Care Quality Commission

# Sevacare (UK) Limited

# Sevacare - Banbury

**Inspection report**

19A George Street, Banbury Oxon, OX16 5BH
Tel: 01295 278 261
Website: www.sevacare.org.uk

Date of inspection visit: 1 December 2015
Date of publication: 22/01/2016

## Ratings

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

## Overall summary

We inspected Sevacare Banbury on the 01 December 2015. The inspection was announced. Sevacare is a domiciliary care service in Banbury that provides care and support to people within the community. At the time of this inspection the agency was supporting 89 people.

The previous inspection of this service was carried out in January 2014 and the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was due to concerns in relation to assessing and monitoring the quality of service provision. We required the provider to take action to improve. The provider sent us an action plan stating they would be meeting the relevant legal requirements by March 2014.

At this inspection we checked to see if improvements had been made. We found two 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.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The staff had a clear understanding on how to safeguard the people and protect their health and wellbeing.

# Summary of findings

Records confirmed the service notified the appropriate authorities where concerns relating to suspected abuse were identified. However management of medicines was not always effective.

People received effective care from staff who understood their needs. Staff received adequate training and support to carry out their roles effectively. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time.

Staff were supported through ongoing meetings and individual supervisions to reflect on their practice and develop their skills. Staff received mandatory training, training specific to people's need as well as any training towards professional development.

People spoke positively about the care they received from staff. People told us the staff were caring and treated them with kindness and compassion. Staff understood the importance of maintaining confidentiality. Staff were respectful of people's privacy and always maintained their dignity. People were encouraged to maintain independence.

People received support based on their wishes and personal needs. The service responded positively to people's requests, views and opinions. Staff respected people's privacy and maintained their dignity.

People benefitted from care that was planned and delivered in a person centred way. We found when people's needs changed the service responded. People and their relatives knew how to make a complaint and the provider had a complaints policy in place.

Leadership of the service was open and transparent and supported a positive culture committed to making service changes that would allow best care to be provided. However, systems in place to assess and monitor the quality of service provision were not being used effectively.

# 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?**
The service was not always safe.

People did not always receive their medicines as prescribed and staff did not always manage medicines effectively.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

**Requires improvement**

**Is the service effective?**
The service was effective.

New staff benefited from a comprehensive induction programme and ongoing training.

Staff received appropriate supervision, appraisals and training.

Staff received the training and support they needed to care for people.

People were supported by staff who acted within the requirements of the Mental Capacity Act.

**Good**

**Is the service caring?**
The service was caring

People spoke positively about the care they received from care staff.

People were supported in a caring, patient and respectful way.

People were supported in maintain their independence.

**Good**

**Is the service responsive?**
The service was responsive.

People were able to raise concerns and were confident action would be taken.

Any changes in people's needs were timely addressed and other healthcare professionals involved appropriately.

**Good**

**Is the service well-led?**
The service was not always well led.

The systems used to monitor the service and to look for improvements were not always effective.

Staff spoke positively about the team and the leadership. They described the registered manager and other senior staff as being supportive and approachable.

**Requires improvement**

# Sevacare - Banbury

**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 1 December 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We did this because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be in. The inspection team consisted of two inspectors.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. A notification is information about important events which the provider is required to tell us about by law. In addition we reviewed the information we held about the service and contacted the commissioners of the service.

We spoke with fifteen people, eight relatives, five care staff, a care coordinator, the registered manager and a regional manager. A regional manager is a person employed by the service with responsibility of overseeing management of a group of services within the same organisation. We looked at five people's care records and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking; this captures the experiences of a sample of people by following a person's route through the service and getting their views on it.

Requires improvement

# Is the service safe?

## Our findings

People did not always receive their medicines in a safe way. For example, one person was prescribed a medicine twice a day. One staff member told us this medicine was an as required medicine that was only given when the person asked for it. Another staff member told us the medicine was administered at night only. Records showed there were 30 occasions when this medicine was not administered in November 2015. This showed that staff were not giving the medicine as directed. Another person required administration of a medicine called Warfarin. According to the service's medicines policy this is a delegated task and staff should not administer this medicine unless they had received training and an assessment of competency by a district nurse. The agency kept a list of staff trained to administer this medicine. However there were 10 occasions in October and November 2015 when staff who were not trained to administer this medicine had administered it.

Another person was prescribed paracetamol which they could have four times a day if required. Staff did not always follow the services policy for managing medicines because they did not record on the person's medicine administration record (MAR) when this medicine was administered. For example, on one day staff had written in the person's daily records they had given the person this medicine on two visits. However, no entries were made on the MAR. This could put this person at risk of receiving too much of this medicine.

