Sevacare (UK) Limited

Sevacare - Leicester

Inspection report

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Date of inspection visit: 5 January 2015
Date of publication: 03/06/2015

Ratings

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

Overall summary

This inspection took place on 5 January 2015 and was unannounced.

Sevacare-Leicester provides personal to people in their own homes. At the time of this inspection there were 48 people using the service. The service provides personal care to older people, people living with dementia, people with learning disabilities, people with mental health needs, people with sensory needs and younger adults.

A registered manager was 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 and associated Regulations about how the service is run.

At our last inspection on 6 August 2014 we identified some concerns with the care provided to people who used the service. People were not fully protected from unsafe care and support because plans of care had not always been reviewed to ensure they met people's changing care needs and risk assessments had not been undertaken for some people who had health conditions. People had been placed at risk because care and support was not always provided at the agreed times.

Summary of findings

Improvements were needed in relation to how the provider monitored the quality of the service provided. We asked the provider to send us an action plan outlining how they would make improvements.

At this inspection we found improvements had been made however further improvements were needed to ensure that people received care and support at the agreed times.

People who used the service told us that they felt safe with staff.

Staff had received training on how to protect people who used the service from abuse or harm. They demonstrated they were aware of their role and responsibilities in keeping people as safe as possible.

Recruitment checks had been carried out to keep people safe.

Medication records did not always show that people had received their medications.

Assessments of the risks associated with people's care required improvement to ensure that staff knew how to provide safe care and support.

People who used the service and relatives told us they found staff to be caring, compassionate and respectful. They thought their rights to dignity, choice and independence were protected by staff. People told us that they were involved in decisions about their care. People told us that their consent was sought before care was provided to them. However, people's capacity to make their own decisions was not always fully assessed.

Continuity of care was not promoted due to care not being provided to people by a consistent staff team. People told us that they were not always aware of which care workers would arrive to undertake their care calls.

Peoples complaints had been investigated but the outcome of the investigation had not always been communicated to them.

Some people were concerned about the poor communication and action from the office of the service.

The provider had internal quality and monitoring procedures in place though these were not always effective. Spot checks to assess the quality of care supplied to people required further development..

The registered manager gave staff the opportunity to share their views about the service provided.

The provider supported staff by an induction and ongoing support, training and development. However, training was not comprehensive to enable staff to be fully equipped to deal with all the needs that people had.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to a breach 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.

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?

Requires Improvement

The service was not consistently safe.

People and their relatives told us that they had not always received care at the agreed times.

Medication records did not show whether people had always received their medication as prescribed .

People told us they felt safe with staff from the agency. Staff were aware of how to report concerns to relevant agencies if the service had not acted properly to protect people.

Recruitment procedures designed to keep people safe were in place though needed improvement.

Assessments of the risks associated with people's care required improvement to ensure that staff knew how to provide safe care and support.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People told us that their consent was sought before care was provided to them. However, people's capacity to make their own decisions was not always fully assessed.

The provision of training needed improvement to ensure staff were provided with up to date skills and knowledge to meet people's specific care needs.

People told us that staff supported them to prepare meals and that they had a choice of food.

Staff monitored people's health to ensure any changing health needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although people and their relatives told us that staff were kind, caring, treated them with dignity and respected their choices, care was not always provided at the agreed times.

People told us that they were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans had been reviewed to meet people's changing needs.

Summary of findings

People's complaints were investigated but they were not informed of the results of the investigation.

Continuity of care was not promoted due to care not being provided to people by a consistent staff team.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had not notified us and all relevant agencies of all incidents that may affect people who use the service, however measures were now in place to ensure this was done.

People told us that the provider's office team did not always listen or act on comments they raised.

Quality checks had not been consistently carried out to ensure that people received care and support at the times they needed.

Sevacare - Leicester

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.

The inspection of Sevacare took place on 5 January 2015 and was unannounced. One inspector undertook the inspection.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They only returned a partially completed PIR and we took this into account when we made the judgements in this report.

We also reviewed information we had received since the last inspection including information we received from the safeguarding team from the local authority.

During our inspection we went to the office of the agency and spoke with the registered manager, the care services manager who was the line manager of the registered manager, one office staff member, and two care staff. We reviewed the care records of six people that used the service, reviewed the records for four staff and other records relating to the management of the service. After the inspection visit we undertook phone calls to nine people that used the service, the relatives of three people who used the service and four care staff.

