did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by people or persons acting on their behalf.

The provider had not ensured there were effective systems in place to monitor and improve the quality of the service provided. This meant they were not meeting the requirements to protect people from the risk and unsafe care by effectively assessing and monitoring the service being provided.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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 were not safe. The service had not made sure there were sufficient staff with the right knowledge and experience to support people. Most people told us they felt "safe". Two people told us they didn't feel safe being supported by strangers and/or inexperienced staff who need more training. Staff were aware of how to raise any safeguarding issues.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

Is the service effective?

Inadequate

The service was not effective. Staff had not been supported to deliver care and treatment safely and to an appropriate standard. Staff refresher training was overdue so staff had not been supported to maintain and update their skills and knowledge.

People's dietary needs were accommodated. However, some people were not receiving regular calls to enable them to eat or drink regularly during the day to maintain their hydration levels.

Is the service caring?

Requires Improvement

Some areas of the service were not caring. During the inspection we receive positive and negative feedback from people using the service. A few people told us they were not treated with consideration or respect.

Regular staff working at the service knew people well and were able to describe how they maintained people's privacy and dignity.

Is the service responsive?

Requires Improvement

Some areas of the service were not responsive. We found the service had failed to ensure the planning and delivery of care met the needs of individual people using the service. Some people did not experience continuity of care.

We found the service had not responded to some people's and/or their representative's concerns effectively and the action taken had not been sustained to address their concerns.

Is the service well-led?

Inadequate

The service was not well-led. The checks completed by the supporting manager and provider to assess and improve the quality of the service had not effectively ensured people were protected against the risk of inappropriate or unsafe care.

Summary of findings

During the inspection we found evidence that neither the supporting manager nor the registered manager had notified CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

Sevacare – Sheffield

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 checked 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.

The inspection took place on 4 December 2014 and 9 December 2014. We told the provider two days before our visit that we would be coming. This was an announced inspection which meant that staff and the provider did know we would be visiting. We announced the visit to the provider to ensure the manager was available and to arrange visits to people in their homes.

The inspection team consisted of three adult social care inspectors; one visited the office, spoke with people using the service and/or their representative. Two inspectors completed telephone interviews with staff.

The Sevacare – Sheffield service provides personal care services to people in their own homes. At the time of our inspection 174 people were receiving a personal care service.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with twenty nine people and five relatives by telephone and visited four people in their homes. We also spoke with the supporting manager, a care coordinator, administrator and team leader at the office and interviewed eleven care workers by telephone. We reviewed a range of records including the following: nine people's care records, eight people's medication administration records, four staff files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Most of the people spoken with told us they felt 'safe'. However, two people told us they did not feel safe because they did not like being supported by care workers who were "strangers" and by inexperienced staff who needed more training. For example, one person told us they felt so unsafe whilst being supported by two inexperienced staff members, they had refused to be supported because they thought they were going to fall. They told us the care workers had asked them for guidance on how they should be moved. Another person told us they dreaded the days their regular worker was off as they didn't know who was going to be supporting them.

Most of the people spoken with told us staff did not show them their identity cards and many of the people looked to see if staff were wearing their uniform. This showed that care workers were not following the guidance in the provider's staff handbook which stated the following: "all employees will be issued with an identity card. This must be carried at all times and shown to service users when starting care". This told us that some people may place themselves at risk by mistakenly allowing someone into their home thinking they were a staff member from the service.

A few people spoken with had time critical calls because they needed to take medication at certain times during the day but they were experiencing late calls. For example, one person commented: "because the calls are late I am not taking my tablets at the correct time to manage my diabetes, I need help getting out of bed and I need to eat first". A few people also raised concerns regarding the competency of staff to administer medication. Their comments included: "it is a worry that you have to tell some staff what tablets you need to take, if you didn't you would go without", "one girl [care worker] about a fortnight ago refused to put my eye drops in, she told me she hadn't had any training" and "a few of the carers [care workers] can't read the English on my medication". This showed that some people were experiencing a negative impact on their health and wellbeing.

A relative spoken with told us it was really important their family member took their medicine at the same time every day to manage their medical condition but often the calls were late. They gave us examples of the late calls from the person's daily records over the phone.