Staff did not always follow the services procedures in relation to the recording of medicines. For example, One person's medicines risk assessment documented the service did not have any involvement in the persons medicine administration. The section of the medicines risk assessment for the administration of topical medicine was left blank. A topical medicine is a medicine that is applied to the skin such as cream or ointment. However the person's personal care risk assessment documented that cream should be applied to the person's legs and feet. There was no care plan for the administration of this cream. We looked at the person's daily record for the previous week and saw three occasions where staff had recorded they had applied this cream to the persons "bottom". No mention of any application to the person's legs and feet was made. Staff told us this person did not always have cream to their legs and feet as they experienced a lot of pain there. This information was not recorded in the person's records. Other people who required administration of topical medicine also had the section of the medicines risk assessment for the administration of topical medicine left blank. There were no body maps used to show where the medicine should be applied.

This was a breach of Regulation 12 Health and Social Act (2008) (Regulated Activities) Regulation (2014).

People were safe from the risk of abuse. There was a clear safeguarding policy in place. The staff completed safeguarding training as part of their induction as well an annual update. Staff were knowledgeable of the types of abuse and the relevant reporting procedures. We reviewed a number of incidents that had been referred in line with the service's safeguarding policy. The service raised safeguarding alerts appropriately.

People were supported by staff who could explain how they would recognise and report abuse. They told us they would report concerns to their manager or senior person on duty. They were also aware they could report externally if needed. One member of staff said "If I am worried about something I can always report to my manager, the police or CQC (Care Quality Commission). We have the guidance for reporting abuse in the office". There was a whistleblowing policy in place. Staff knew how to whistleblow if necessary.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to reduce the risks. For example, One person had stiffness and weakness in both legs. The moving and handling assessment gave guidance to staff on how to safely move the person from one area to another. Staff were advised to 'use a hoist when moving the person from bed to chair and use a sliding sheet when turning them in bed'. Staff told us they were following this guidance and the daily records evidenced staff were using the hoist and sliding sheet during moving and handling.

People we spoke with felt safe. Comments included, "I feel safe, staff are lovely", "I have known staff for a while and yes I feel safe" and "I am happy with the care I am getting". The people's relatives we spoke with felt their relatives were safe. One relative said "My wife is perfectly safe and staff are doing a marvellous job". Another said "Safety is not an issue, we know the staff very well"

People told us staff were punctual and rarely late. Comments included; "Occasionally late for calls but they

Requires improvement

# Is the service safe?

always call to let me know. They apologise when they get here", "Late calls very rarely and there would be a good reason for it. They called to let me know and explain" and "Very timely calls and would call me to let me know". The service had a system for managing late calls. If a member of staff did not log in the Electronic Time Management System (ETMS) at the scheduled visit time an alert was raised by the system with a supervisor. This meant the supervisor could contact staff to ascertain reason for the late call, contact the person and redirect another member of staff if required. We looked at the system and saw there were very few missed visits recorded. People we spoke with said they had experienced missed calls very rarely. One person said "One missed call in six years". Another person said "No missed calls in five years".

There were sufficient numbers of suitably qualified and experienced staff to meet people needs. Staffing levels were determined by the number of people using the service as well as their needs. These were adjusted accordingly when people's needs changed. For example, when a person's mobility had decreased, we saw that the number of staff caring for them had increased. The registered manager also considered potential sickness levels and staff vacancies when calculating how many workers needed to be employed to ensure safe staffing levels. There was an out of hour's service which responded to any issues arising outside working hours.

There was a thorough recruitment process in place which ensured staff were safe to support the people who used the service. The five staff files we looked at contained appropriate references and a Disclosure and Barring Service (DBS) check ensuring that staff were safe to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable people.

The service had contingencies for emergencies in place for extreme bad weather, power failure and fire. Contact details were held in people's homes and included details for the registered manager and out of hour's response team.

Good

# Is the service effective?

## Our findings

People told us the staff who supported them were knowledgeable. Comments included "Staff are knowledgeable and honest"; "The regular carers are brilliant, they know what they are doing"; "Weekly calls are good. We get the same nice carers that I know" and "They know me and know what I need".

Newly appointed care staff went through an induction period which followed nationally recognised standards. For example, catheter care, dealing with emergencies, health and safety and shadowing an experienced member of staff. This prepared staff for working with people safely. Staff were happy with the training and told us it prepared them for when they were looking after people in the community. Staff comments included "I had never done care before and the induction helped a lot"; "I think the induction here is very good. It includes common conditions like Parkinson's and stroke which we come across every day" and "My favourite induction ever, I could ask things over and over until I understood".

