Sage Care Limited

Sagecare (Peterborough)

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection of Sagecare (Peterborough) took place between 21 June 2018 and 4 September 2018. Our visit to the office was announced to make sure staff were available.

Sagecare (Peterborough) is a domiciliary care agency that provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. At the time of our visit 158 people were using the service.

Not everyone using Sagecare (Peterborough) received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager at this agency who was supported by an office manager and other senior staff. 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.'

At our previous inspection between 7 and 9 June 2017 we rated this service as Requires Improvement in relation to medicine management and care plans. The rating has improved to Good at this inspection. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Well-led to at least Good. They told us that they would meet the legal requirements by 30 September 2017.

The provider's monitoring process looked at systems relating to the care of people, where issues were identified action was taken to resolve these. People's views were sought and action put into place to improve issues that were raised.

Medicines were administered safely and there was clear information and guidance in people's care plans for staff to follow when giving medicines in specific ways. Care plans were written in detail and contained guidance for staff to follow.

Staff knew how to respond to possible harm and how to reduce risks to people. Lessons were learned from accidents and incidents and changes to practise were shared with staff members to reduce further occurrences. There were enough staff who had been recruited properly to make sure they were suitable to work with people. Staff used personal protective equipment to reduce the risk of cross infection to people.

People were cared for by staff who had received the appropriate training and had the skills and support to carry out their roles. Staff members understood and complied with the principles of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives and staff supported

them in the least restrictive way possible. People received support with meals, if this was needed.

Staff were caring, kind and treated people with respect. People were listened to and were involved in their care and what they did on a day to day basis. People's right to privacy was maintained by the actions and care given by staff members.

There was enough information for staff to contact health care professionals if needed and staff followed the advice professionals gave them. People's personal and health care needs were met and care records guided staff in how to do this.

A complaints system was in place and there was information available so people knew who to speak with if they had concerns. Staff had guidance to care for people at the end of their lives if this became necessary.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicine administration records were accurately completed and medicines were given as prescribed.

Staff assessed risks to protect people from harm and followed infection control practices to reduce the risk of cross infection.

There were enough staff, who had undergone recruitment checks, available to meet people's care needs.

The systems in place to learn lessons from incidents were completed effectively.

Is the service effective?

Good

The service was effective.

Systems were in place to make sure people's care and support was provided in line with good practice guidance.

Staff members received enough training to provide people with the care they required.

People were supported eat and drinks as independently as possible.

Staff worked with health care professionals to ensure people's health care needs were met.

Staff supported people to continue making decisions for themselves.

Is the service caring?

Good

The service was caring.

Staff members developed good relationships with people using the service and their relatives, which ensured people received the care they needed.

Staff treated people with dignity and respect and people's preferences were always respected.

Is the service responsive?

Good

The service was responsive.

People had their individual care needs planned for.

People had information if they wished to complain and there were procedures to investigate and respond to these.

Guidance was available staff about how to care for people at the end of life.

Is the service well-led?

Good

The service was well led.

The quality and safety of the care provided was effectively monitored to drive improvement and it identified and addressed issues and shortfalls.

People's views about the agency were obtained and action was taken to address issues.

There was a good working relationship between staff members and people.

Staff contacted other organisations appropriately to report issues and provide joined-up care to people.

Sagecare (Peterborough)

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 between 21 June 2018 and 4 September 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and we wanted to make sure staff would be available to speak with.

On 21 June 2018 we visited the office to speak with the manager, office staff, to review care records, and policies and procedures. We spoke with people on 15 June 2018 before our visit to the agency office and with staff providing care between 21 June and 4 September 2018.

This inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvement they plan to make.

We spoke with five people using the service. We spoke with five members of care staff and the registered manager. We checked six people's care records and medicines administration records (MARs). We checked records relating to the management of the service, such as audits, staff recruitment, training and health and safety records.

Good

Is the service safe?

Our findings

At our previous inspection in June 2017 we found guidance for staff in relation to administering medicines was not always sufficient. At this visit we found there had been an improvement in the level of detail in care records about administering these medicines.

