Sage Care Limited

Sagecare (Lincoln)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Sagecare Lincoln is a domiciliary care service that provides personal care and support for people in their own homes. The service can provide care for adults of all ages and covered Lincoln and surrounding areas.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Systems and processes in place were not always effective in sustaining improvement. The registered manager had failed to inform relevant agencies of significant events.

Medicine management required improvement. We found concerns with the administration of medicines, which placed people at risk of harm.

Safeguarding systems were in place and staff knew how to recognise the signs of abuse. People told us they felt safe. However, systems in place to learn from safeguarding incidents were ineffective.

The provider had a system in place to monitor care call data, however, due to staffing issues people and staff told us there were shortfalls in care delivery, meaning people's care calls were directly impacted.

People, relatives and staff knew how to complain and who to raise this to. However, some staff and people told us they did not feel listened to or they could not contact the office to raise the concern in the first instance.

Staff and people told us they wore appropriate personal protective equipment (PPE) for the tasks they were completing. Staff took part in regular COVID-19 testing.

People were supported by staff who had been safely recruited and had sufficient training relevant to their role.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 09 August 2019). The service remains

rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to poor care standards, peoples care needs not being met, poor communication and safeguarding concerns. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service remains require improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sagecare Lincoln on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines, management of safeguarding concerns and service quality oversight at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Sagecare (Lincoln)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two Inspectors, a bank Inspector 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and, specialist housing.

The service employed a manager who was also the registered provider and who was registered with the Care Quality Commission. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the service 24 hours' notice to ensure measures could be put in place to reduce COVID-19 risks.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with 20 people who used the service and their relatives about their experience of the care provided. We spoke with 16 members of staff including the provider, registered manager, deputy manager, field care workers, care workers.

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from abuse. Records showed staff had received safeguarding training and demonstrated an understanding of how to raise a safeguarding concern. However, some staff told us the office staff did not listen to or act upon concerns raised.
- Systems had not always been effective in preventing the reoccurrence of safeguarding incidents. This was demonstrated by the number of safeguarding incidents and the consistent theme of poor care and poor communication. The provider had failed to put adequate measures in place to mitigate further risk to people.
- Healthcare professionals had raised concerns in relation to people's safe care and treatment, we looked at documentation including improvement plans. However, concerns raised were not part of the actions within the improvement plan, meaning poor communication could limit improvements for the service. This demonstrated a failure to understand the importance of safeguarding vulnerable adults.

Learning lessons when things go wrong

- The provider lacked robust systems to review incidents. Opportunities to learn from incidents had been missed. At the time of the inspection the local authority had investigated several safeguarding concerns relating to poor standards of care. The cases involved concerns relating to neglect, risk management, care planning, recording of information, poor communication and accessing healthcare services in a timely manner.
- The manager was responding to the concerns raised, however, as timely action had not been taken to mitigate risk, further similar incidents had occurred in all of the aforementioned areas. Staff meetings showed some guidance was given to staff on reporting of incidences but lacked personalised guidance to deal with incidence relating to individuals. This demonstrated that the provider did not always learn lessons when things went wrong.
- We spoke to the registered manager about learning from incidents. They told us that whilst the provider reviewed incidents from across the organisation there was no system for reviewing specific location-based incidents. This meant systems were not robust enough to address and learn from incidents.

Using medicines safely

- Medicines were not managed safely. The provider had systems in place to train, monitor and assess staff in the safe administration of medicines. However recent medicines errors had placed people at risk of harm.
- We found significant medicines errors had occurred recently. For example, one person was given too much of their medicine, requiring emergency medical services to attend.
- Further examples included a staff member using one person's medicine to give to another person. In each

event the registered manager took timely action to manage the risk. However, records showed actions specified by the registered manager were not always followed, meaning people were at risk form further errors and potential harm to their health and wellbeing

The provider failed to learn from accidents and incidents and to ensure the safe administration of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There were not enough staff. The service was experiencing staffing issues at the time of the inspection, factors contributing to this were staff sickness, including COVID-19 isolation rules. The registered manager told us they were struggling to recruit and had a high number of vacancies; they had implemented a contingency plan. Weekly meetings were held with the local authority to discuss the current and ongoing staffing deficit and the impact it was having on the service.

● Staff told us they had experienced last-minute changes to their rota due to staff shortages and sickness. They were not always told of these changes which had impacted on people's care calls or resulted in too many staff turning up.

● Staff told us that due to lack of staffing, care calls were reduced or changed. For example, one staff member told us, "At times calls are back to back with no travel time". Another staff member told us, "One problem with Sagecare. [We go from] one house to another and it is exhausting. A person wants more time which we are not able to do."

● We had a mixed response from people regarding staff. One person told us, "There has been days when a carer has not turned up, I call the office and get excuses." Another person told us, "They [staff] can't stay for the full time, because of staffing problems, but I don't feel rushed."

● Safe recruitment practices were followed. We looked at the way in which the registered persons had recruited staff and records showed that a number of background checks had been completed. These included checks with the Disclosure and Barring Service to show that the staff concerned did not have criminal convictions.

Assessing risk, safety monitoring and management

● People were protected from risks associated with their care and support. Records showed risks to people's safety were identified, and assessed, with measures in place to mitigate the risks and ensure people's needs were met. Risk assessments were regularly reviewed. A member of staff told us, "High risk people are reviewed every four weeks, medium every six weeks and low risk every eight weeks".

● People told us they felt safe with the service they received. One person told us, "I do feel safe with them, staff know what they're doing."