We also spoke to commissioners who funded a number of people to use the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 6 August 2014 we identified that people had experienced 'missed' and 'late' calls. This meant that they had not always received care and support at the agreed times which placed them at risk. The provider sent us an action plan outlining how they would make improvements.

At this inspection, we found that the incidences of 'missed' and 'late' calls had reduced, however further improvements were needed to ensure that people received care and support at the agreed times.

Two people and a relative told us that staff always arrived at the agreed times. However, three people told us that they had experienced some late calls. They told us that they had contacted the provider's office staff to find out where their care workers were. They told us that after this, their care workers did arrive.

One relative told us that there had been recent occasions where care workers had not arrived to provide care for their family member. They told us "This has happened on three or four occasions. The last time was within the last month. It is not acceptable." From checking records we found a number of occasions where staff were not turning up on or near the agreed call time.

We discussed this with the staff team. They told us that there had been occasions where the provider's office staff had changed people's care call times without consulting people or informing them that this was to occur. This meant the person did not know when their care worker was due to arrive. This caused anxiety and meant that on occasion care was not provided at the agreed times in order to meet people's needs. For example, they told us about a person who had agreed call times so that care could be provided to prevent the risk of pressure sores. They told us that care had been provided to this person later than at the agreed times which had resulted in deterioration of the condition of their skin.

Staff also told us that they had been provided with travel time in between care calls since the last inspection. Some staff told us that overall travel time was sufficient although some staff said this time had not always been sufficient. This increased the risk of staff not being able to make agreed appointment times.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive appropriate care and treatment to meet their needs because care was not always provided at the agreed times.

We discussed this with the manager who told us that the incidences of 'missed' and 'late' calls were reducing but acknowledged that further improvements were needed. Shortly after our inspection thecare services manager sent us information about how 'missed' and 'late' calls would be monitored and actions that would be taken should these occur.

At our last inspection on 6 August 2014 risk assessments had not been undertaken for some people who had health conditions. This meant that there was a risk that people had not always received care and support that met their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that some improvements had been made. Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person. These included information about action to be taken to minimise the associated risks. People told us that they felt safe when staff used equipment as part of their care.

However, we did note that further improvements were needed to ensure that risk assessments always included specific guidelines for staff to follow in order to meet people's needs.

People we spoke with told us they felt safe using the service. One person said: "There is no question I feel safe with the carers."

Staff had received training in safeguarding people who used the service. The provider's safeguarding policy was available and staff were required to read it as part of their

Requires Improvement

Is the service safe?

induction. Staff spoken with were knowledgeable in recognising the signs of potential abuse and the relevant reporting procedures. This meant people would be protected from the risk of further abuse.

The manager told us that they were actively recruiting additional care workers to undertake care calls. They did, however, advise that office staff who had experience in providing care were undertaking care calls, in order to cover this shortfall on a temporary basis. However, people told us that this had an impact on continuity of care workers who provided their care.

Safe recruitment procedures and checks were undertaken before staff commenced employment . However, we noted that for one person, the reason why they left theor previous employment had not been recorded. This could have had implications as to the suitability of the person to provide care. The manager told us that they would ensure this was properly monitored in the future.

Prior to our inspection the local authority told us that they had investigated and substantiated a concern that a person had not received their medication, so we followed this issue up.

People who needed assistance with their medication told us that staff provided support with this as agreed and required.

Staff had undertaken training about medication administration. However, we found a number of gaps on the medication record charts which meant that we could not establish whether some people had received their medication or not. We noted that the manager had previously raised with the staff team about the importance of keeping accurate medication records. We discussed this with the manager who agreed with our findings and told us that they would again discuss this issue with staff. Shortly following our inspection the care services manager sent us an action plan outlining how they would ensure that improvements were made in relation to this issue.

Requires Improvement

Is the service effective?

Our findings

Most people told us that they thought that staff had sufficient skills and experience to support them, in order to meet their care needs. One person said; “They seem to know what they are doing.” They also told us that they were happy with the care and support provided to them. Another person said; “I tell them what I need and they provide it.”

The manager provided us with the provider’s programme of training that staff received to ensure they had the knowledge and skills related to their roles and responsibilities. This showed that staff had received training on essential topics such as moving and handling, infection control, health and safety and medication.