People were given their medicines at the time prescribed for them and records were completed appropriately. To ensure that it was clear who the medicine was prescribed for, information such as identification, specific administration instructions, allergies and contact details for each person's GP and pharmacy, was also available. One person received their medicines covertly. Covert is the term used when medicines are administered in a disguised form, for example in food or drink. This is without the consent of the person receiving them, usually because they do not have capacity. There was clear information for staff on how to administer the medicines covertly that included a detailed risk assessment and guidelines from the person's GP and the agency's own policy. The service carried out regular medicine audits and where issues had been found such as poor recording or gaps in medication administration records (MARs) actions had been taken to address this, and improve practice.

People said that they had never had any concerns about staff members. Staff knew how to protect people from harm, they told us they had received training and they understood what to look out for, and who to report to. Staff had been provided with a hand book that contained contact details of external agencies to report any concerns if they needed to. Information about maintaining security of people's homes was included in care records. The registered manager was aware of their responsibility to report issues relating to safeguarding to the local authority and the CQC. Information received before our inspection showed that incidents had been reported as required and staff had taken appropriate action to protect people and reduce risks to them.

Risks to health and welfare were assessed for each person, reviewed and actions were taken to reduce those risks. These areas included moving and handling, showering or bathing, and for the risk of developing pressure ulcers. Staff had also completed a risk assessment for one person who was at risk of financial abuse. They had developed a way to ensure the person did not become upset but also kept safe from the possibility of this, that suited the person and their family. Information was available to guide staff if people had a health condition, such as diabetes or epilepsy, which included details of what staff should do in certain situations, what to look for and where to get further advice. These documents in particular were detailed to guide staff and covered many scenarios.

Environmental checks of people's homes had also been completed. This provided staff with an overview of where there may be risks, such as for manoeuvring moving and handling equipment on carpeted floors. Actions were available to show staff how to reduce these risks, although servicing and maintenance check dates were not recorded. We spoke with the registered manager and they confirmed that they would start documenting when equipment checks were next due.

People told us that there were enough staff but that they did not always arrive on time. Most people said

that they had regular staff and that when these staff were late it was due to unavoidable reasons. They told us that staff were either on time or up to 30 minutes late, which was the agency's expected time range for staff to arrive for their visit. However, one person told us that their staff could sometimes be up to an hour and a half late. Staff had varied views about staffing levels, although they were always able to provide care to people.

Although the registered manager told us that they had additional staffing hours available, they were not able to tell us how many these were. However, they monitored the care hours against available staff hours on a weekly basis to ensure there were enough staff employed. If they got to a stage where the available staffing hours was reducing, they put a freeze on accepting any new care hours. The registered manager also told us that they had bank staff that they could call on to work at short notice.

Staff recruitment files showed, and staff confirmed that satisfactory checks were carried out before a new staff member worked with people. These included criminal record checks (DBS), identification and a health declaration to ensure that they were suitable to work with people who were vulnerable. New staff completed induction training and shadowed more experienced staff so that they had an understanding of people's needs and how to keep them safe while providing care and support.

Processes were in place to help prevent cross infection. One person told us that staff always wore gloves and aprons when supporting them with personal care and that these were removed or replaced appropriately for other tasks. Staff had received training in infection control and prevention, which provided them with the skills to reduce risks to people. Care records also guided staff in how to reduce these risks. For example, how to ensure food was properly, which showed us that processes were in place to reduce the risk of infection and cross contamination.

Incidents, accidents and other monitoring systems were responded to appropriately at an individual level and information about these fed into broader analysis to support lessons learned. For example, analysis of a concern for one person's risk of developing pressure ulcers had identified a communication issue between staff and health care professionals. Following this staff were required to check health care professionals' records if they had visited people to ensure any messages or advice would be properly passed on and acted upon.

Good

Is the service effective?

Our findings

Needs assessments were completed for people using the service before care started. These assessments were completed with information from the person and or their families and health or social care professionals, where available. The registered manager told us that staff worked with health care professionals, such as GPs and district nurses, to ensure they had advice about working with current guidance. They told us how they had incorporated information about one person's health condition into the person's care plan. This gave them information about how the condition affected the person and current good practice guidance about how to care for them.