We spoke with the supporting manager who told us staff received medication training as part of their induction. However, we found that a medication observation assessment was not undertaken as part of induction training. It is important that an observation is undertaken to ensure staff can administer medication safely so people are protected from the risks associated with medicines. In the staff handbook there was no guidance under the medication section on what to do if a staff member identifies an error. For example, when the medication administration record (MAR) had not been signed by staff. It is important that staff are provided with clear guidelines on the action to take if they identify a medication error.

On the first day of the inspection we asked to see five people's completed MARs that had been collected from their home. The supporting manager told us they had been archived and they would need to retrieve them. Some of the care workers spoken with told us there had been numerous medication errors and identified different areas where they worked where the highest level had been seen. We saw examples where people's medication records had been audited where concerns had been raised via a complaint or where a concern had been raised by the local authority. However, the supporting manager told us that due to staffing levels at the service there had not been capacity to audit people's medication records where concerns had not be raised. It is essential to have a robust system of audit in place in order to identify concerns. Also to record the actions taken to make the improvements and changes needed to ensure medicines are managed safely.

We found there was no information and guidance in place for staff to follow in people's care plans about medicines when they had been prescribed to be given 'when required' to ensure people were given their medicines safely and consistently. For example, one person had been prescribed a medicine for pain but there was no information on how they communicated they were in pain.

During a visit to a person's home we reviewed the person's MAR and found there were gaps where staff had not signed the MAR to confirm medication had been administered. For example, for one medicine there were eight gaps. We also found there were no arrangements in place to ensure the person took their medicine for best effect. For example, thirty minutes before food. During the visit the person told

Is the service safe?

us they had given a care worker a prescription to be filled but they were concerned they had not received it. We spoke with a care coordinator who assured us they would follow up this concern.

On the second day of the inspection we reviewed the person's daily records which had not been available to review at their home. We found one staff member had identified three gaps in the person's MAR chart for the three bedtime calls in November 2014 but we found no evidence of any action taken by staff. We spoke with a team leader who told us the person's prescription had been located in the person's home and filled. We noted an entry in the person's daily records dated the 27 November 2014; the person had requested assistance for a prescription to be filled. This showed the person had not being appropriately supported to manage their medication.

We found the service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines. These findings evidenced a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Out of the thirty three people spoken with, nine people were fully satisfied with the service being provided by Sevacare. People made very positive comments about staff if they had regular care workers providing all or some of their care. However, people told us they wanted regular care workers who came at regular times who had been trained properly.

The provider operated an on call service for people to contact out of office hours. Information on how to contact on call was included in people's care records in their home. A few people expressed dissatisfaction with the on call contact arrangements. Their comments included: "they put you through to Birmingham, the office in Sheffield doesn't open until 9am, you don't get to speak to people in the office" and "the Birmingham call centre they don't know the people, the staff or the area and half the time the staff don't answer the phone".

People told us the service found it very difficult to obtain staff to complete a call when staff were absent or delayed. People also told us the service had obtained staff from other Sevacare services outside Sheffield to deliver calls because they were so short staffed. Their comments included: "there is no back up when staff don't turn up", "one of my care workers didn't turn up, the care worker rang the office for another care worker to come but nobody was available so she dealt with me on her own" and "poor organisation and coordination of calls and no back up when staff call in sick".

All the relatives spoken with told us they wanted their family members to be supported by regular care workers all the time, who came at a regular time and who been trained properly. Their comments included: "principally there is a shortage of staff" and "we need staff who know the person, weekends are always a problem". Relatives spoken with raised concerns regarding the safety of their family members. For example, one relative observed and provided guidance to new and inexperienced staff on how to use a hoist to keep their family member safe. One relative described how their family member had been placed at risk because the service had failed to deliver any calls over an eighteen hour period in October 2014.

Staff comments regarding the staffing issues at the service included: "staff are rung to see if they can cover, you have to fit it in around other calls on the rota. It means that calls are rushed", One care worker who provided support to one person who needed two people for their calls told us that at the weekends a second care worker sometimes did not turn up all. The explanation given by office staff to them was there were not enough staff at the weekend to cover.