Preventing and controlling infection

● People were protected from the risk of infection. People told us staff wore appropriate personal protective equipment (PPE) when supporting them.

● The provider had a system in place for staff to complete regular COVID-19 testing. Some staff had chosen not to have the COVID-19 vaccine; however, the provider had taken steps to assess and mitigate risk from unvaccinated staff in regards COVID-19.

● The provider had up to date infection control policies and had systems in place to ensure any government guidelines was communicated to staff.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support

- People told us they were supported by staff to access health professionals when needed. For example, one person told us, "They [staff] have been going out and getting my medication. I have not been too well at the moment; the staff organised a doctor for me."
- The provider had established links and worked effectively with the local authority to discuss care and support for people.
- People's care plans contained clear information about their health needs. For example, one person's care plan detailed how they received physiotherapy over the phone during the COVID-19 pandemic. .

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People needs were assessed and this was recorded in their care plans.
- Care plans contained person-centred information within them. For example, people's likes, dislikes, routines and choices. Care plans held specific information within them detailing how a person wanted to be supported. When we spoke to staff, they confirmed relevant information about people's capacity and preferences was available through the phone app.

Staff support: induction, training, skills and experience

- People were supported by competent staff. People also told us they felt staff were able to meet their needs. One person said, "I feel safe with staff, they have training and knowledge to keep me safe."
- We reviewed the providers training matrix which showed staff had received training appropriate to their role. Staff told us the provider would contact them to remind them of what refresher training was required. If they did not complete this, they would not be able to deliver care until training was completed.
- The provider also had a system in place for spot checks. This meant care staff were observed whilst delivering care and assessed on their ability.
- Records showed a system in place for staff supervision. Staff told us they should receive one to one meetings every three months. However, some staff said they had not had regular one to one meetings, this meant there was a risk staff may not get the support they required.

Supporting people to eat and drink enough to maintain a balanced diet

- People received effective support to eat and drink, when required. Not all people required support with food and drink, however where people did, we received positive feedback. For example, one person said, "My water is filled up fresh every day. Staff do my food for me; it works fine thank you". Another person told us, "Staff prepare the food, its working fine. They encourage eating and drinking and give me a choice about

food."
● Care plans detailed people's specific needs regarding food and drink. Staff were able to demonstrate their knowledge. When we spoke with staff, they confirmed information was available on the phone app used by the service. It contained information regarding peoples preferences.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

● People's rights under the MCA were upheld. People told us staff always gave choice and asked before commencing personal care. One person told us, "They always talk it through with me, they know what they're doing." Another person told us, "We have a chat before they start care."
● We found where people lacked capacity documentation was in place and meetings had been held with all appropriate people involved to ensure decisions were made in the persons best interest.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.
At our last inspection, in August 2019, the provider had failed to ensure the service was well-led. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was not sufficient improvement made at this inspection and the provider was still in breach of Regulation 17.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had not developed a positive culture within the service. Some staff we spoke with told us they worked excessively and felt undervalued due to the current staff shortages. One staff member told us, "Staffing issues are the main problem." Another told us they had insufficient time in between calls so they either ran late or had to rearrange calls themselves so they visited people on time and could deliver the care people needed.
- Systems and processes in place to ensure people received person centred care were not consistently effective. People told us different staff attended care calls and didn't always know the needs of the person. For example, one person told us, "A staff member came yesterday, didn't understand my need, didn't know where anything was or ask what I wanted doing."
- Feedback from people who used the service was not always positive. The provider had a system in place to obtain the views of people using the service by sending out an annual survey. Responses and information received from the surveys were used to develop an action plan. However, we found some people felt little improvement had been made. For example, communication had been highlighted as an issue in the 2020 / 2021 customer survey, however this remained an issue at the time of our inspection. For example, one person told us, "The main issue is, if you try to call the office, you are rarely successful."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Organisational governance and quality monitoring arrangements had been ineffective in assessing, monitoring and mitigating potential risks to people's safety. There were systems in place to monitor the safety and effectiveness of service provision, however, these were not always operated effectively. For example, staffing issues led to shortfalls in care delivery, meaning peoples care calls were directly impacted, as detailed in safe. The inconsistent approach to ensure these audits were effective, significantly restricted the ability to identify risks and address shortfalls, exposing people to the risk of avoidable harm and poor-quality care.

● The medicines audits had not always been effective. We found evidence medicines had not been administered according to peoples prescribed instruction. Actions as detailed in Safe were not always followed. This meant opportunities had been missed to proactively address potential risks to people's safety and welfare.
● Audit documents we reviewed for accidents and incidents were also ineffective. Whilst the provider responded to incidents, no organisational learning had been implemented in response to the highlighted concerns. Consequently, themes and trends identified during the inspection had not been acted upon in a timely way which posed risk to people.

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care; Working in partnership with others
● The provider failed to achieve and sustain improvements since the last two inspections at the service. When we spoke to staff some told us communication was inconsistent and they didn't feel supported. This meant there was a risk improvement plans would not be sustained in the long term
● The registered manager was open and transparent throughout the inspection. They were honest about the challenges the service was currently facing and the impact this had on people and staff. The registered manager had failed to notify us of significant events.
● The registered manager was committed to improving the service and ensuring people's needs were met. The registered manager was working with partner agencies to put actions plans in place to mitigate the risk of lack of staffing and the impact this had on the care people received.
● The registered manager felt the improvement would only really start when they had a change of contract meaning they delivered care to half the current people. Improvement plans in place also reflected this stating a review process would be in place from October 2021.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe management of staffing and medicines. The provider had also failed to put in place adequate measure to mitigate further risk to people.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

Warning Notice