Staff told us that they received enough training and support to give them the skills needed to carry out their roles. One staff member commented that their training was, "Very good." They went on to describe that they received additional training if needed this and that training was updated if any aspect changed. For example, medicine administration records changed and staff all received additional training in how to properly complete the new records. Staff training records showed that staff members had received training in subject areas relevant to their role and when updates were next due.

Staff members said they received enough support from the registered manager and other staff to do their jobs. They explained that they were visited by a member of senior staff who carried out spot checks and could discuss any practical issues with them. They received individual meetings that allowed them to discuss their training and development needs and ongoing issues.

We saw that where needed, people were supported to eat and drink. One person told us that although they did not need support to make meals or drinks, staff members always made them breakfast when they visited in the morning. Another person told us that the staff member who visited them, "Gets me my breakfast, I tell her what I would like." Care records contained information about people's likes, dislikes and what staff needed to do to support the person. They were specific for each person and were written in a person-centred way (a way that puts the person's wishes and preferences first). For one person this meant describing how they swallowed so that staff did not try to give the person more food before they were ready.

The registered manager told us that they worked with health and social care professionals for those occasions when people used other services, such as hospital admissions. The registered manager told us how they worked with social workers when people were in hospital. This ensured that hospital staff were aware of the care needs and equipment the person already had in place before their admission to hospital.

People's care records showed that they had access to the advice and treatment of a range of health care professionals. These records provided enough information needed for staff to contact health professionals and to support people with their health needs, if needed. We saw several records that showed that a health professional had been contacted for advice. One after the person's mobility declined, another when a person injured their skin and another when a person's medicines were reviewed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff understood the MCA and worked within its principles when providing care to people. One staff member explained that they had received training and always presumed people were able to make their own decisions. Staff could access guidance to help people continue to make their own decisions. There were clear explanations of how to do this for people who did not have capacity, which advised staff to continue involving people in these decisions. Copies of legal documents giving other people the authority to make decisions on behalf of someone were available and ensured staff were able to contact the appropriate person if needed. Where specific decisions had been made on behalf of people, such as for the administration of covert medicines, staff had specific guidance so that people received their medicines in the least intrusive way. For example, in the form of a best interest decision made on their behalf, in line with the legal framework.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. Staff were described as, "[Staff member] is very nice and always very polite," "[Staff member] is very polite and funny, we always have a laugh," and "[Staff] are really nice."

Care records contained some details about how people wanted to be addressed, their likes and dislikes and their preferred routines. One person's plan asked staff to tell them what staff were doing as this offered reassurance for the person. We found that staff knew people well and that they were able to anticipate people's needs. One staff member described how they acted with people, "I treat people how I would like to be treated, with respect, choice, friendly, involving them. You are their support network, make them smile and have a laugh with them. It's just knowing them." A person told us how they had requested a change of care staff and office staff acted on this. The person said their concern had been resolved.

People told us that they were aware of their care records and staff spoke with them about how they wanted their care given. Care records were signed by people to say they were happy that the information reflected their care needs and wishes for how staff should support them.

Staff respected people's right to privacy and to be treated respectfully. One person's relative told us, "They're always nice people and mind his privacy." This was evident in the way staff spoke about people with thoughtfulness and concern. Staff told us that they greeted people before entering rooms, knocked on doors and called people by their names. Curtains and doors were closed when people received personal care and people were covered as much as possible when receiving a wash.

We saw that care records contained some information that advised staff to consider people's right to privacy and dignity whenever they provided care and support. For example, one person's plan asked staff to wake them gently to give them time to wake up.

Good

Is the service responsive?

Our findings

At our previous inspection in June 2017 we had concerns that not all care plans were written in enough detail to provide staff with the guidance to care for people properly and in a person-centred way. At this visit we found that there had been an improvement in the way care plans were written and the level of detail that described how staff should provide care.