The supporting manager acknowledged there were staff vacancies at the service and told us they were actively recruiting staff including workers from the European Union. We found that people's health, safety and welfare had not been safeguarded because there was not sufficient numbers of suitably skilled and experienced staff. These findings evidenced a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a process in place to respond to and record safeguarding vulnerable adults concerns. The supporting manager told us they could access the local authority safeguarding adult's protocols but did not have a hard copy of the protocol. The supporting manager told us they would obtain a hard copy to ensure staff had access to the procedures to follow to report any events and safeguard people from harm. The supporting manager showed us

Inadequate

Is the service safe?

two safeguarding alerts they had sent to the local authority safeguarding section. However, we found that a notification had not been sent to CQC for either alert which is a requirement under the Health and Social Care Act 2008.

Staff had received training in safeguarding vulnerable adults as part of their induction training. The staff handbook contained a range of information for staff including the following: safeguarding vulnerable adults, receiving gifts and bequests. It was clear from discussions with staff that they were aware of how to raise any safeguarding issues. However, we found some staff did not demonstrate a good understanding of the provider's whistleblowing procedures.

The arrangements in place to help protect people from the risk of financial abuse needed to be more robust. For example, a few people spoken with told us that they were not asked to sign a financial transactions form when their care worker regularly bought them small items of shopping. A few care workers spoken with acknowledged that they should use the form. We looked at the provider's policy for dealing with service user's financial matters, which stated that where a staff member is regularly dealing with a person's money that a written record of all transactions must be kept and all receipts must be obtained. We spoke with the supporting manager who told us that financial transactions records were collected when they were full but these were not checked. We found there was not a system in place to check people's financial transaction records to safeguard them from financial abuse. These findings evidenced a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities)

We looked at people's care records. People had individual risk assessments in place so that staff could identify and manage any risks appropriately. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. However, we found that people's risk assessments were not being regularly reviewed and some of the entries on people's risk assessments could be more tailored to the person's individual needs. For example, if a person did not received a medicine consistently this would increase their risk of a developing a unitary tract infection which would increase their risk of falls.

We reviewed staff recruitment records for three care workers. The records contained a range of information including the following: application, interview records, Disclosure and Barring Service (DBS) check, references including one from the applicant's most recent employer and employment contract. This told us people were cared for by staff who were fit to work in this field. However, a few people expressed concerns regarding the standard of English of some of the workers who had recently been recruited from the European Union. Their comments included: "we have a new one [care worker], his English isn't too good, he reads the care plan but still does things wrong, tries to do his best but just doesn't get it right", "a complete stranger [care worker] when he came, he couldn't understand what I wanted" and "they [care workers] can speak English but it is more difficult to communicate with them, they try to help me the best way they can". A few of the care workers spoken with also raised concerns about a few of the new starter's fluency in English.

Inadequate

Is the service effective?

Our findings

People and relatives did not raise any concerns about the training of the staff who were experienced regular care workers. People's comments included: "my regular workers are marvellous they are all very good" and "[care worker] is absolutely first class, really experienced, really caring".

However, people expressed concerns about the training and competency of new staff. People's comments included: "they need training in basic things, some of them [care workers] don't even know how to make a bed", "a couple of them don't use gloves to handle food but at least they wash their hands", "some of the carers that are coming don't know how to set up my night bag", and "they [care workers] didn't know how to use a slide sheet". A few people described how some staff would ask them what tasks they wanted completing and did not read their care plan. Their comments included: "I am lucky, I have the wits to tell them what to do, they don't read the care plan", "I am tired of telling them [care workers] what to do and where everything is" and "I don't know what to tell them, I can't remember".

Relatives also expressed concerns about the training and competency of new staff. Their comments included: "the staff definitely need more training in providing basic care" and "they are sending them out too soon to support people they need more training". One relative described how a care worker had assumed their family member was not in even though they were upstairs in bed, waiting to be supported to get up, have their breakfast and given their medication. The relative confirmed that the incident had been reported to the provider and the local authority to investigate.

In the statement of purpose and service user guide it stated under staff training: "our staff receive a comprehensive induction programme". Also as part of the provider's quality assurance processes care worker competency assessments would be completed and the team leaders would work with care workers and identify areas of their performance that required improvement. We found that out of seventy five staff only fifteen carer assessments had been completed. For example, one in November and two in October 2014.