However, we noted that staff had not undertaken training about people's specific health conditions such as diabetes, epilepsy, multiple sclerosis, stroke and Parkinson's disease. We discussed this with the manager who told us that information was available to staff about these conditions, however full training had not been provided. This meant that there was a risk that staff did not have all of the knowledge they needed to provide care to these people. Following our inspection the care services manager confirmed that this training would be provided.

We spoke with staff about the training they had received and they told us that, overall, they had received the training they needed in order to meet people’s needs. However, two staff members told us that they had not undertaken training about how to use a specialist piece of equipment used to transfer people who were not able to move independently. They told us that advice from the provider’s office staff was to use this equipment before receiving training in how to use this safely. This meant that there was a risk that people and staff could sustain injuries if using this equipment without receiving training first. The care services manager said this issue would be followed up with staff but such training was provided in induction training.

Staff told us that they received useful supervision from the manager. These processes gave staff an opportunity to discuss their performance and identify any further training they required. However, improvements were needed in relation to the recording of staff supervision sessions in order to ensure that any actions planned as a result of these were followed up.handwriting on the supervision records was difficult to read and there were no details as to discussions held with staff. Following the inspection the care services manager told us about the improvements they were making in relation to the recording of these.

At the time of our inspection, the majority of people who used the service had capacity to make their own decisions about their care and day to day lives. People told us that staff sought their consent before they provided care to them and that they had signed to confirm that they agreed with their plans of care. Records looked at further supported this.

The Mental Capacity Act (MCA) 2005 is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. Staff told us they had received some training in the Mental Capacity Act (MCA) 2005 although when we discussed the issue with them, they were unsure of how to assess people's mental capacity to make decisions and what deprivation of liberty meant in practice, should the need for this arise. We noted that covert (hidden) medication had been given to a person in their food and this action had been agreed with their family. There were no assessments of the person’s capacity to make this decision and no details as to who was involved in this decision. A best interests meeting to discuss and agree this issue had not been undertaken.

We discussed this with the care services manager who confirmed that further staff training in this area was being provided to all staff in the months following the inspection and that mental capacity assessments would be carried out for people if required.

All people who needed assistance with eating and drinking told us that they happy with the care and support provided to them in this area. One person said: “They [care staff] ask me what I want and I always get this.”

People were supported at mealtimes to have food and drink of their choice. Staff were required to reheat and ensure meals were accessible to people who used the service. We spoke with two staff members who confirmed they supported people with their meals in this way. Staff had received training in food safety to be able to carry this out in a safe way. Staff told us that before they left their visit they ensured people were comfortable and had access to food and drink.

Requires Improvement

Is the service effective?

People using the service and their relatives told us that most of their health care appointments and health care needs were co-ordinated by themselves or their relatives. Staff were also available to support people to access healthcare appointments if needed and liaised with health and social care professionals involved in their care if their health or support needs changed. For example, a person told us that their care worker helped them to arrange appointments with their nurse and GP. Another person told us that staff had contacted their GP on their behalf when they had not felt well.

Requires Improvement

Is the service caring?

Our findings

People told us that they had been involved in decisions about their care and that staff had a good understanding of their preferences in the way their care and support was provided. For example, one person told us "Staff always listen to me." For people who wished to have additional support whilst making decisions about their care, information about advocacy services was available in the staff handbook. The manager agreed that this information needed to be accessible to people, for example in the information guide supplied to people when they first began to use the service.

People told us that staff were caring and friendly and that they provided care at their pace. They told us that they did not feel rushed, even if staff were running late. Some people told us that they had experienced missed and late calls. They told us that this had made them feel anxious as to whether staff would arrive or not.

People told us that staff respected their privacy, dignity and maintained their confidentiality. One person said "Staff respect my dignity when using the toilet." Another person said that staff respected her choice of preferred name. A relative described staff as "Very friendly and polite." Staff told us they gave people privacy whilst they provided personal care.

Everyone said that their independence had been encouraged by staff. One person told us that she was able to wash certain parts of her body rather than the staff member taking over and doing all her personal care.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 6 August 2014 we identified some concerns in realtion to the care provided to people who used the service. People were not fully protected from unsafe care and support because plans of care had not always been reviewed to ensure they met people's changing care needs. This was a breach of

The provider sent us an action plan outlining how they would improve.

At this inspection we found that improvements had been made. Assessments were undertaken to identify people's support needs and plans of care were developed outlining how these needs were to be met. There was information about people's preferences and care plans had been reviewed.

Staff spoken with were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their support needs, which enabled them to provide a personalised service, that met their needs.