Plans provided clear written guidance for staff members. Information included why people needed the care and support they received, the difficulties the person experienced, what they needed help with and how staff should do this. Information was set out for different types of care needs, such as washing and dressing, continence and medicines management. Plans were written in a person-centred way, meaning that people's wishes were put at the forefront of the care process. For example, one person was at risk of choking and their care plan gave step by step instructions to staff about how to support them safely and how they preferred to eat and drink.

Care plans for those who had additional health conditions were also available. These provided guidance regarding what staff should do if the person became unwell and described the effect this would have on the person. Staff we spoke with had a very good understanding of people's needs in this area. They told us that there was enough information in care plans to guide them in supporting each person. We saw the care plans had all recently been reviewed and if new areas of support were identified, changes had been made. Daily records provided evidence to show people had received care and support in line with their support plan.

People told us that they received the care they wanted and needed, in the way they wanted. One person commented, "It's brilliant, they're really helpful and the [staff] are really nice." Another person said, "I am quite happy thank you," and went on to tell us when staff visited and how they helped them. A third person told us that they had received care from staff with the agency for several years and was very happy with the care they received.

People and a relative told us that they knew how to make a complaint and who to contact for this. One person told us that they had contacted the agency with a concern a few months ago, action had been taken and the concern was resolved. There were copies of the complaints procedures in each person's care records. Records showed complaints had been investigated and detailed the action that was taken to resolve these. These also showed that people were happy with the outcome of their complaints.

The organisation had a policy and procedure for end of life care in place to support staff in meeting people's needs. Staff had received training in caring for people at the end of their life, if this should occur. There was no one at the time of this visit who was receiving end of life care.

Good

Is the service well-led?

Our findings

At our previous inspection in June 2017 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because audits did not always identify areas for improvement and were therefore not always effective. The provider wrote and told us they would review their auditing system and introduce additional spot checks to further audit the care people received. They told us they would also provide audit training for those staff responsible for completing audits to make sure staff had the skills to carry them out correctly. At this inspection we found that there had been an improvement in how the agency audited its records and the actions it took to address any shortfalls found.

There was a registered manager in post, who was available for our visits to Sagecare (Peterborough). The registered manager was supported by an office manager, office staff and care coordinators in the running of the agency. Staff told us that expectations of staff were discussed in staff meetings, so that they were all aware of their responsibilities. The registered manager confirmed that any issues identified during the auditing process were also discussed at staff meetings and this made sure that all staff were aware of the actions to address these and the improvements required.

Staff told us that the manager was approachable and they were able to discuss any issues with them. One staff member told us, "I enjoy the job, I love the work – I will stay here until I retire." Another staff member said that they tried to keep good relationships with people who used the service and one way they managed this was through communication with the office staff, who passed on messages to people. They told us, "If I needed to phone office staff for support, it's there. The relationship is very good." This staff member went on to explain that the registered manager was easily available to listen to any concerns staff had and she let staff know what action had been taken.

The registered manager used various ways to monitor the quality of the service. These included audits of the different systems used by the agency, such as care and medicine records and spot checks at people's homes. Both systems identified issues and the action required to address them. For one person this resulted in a change to the way staff washed the person's hair. For another person staff worked with the person's GP to bring their medicines prescription in line with medicines administration records. This reduced the risk of errors occurring or the medicines running out. The provider organisation carried out internal audits every three months and these showed a continual improvement over time.

The views of people were obtained through questionnaires. Questionnaires had been sent to people and their relatives before our visit and had been collated into a report. We had a look at the returned questionnaires and found that responses were mostly positive. However, there was a high number (40%) of people who said they were not told if staff were going to be late. We saw through discussions with care staff that interactions and communication between them and office staff had improved. Care staff were better able to request that office staff advise people if they were going to be late. A spot check visit form for one person included the comment, "Office staff are so much better than they used to be." An action plan had been completed and showed the actions to be taken to improve people's experience of receiving care from the agency.

Information available to us before this inspection showed that the staff worked in partnership with other organisations, such as the local authority safeguarding team. We saw that the registered manager contacted other organisations appropriately and in relation to safeguarding, investigated the issue and took action where this was required. We saw that information was shared with other agencies about people where their advice was required and in the best interests of the person.