One care worker told us they no longer worked at the service. They had completed the induction training and had spent two days (16 hours) shadowing another care worker in November 2014. After the 16 hours the service told them they were now able to support people on their own. The care worker told us they did not feel confident or competent to do this and had left. They told us the induction process was insufficient to meet their needs particularly as they were new to this type of work. This showed the staff member had not been appropriately supported to provide care to people who used the service.

We reviewed three files for staff. Each care worker had completed a three day induction course. We found the amount of time a new care worker shadowed another care worker as part of their induction varied. For example, one care worker told us they had shadowed another care worker for five hours, another care worker told us they had spent two days shadowing. We spoke with the care coordinator who confirmed that the amount of time new staff worked alongside another care worker varied according to experience and whether they were from the European union. They also told us that a carer assessment was not completed at the end the shadowing period to check for competency and identify any areas requiring improvement. This showed that there wasn't a robust system in place to ensure staff were competent to provide care and support to an appropriate standard.

We reviewed one care worker's file who had transferred under Transfer of Undertakings (Protection of Employment) (TUPE). A training certificate had been issued stating the care worker had attended training on the 7 April 2014. There was a range of training listed on the certificate which included: infection control, health and safety, safeguarding vulnerable adults, safer people handling, personal care, policies and procedures and dealing with emergencies. The expiry date on the certificate was the 7 October 2014. We spoke with the supporting manager, who told us that TUPE staff had received training over a period of time. However, staff spoken with who had transferred under TUPE told us they had only attended medication training since they started working for the provider.

We reviewed the services supervision schedule and found staff had not received regular supervision. For example, ten staff who had started working for the service in April 2014 and had received supervision at the beginning of December 2014. A supervision is regular, planned and recorded session between a staff member and their manager to discuss their work objectives and wellbeing.

Inadequate

Is the service effective?

We received mixed views from care workers about the support they received from the office based staff. The negative comments included: “sometimes I feel that we are just here to do a job, don’t hear from the office, usually don’t ask how we are, I don’t feel supported”, “you can never get through to a coordinator, they say they will ring you back but they never do”, “sometimes they [office staff] are not listening” and “the only thing I don’t like is how they [office staff] talk about other care workers”. The positive comments included: “best company I have ever worked for, the office staff are all fine” and “yes, absolutely brilliant, I can honestly say this is the best company I have ever worked for”. Care workers also told us that in the past they received a week’s rota in advance. At the time of the inspection a three day rota was being provided to care workers. A few care workers told us this made it very difficult to make childcare arrangements.

We found the provider had not ensured that care workers were appropriately trained and supported to enable them to deliver care to people safely and to an appropriate standard. These findings evidenced a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service caring?

Our findings

We received mixed views regarding the staff working for Sevacare. Some people made very positive comments about the staff in particular their regular workers. The positive comments made included: "one care worker told me they had got two minutes so they sat down and had a chat with me the other day", "the two [care workers] I had this morning were marvellous, they brightened my day", "you can have a laugh with them [care workers]" "no problems, I have got a nice bunch of care workers" and "both [care workers] of them are very good, very kind".

People's mixed and negative comments included: "I am treated with dignity and respect but some carers treat you better than others", "some of the care workers have a bad attitude", "some [care workers] shouldn't be carers at all because it is just a job for them, some of them are not caring", "some of the staff are marvellous, others need training in basic care and how to treat people with care and dignity", "they talk down to me, talk to me as if I am a child", "I have had carers for twenty years, some of these are the worst of the lot", "I am not treated with dignity and respect" and "some of them [care workers] are right bossy and keep telling me what to do I am not treated with respect" and "I may feel safe but they [care workers] don't care".

Relatives made positive comments about their family member's regular care workers. Their comments included: "[care worker] is a brilliant girl, I am totally confident to leave [family member] in her care" and "[care worker] is excellent care worker",

Staff spoken with gave examples of how they treated people with dignity and respect and maintained their privacy. The examples included the following: making sure curtains and doors were closed; making sure people were appropriately covered. Their comments included: "I always make sure the curtains and the door are closed" and "I am sensitive to the person and their wishes". Staff described how they promoted choice and independence. Their comments included: "I try to give people as much independence as possible and encourage them to do things for themselves", "I show different choices of food, speak to them and explain and write things down for people with a hearing loss" and "I give people choices where possible in order for them to make their own informed decision".