People told us they were given choice and control to get the right care and that their disabilities were taken into account when care was provided. One person said; "Staff know my care and let me do things."Everyone said staff gave them choices.One person said ''They give me the food I like. I choose what I want to wear." People also told us that they were able to choose the gender of their care workers, if they wished to do this.

However, three people that used the service, one relative and two staff members told us that there were often too many different staff members involved in providing a person's care. This did not promote continuity of care for the person. One person said; "I get really anxious when they send new staff all the time. They don't ring me up to tell me this and it gets me down because I have to explain everything again." Shortly after our inspection the care services manager told us how continuity of care would be monitored to try to ensure people were supported by the same staff.

People using the service and their relatives told us they were aware of the formal complaint procedure. We looked at complaints records. This showed that investigations had been undertaken into complaints made although a response letter to the complainant had not been sent. The care services manager said this would be carried out in the future, as it was company policy, to ensure complainants could quickly see how their complaint had been dealt with.

Five people had raised concerns about the service they received. Most of these people had had a positive response. One person was unhappy as they expressed concern that a call was early and it took three or four times for the office to change this. Three people said there had been no warning from the office that there would be a new staff member. Another person said there were three or four occasions where no staff had turned up to the call for her father. The manager had apologised but this kept on happening. The care services manager stated this was unacceptable and she would ensure that these issues were followed up. Following the inspection we received an action plan outlining how these improvements would be made.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 6 August 2014 we identified that the provider's quality assurance system had not identified that record keeping required improvement. This was a breach of

The provider sent us an action plan outlining how they would improve. At this inspection we found that improvements had been made, with the exception of medication records. However, actions were being taken by the provider to address this.

The provider had notified us and the relevant authorities of the majority of incidents and significant events that affected people's health and safety, as required by law. However, we noted that the provider had not notified us about two incidents. We discussed this with the care services manager who assured us that notifications of all changes, events and incidents would be sent to us in the future.

There was a registered manager in post. Staff told us that they received support from the management team via phone calls, supervisions and staff meetings. They told us that the management team were available if they had any concerns. One staff member told us, "I have no concerns about the support I get." Staff said the manager was approachable and listened to them.

Five people we spoke with expressed positive views about the support provided by the provider's management team. One person said; "I had a problem but it was all sorted out very quickly." However, some people told us that they had not had a positive response when they contacted the provider's office . For example, one person told us that they had contacted the office to raise that too many different care workers were providing their care and support. They told us that they had not been satisfied with the response because the actual issue raised had not been addressed. Other people also told us that communication from the agency's office was unsatisfactory. A staff member told us that office staff did not always tell people if call times or staff members had been changed. Two staff members also told us that they had turned up for calls when people have been in hospital and office staff knew that they had gone into hospital but did not inform staff.

Three people told us that the agency used to send them a weekly timetable that identified which care workers would be providing their care over that time period. They told us that they no longer received this information and that they wanted to have this information supplied again. Two staff members also told us that the office staff did not notify people when new care workers would be coming to see them. The care services manager stated that people would be sent a weekly timetable and that people using the service would be informed before new staff started to provide care.

The management team monitored the quality of the service by speaking with people on the telephone to ensure they were happy with the service they received. However, we noted that that this was not always meaningful. For example, people with dementia assessed as having difficulty in communicating were being asked their opinion of the service by telephone without also contacting their representative to provide support for the person. The manager agreed and stated that peoples' representatives would also be contacted in future.

The manager explained that as the agency had only been registered for a year, service satisfaction questionnaires had just been sent out to people using the service. The care services manager stated that this feedback would enable them to identify and make improvements to the service. Three people confirmed they had received questionnaires to complete. This gave people the opportunity to share their views about the service provided.

'Spot checks' were undertaken at people's homes to check on the quality of care provided by staff. However people we spoke with had not received a 'spot check' to date. The manager stated these would become more frequent in the future so that issues could be picked up earlier and acted upon if necessary. The care services manager sent us an action plan outlining how people's needs would be regularly reviewed.

We noted that the provider's auditing system had identified that issues such as medication documentation and staff training required improvement and an action plan had been produced to address the shortfalls, although this did not include shortfalls in missed and late calls. After the inspection, the manager sent us an action plan covering the issues identified at this inspection.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People did not always receive appropriate care and treatment to meet their needs because care was not always provided at the agreed times.

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.