Staff received an annual appraisal and had regular one to one supervision (meetings with their line manager) where they could discuss the needs of people they supported and any training and development they might wish to follow. Staff were regularly observed by the registered manager or care leader whilst carrying out their roles. Where areas for improvement had been identified this was discussed and followed up in supervisions. Staff had a clear action plan to follow to ensure the improvements were made.

The GP or emergency services were contacted promptly if needed. People were referred for specialist advice and we saw evidence this advice was followed. For example, one person had recently been referred to a district nurse and an occupational therapist (OT) when staff were concerned that the equipment was causing marks on the persons skin. The OT had recommended that a new specially made hoist sling was obtained. Staff had ordered this in line with recommendations.

Another person's needs had changed in relation to their mobility. They had been referred to an OT for assessment and a hoist was used for moving and handling. This person's care package had changed to allow for two staff to support when using the hoist.

Staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA). Where people lacked capacity to make decisions or consent, mental capacity assessments had been completed in line with legal guidelines. These guided staff to ensure decisions were made in the best interest of the people. Staff knew to always ask for people's consent prior to any care provision or support. A member of staff said "I always explain what I am about to do and ask for their permission". Another member of staff commented "It's natural for me, I tell them what I am about to do and if they agree then I will continue".

The registered manager understood their responsibilities with the MCA. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected.

People confirmed they consented to the care they received. They told us new staff always asked them how they wanted care to be given. Consent was always sought before giving care or support. People's records also showed staff had recorded when people had consented to care. We also saw records signed in people's files confirming they had agreed with the planned care. People told us staff still asked for consent to give care even if they knew them very well.

Where required people were supported with food and drink. People were given choices about what to eat. Staff ensured people ate their food. One daily record documented how on a later call the care worker had found the person had not eaten all of their meal. The person told the care worker they had not wanted the food because it had gone cold. The care worker had made them something else to eat.

People were referred to health care professionals timely and when their care needs changed, for example, when staff recognised people's mental health needs had changed.

Good

# Is the service caring?

## Our findings

People told us the staff were caring and treated them with kindness and compassion. One person said "Excellent service, staff are very caring". Another one complimented "Staff are caring and have time for me". Comments from the staff included "I do this job because I feel I can make a difference"; "I like helping people get the best quality of life and independence"; "The service user is my number one" and "I like making a difference in someone's life, put a smile on their face".

Staff spoke about people in a caring and respectful way. Care records reflected how staff should support people in a dignified way and respect their privacy. For example, one person's care records stated a person wished to be assisted to the toilet at every visit and staff should 'leave me to use privately'. Staff described how they supported this person in line with these instructions.

Staff knew the people they supported. Relationships between people and staff were established from the very first meeting. One relative said, "You should see the smile the carers get when they get here, it's beautiful". Another relative said "There is so much giggling when they give them care, always happy to see them".

Most people we spoke with told us they had regular staff during the week but different staff during weekends. One person said "Week calls are good but weekends I get different carers". This was also highlighted by a member of staff we spoke to who felt that was not the same as during the week. One member of staff said "People are often happy to see familiar faces during the week". Despite some relatives raising concerns over weekend staffing, they were still happy with the care they received generally. The staff rota did not show any gaps at weekends.

Staff were respectful of people's privacy and always maintained their dignity. Staff comments included "I treat people the way I would like to be treated", "During personal care I make sure doors and curtains are closed to maintain privacy, it dignifies them" and "I am a guest in their house and their dignity matters". People told us staff respected their dignity. Comments included, "Staff are respectful and maintain my privacy during personal care", "It's nice to have a bit of my dignity intact, staff are good like that" and "They (staff) make me feel like any other person out there".

Staff knew the importance of maintaining confidentiality. Staff comments included, "Information sharing is on a need to know basis"; "I record in notes as general as possible. I tell only people who need to know" and "I am aware of when to share confidential information".

Staff understood the importance of promoting independence and involving people in daily care. They explain how they allowed enough time for tasks and did not rush people. This enabled people to still do as much as they could for themselves with little support. Staff comments included, "I let them wash themselves if they can", "I encourage them (people) to do what they are able to" and "You can't seem to be taking over, I work with them always".