We spoke with the team leader who described how they involved people in their assessment of needs. Prior to the assessment taking place they always asked whether a family member and/or representative wished to be involved in the assessment. They told us at the meeting in the person's home they started the assessment by giving an overview of the service and went through the service user guide. They also told us they tried to involve the person and/or their representative as fully as possible in their care planning. One person commented: "I have been fully involved in my care planning".

There were details of advocacy services in the service user guide provided to people. However, the service user guide stated the following: "we have included in your information pack details of independent advocacy services in your area". The care plans reviewed whilst we visited people in their homes did not contain any information regarding advocacy services in their area. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services, defend and promote their rights and responsibilities and explore choices and options.

Requires Improvement

Is the service responsive?

Our findings

People made very positive comments about their regular care workers and were satisfied with the quality of care they were receiving. However, when people were not being supported by regular workers they expressed concerns about the standard care that was being provided. Their comments included: "what I need is regular care workers, who know what they are doing and happy doing it", "they don't understand me, they don't know what they are doing" and "I am supported by people that I have never met before" "I have got really depressed because I don't have regular workers", "you look up and there is a stranger there" and "I like having regular care workers, you form a kind of friendship, they get to know you".

All the relatives spoken with also told us they were satisfied with the quality of care their family member received from their family member's regular care workers but expressed concerns about the care provided by staff who did not know their family member well. They were also concerned about the coordination of the care. For example, the timing of calls during the day. One relative commented: "they [care coordinators] don't coordinate the care for the customer".

Records showed that most people did not have regular call times and/or were experiencing late calls so some people were not being appropriately supported with their nutrition and maintaining their hydration levels. It is important that people maintain their hydration levels by drinking fluids during the day and reduce their risk of dehydration. For example, one person told us they kept a supply of biscuits and crisps by the side of the chair because they never knew what time they would receive their breakfast. Another person told us that some of the new staff did not know how to make a decent cup of coffee so they didn't want to drink it.

A relative spoken with described how their family member did not want to eat or drink if the call times were too close together. "he has just had his lunch and then they [care workers] are turning up to give him his tea at 3 o'clock, he isn't hungry yet and then he has to wait till the bed time call for something to eat and drink".

One care worker described how they had arrived to support a person with their lunch and found the care worker from the morning call was there. The person did not want lunch because they had just had their breakfast. Another care worker described how one person's morning call and lunch call had run together so they had been provided with "brunch" and missed out on a call. We found that some people were not being protected from the risks of inadequate nutrition and dehydration.

We spoke with the supporting manager who told us that people's care plans were reviewed annually and that care workers would contact the office if people's needs had changed. The statement of purpose and service user guide included details of how the provider intended to monitor and evaluate the quality of the service provided with the person. For example, a check on how things were working after the first week by speaking to the person by telephone or in person. A formal review would be completed after they had been cared for them for four weeks. If everything was progressing steadily they would review the situation again after six months and then annually if they are still needed the support. We spoke with a team leader; they confirmed that regular reviews were not being completed. This meant that people's care plans had not been regularly reviewed for their effectiveness, changed if found to be ineffective and kept up to date in recognition of the changing needs of the person using the service.

We also found there were not robust arrangements in place to ensure care workers were introduced to people and care workers were given time to read people's care plan. In the statement of purpose and service user guide under customer liaison it states "whenever new care workers are assigned to a service user we endeavour to introduce the care worker prior to commencing duties". Staff spoken with told us they were not always introduced to people prior to commencing duties. Their comments included: "sometimes we have time to read the plan, sometimes we don't", "you need to look at the client folder to find out the client's needs, the office do not give any verbal information prior to the visit" and "the only information provided prior to the first visit is the address, then you have to read the care plan and talk to the service user". A few care workers told us that there had been a few times when a care plan had not been in place at the first visit but this had improved recently.

The statement of purpose and service user guide under continuity of care, gave details how the provider sought to ensure that people experienced continuity of care by providing regular care workers and the provision of clear

Is the service responsive?

care instruction. It also gave details of how the care management system was designed to allocate default care workers, who would be routinely assigned to duties with people using the service. The supporting manager told us the provider's quality monitoring systems had calculated that twenty seven percent of people using the service had been allocated regular care workers on the 24 November 2014. They told us this was an improvement in performance; on the 10 November 2014 it had been eighteen percent. This showed that seventy three percent of the people using the service were not experiencing continuity of care.

We reviewed five people's planned care over a two week period in November 2014 and found the actual time scheduled for some calls was inconsistent. For example, the morning call for one person were scheduled at different times. This was further exacerbated by the inconsistency of the times when the call was actually delivered by care workers. This showed that planned care was not centred on the person's preferences and needs. We also found many examples where care workers were not staying the allotted time. For example, one person had a fifteen minute call in the morning. They had received two four minute calls and one five minute call during a seven day period in November 2014. One care worker told us they were meant to go at the times specified on the rota but sometimes they would go at a different order to meet peoples preferred times.

Some of staff spoken with told us that travelling time was not always included in rotas and where staff were walking in-between calls the amount of time allotted was not adequate. Their comments included: "sometimes I am only allocated five minutes to get from one house to another but it takes ten to fifteen minutes to walk, it impacts on the time getting to the next call" and "sometimes there is not enough travel time between clients particularly at busy times when the traffic is heavy". We reviewed six staff care rotas for November 2014. We found examples in each staff rota where travelling time had not been included. A few of the care workers also described calls where care workers had been double booked for the same call. One care worker told us that on four occasions recently a care worker had arrived at the person's home when they were already supporting them. We found the service had failed to ensure the planning and delivery of care met the needs of individual people using the service. These findings evidenced a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Details of the provider's complaints process had been included in the statement of purpose and service user guide. The service had a process in place to respond and log people's complaints. We looked at the service's complaints file which contained details of people's complaints but we saw the file did not contain any responses. The provider's compliment and complaints policy states "copies all correspondence and information relation to each individual complaint must be recorded in the branch complaint file". It also stated that verbal complaints should be acknowledged in writing. The supporting manager told us all the correspondence was on the provider's computer system. We were unable to ascertain whether the provider's complaints policy had been adhered to. For example, the complaint had been acknowledged and responded to. The supporting manager also told us that the service received concerns via the local authority and that these were being investigated by the provider's quality team. They showed us an example of an on going investigation.

People and relatives spoken with who had a made a complaint told us their complaint had not always been effectively addressed and any action taken was not sustained. For example, a person needed staff to be on time and receive regular calls times to attend appointments. A few people told us they repeatedly contacted the service to complain. People's comments included: "it's like banging your head against the wall", "I phone the office, they put you on hold and play music all the time", "I am fed up with ringing them [office staff], they have been awful" and "it is a waste of time trying to contact them in the office, they don't listen". Two relatives spoken with also told us their verbal complaints had not been acknowledged. Relatives comments included: "I have contacted them on numerous occasions, complaints are not resolved effectively most of the time", "they promise to ring back but they don't, and "I don't get any feedback when I make a verbal complaint, they [Sevacare] need a robust complaints process".

We spoke with the supporting manager who told us that due to staffing issues at the service, it had been very difficult to sustain the action agreed as an outcome of

Requires Improvement

Is the service responsive?

people's individual complaint. We found the service did not have an effective system in place to deal with complaints so people experienced an improvement in the quality of the care provided. These findings evidenced a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care records showed that people had a written plan in place with details of their planned care. We found people's care planning could be more person centred. There wasn't an account of the person, their personality and life experience included in their plans. People's individual needs had been assessed and any risks identified but we found this could be more detailed and individualised. We also found details of people's preferences could be more detailed. We spoke with the supporting manager who told us that Sevacare were currently reviewing their care plan documentation. We also noticed that some care plan documentation was incomplete; a signature was missing or a date was not included. For example, permission for the care worker to use the person's phone to log in and out was not signed on one file.

We looked at seven untoward incidents that had been sent to the local authority to inform that a person's needs had changed. An untoward incident was used by the service to inform the relevant assessment and care management team so appropriate action can be taken. For example, a person's mobility has changed and their care needs have increased. The supporting manager told us that the timeframe for response and action was dependant on the availability of a social worker.

Inadequate

Is the service well-led?

Our findings

In the statement of purpose and service user guide it gave details of the registered manager. It stated the following: "this is the manager of the local office that directly manages the service provided to service users on a day to day basis. The person registered as the manager by the Care Quality Commission is Janet Senior". We spoke with the registered manager by telephone, they told us they had initially helped to set up the service in April 2014 but they did not directly manage the service on a day to day basis or regularly visit the service. The service had recruited two managers since April 2014 but they had both left. At the time of the inspection the provider had appointed one of its supporting managers to manage the service in the register's manager's absence.