Good

# Is the service responsive?

## Our findings

People were assessed prior to commencement of care to make sure their needs could be met. The manager visited people and assessed their needs and discussed their care and support with them and their families. Personal details were recorded which included preferences, religion, preferred names and hobbies. A health and care needs assessment was also conducted which included eating and drinking, personal care, behaviour and communication. These assessments were used to complete personal care plans.

The service performed a full consultation on people who were looking at using their services. These consultations involved the person who would be receiving care, relatives, friends, advocates as well as health and social care partners. Records showed that the care and support planning was always completed 48 hours before care or support was given. This allowed room for person centred planning for each individual.

People benefitted from care that was planned and delivered in a person centred way. One relative told us their relative had communication problems due to suffering from a stroke. The staff who were initially attending to them were struggling with understanding their needs. This was raised with the service and suitably qualified staff were allocated to support them with the help of the speech and language team (SALT).

People were offered choices. One person said "I have a choice of when staff can help me. We agreed on the best time for me". Another person said "Staff ask me what I can't do and how I want it, it's nice to have choices". Staff told us they always gave people options and choices during care. One member of staff said "I do it naturally, when you give someone a choice, they have options".

We found when people's needs changed the service responded. For example one person needed support with mental health problems. Staff had recognised the sudden changes in personality and had referred them appropriately to the mental health support team. When we spoke to staff about such incidents, it was clear they knew people well. Another person had a urine catheter and staff ensured the district nurses knew about them and monitored them as necessary.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. People were provided with information of how to make a complaint or compliment as well as contact information for the local authority and CQC. People who had raised minor complaints said that these had been resolved quickly. Comments included, "I complained to the manager about a member of staff and she investigated it quickly"; "I can confidently make a complaint if I need to" and "I raised a concern with the manager and it was sorted in good time".

Requires improvement

# Is the service well-led?

## Our findings

At our last Inspection in January 2014 we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation (2010) which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. We found the systems in place to assess and monitor the quality of service provision were not being used effectively.

At this inspection we found improvements had not been made. Systems in place to assess and monitor the quality of service provision were not being used effectively. The service had identified service user reviews, telephone monitoring and satisfaction surveys as some of the systems used to monitor the quality of care but these were not always utilised. We saw weekly file audit forms were completed. These had identified some issues and actions to be followed up by the manager. However, when we looked in people's care plans the actions had not been completed.

People were involved in their care plans and reviews. People's home care files were untidy and had loose sheets in them such as their medication records. This put people's delivery of their correct care at risk as this information could be lost. Care plans did not always contain information about people. For example, one person had a medical condition called diabetes. Although this was listed on their assessment, it was not documented in their care plan or on their risk assessments. This person was also lactose intolerant. Staff made hot drinks for this person and assisted them with their food. Although this was documented on their nutrition risk assessment there was no guidance for staff to follow to mitigate any risks this may cause. There was no mention of them being lactose intolerant in their care plan.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager who had been in post for 2 months. They were supported by an area manager, two team leaders and a care coordinator. The registered manager and the provider were in the process of making changes towards rectifying the previously identified issues. We found they were open and transparent about the service and the improvements still required. We saw a new assessment plan had been developed which would capture more information on how to safely support people with medicines and manage any potential risks. This included a body map chart to help with the application of creams.

The registered manager demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service. Staff felt the registered manager was supportive and approachable. Comment included, "Manager is accessible anytime, I can talk to her"; "Manager is approachable, I am listened to when I talk to her" and "Manager is fantastic, she cares about us". People knew the manager and felt they could talk to her anytime. Comments included, "Manager is very good, she gets things done"; "Manager is forthright and honest" and "I have confidence in the manager, she is really good".

Incidents and accidents were being recorded with a clear process of learning in place for each event that occurred. Any accidents or incidents relating to people were documented and actions were recorded. Incident forms were checked and audited to identify any trends and risks or what changes might be required to make improvements for people who used the service.

People participated in an annual service user survey. This survey had a theme of 'how do we do' which gave people a chance to review and rate the care and support they received. The results of the survey indicated people received continuous care from caring staff who hardly missed calls. Where delays had occurred, people had been informed and apologised to for inconviniences. People told us staff were very rarely late and always apologised for any delays.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met: The provider had not ensured the proper and safe management of medicines. Regulation 12 (2) (g). |

**The enforcement action we took:**
We have issued a warning notice to the Provider and the Registered Manager.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>How the regulation was not being met: The registered manager and provider did not always have effective systems to monitor the quality of the service people received. Regulation 17 (1), (2) (a) (b) (e) (f). |

**The enforcement action we took:**
We have issued a warning notice to the Provider and the Registered Manager.