People's care plan reviews as detailed in the provider's statement of purpose and service user guide were not being completed. For example, a four weekly formal review to check people were satisfied with the service. We saw examples where people and/or family member or representative had been contacted via telephone and a monitoring form was completed. However, we found that this information was not being collated or analysed to identify good practice or improve the service provided. People's comments regarding the service's performance monitoring included the following: "I am never rung to check if I am satisfied, the staff need to be spot checked, I want somebody to come and look and see what is happening, I am extremely disappointed with Sevacare" and "I have lost confidence in the service, a waste of time". Four out of five relatives told us they had not been contacted by the service for feedback. One relative commented: "I have never been contacted or been requested to give feedback about the service". We found the service had not actively sought peoples and/or relatives or their representative's views effectively.

During the inspection we found evidence that neither the supporting manager nor the registered manager had notified CQC about two notifiable incidents in line with the Health and Social Care Act 2008. We spoke with the supporting manager who told us it was the registered manager's responsibility to notify us and they assured us that a notification for each safeguarding alert would be sent to the CQC.

We found the service had not held regular staff meetings with care workers. There had been two meetings held with office staff in April and July 2014. One care worker told us that a staff meeting had been arranged and then cancelled because the previous manager had left. It is important to have regular staff meetings to ensure that key information is shared in order to enable the service to continually improve and reduce the risk of unsafe care and support.

The provider's compliments and complaints policy stated the branch managers will prepare a weekly report for discussion with staff and directors. For example, number of complaints received, the nature of complaints, care workers involved. We were not provided with any evidence that this report had been undertaken or discussed on a weekly basis.

We spoke with the supporting manager who told us that they completed a weekly report. This covered a range of areas including the following: weekly branch hours, recruitment and retention, new packages, number of complaints, number of compliments, number of staff supervisions, carer assessments and spot checks and an update of the issues. However, the report did not reflect the actual performance of the service. For example, the number of staff who had not received a supervision or refresher training. The details of audits that had not been completed in line with the provider's quality assurance processes.

On our arrival on the first day of the inspection we noticed confidential information was in a tray on open view in the reception area. We spoke with the supporting manager and asked for the information to be removed and stored securely. On the second day of our inspection we noticed boxes of confidential information were not being stored securely; they were awaiting collection at the back door to be shredded.

We spoke with the supporting manager regarding incomplete documentation contained within people's care plans. For example, a consent form for care worker's to log in had not been signed on one person's care plan. We saw a care plan audit form at the front of a few of the files but they had not been completed. The supporting manager told us the service had not had capacity to complete a care plan audit

The provider's quality management policy stated the quality of services will be reviewed through the following:

Inadequate

Is the service well-led?

assessment of staff performance, monitoring customer satisfaction, auditing communication logs, auditing of financial transaction forms and using data from the electronic call monitoring. We found that staff performance, customer satisfaction was not being monitored effectively. Communication logs, medication administration records and financial transactions forms were not audited unless a concern had been raised.

The supporting manager was unable to provide us with details of how the electronic call monitoring was being used to monitor the overall performance of the service. For example, the number of times a care worker failed to log in and out and the staff member was contacted to confirm they had attended the call but the person was not contacted to confirm they had received the call. We also found that safeguarding concerns and incidents were not being monitored and analysed effectively to identify trends and patterns. We found the service did not have effective systems in place to protect people against the risks of inappropriate or unsafe and care. These findings evidenced a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The health, safety and welfare of people who used the service were not safeguarded because there was not sufficient experienced staff to meet people's needs.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met: The provider did not an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by people or persons acting on their behalf

Regulated activity	Regulation
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

People were not protected against the risk of abuse because the provider and not reasonable steps to identify the possibility of abuse and prevent it before it occurs.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People were not protected against the risks of receiving care that is inappropriate or unsafe.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: People were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.

The enforcement action we took:
A warning notice was issued

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: Staff had not been supported to enable them to deliver care to service users safely and to an appropriate standard.

The enforcement action we took:
A warning notice was issued