Care Quality Commission

Sevacare (UK) Limited

Sevacare - Northampton

Inspection report

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Ratings

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

Overall summary

This announced inspection took place over two days on the 5 and 6 March 2015.

Sevacare – Northampton is a domiciliary care agency that provides care and support to adults that live at home.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People were cared for in their own homes by trained care workers that were able to meet people's needs safely. People's rights were protected. Risk assessments were in place to reduce and manage the risks to peoples' health and welfare.

People were protected from the risks associated with the recruitment of care workers by robust recruitment systems, training and the availability adequate numbers of care workers.

Summary of findings

People's care plans reflected their needs and choices about how they preferred their care and support to be provided. People were encouraged to be involved in the development and review of their care plan.

People had not always been kept informed in a timely way about care workers who were going to be arriving late, or when another care worker had to be substituted at short notice.

People received support from care workers that were able to demonstrate that they understood what was required of them to provide people with the care they needed. Care workers were caring, friendly, and attentive. People were treated with dignity and their right to make choices about how they preferred their care to be provided was respected.

The provider had not verified that the application to register the manager had been submitted to the Care Quality Commission (CQC).

There were systems in place in place to assess and monitor the quality of the service. People's views about the quality of their service were sought and acted upon.

People knew how to raise concerns and complaints. Complaints and allegations were appropriately investigated and action was taken to make improvements to the service when this was found to be necessary.

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 safe.

People received care and support in their own homes by suitable staff that had been appropriately recruited and trained.

Risks had been assessed and acted upon to prevent unsafe care.

Good

Is the service effective?
The service was not always effective.

Communication between staff and people regarding delays or other changes to their service had not always been timely.

People received care and support in their own homes from staff that were appropriately supervised and knew their job.

Staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) when providing support and care to people in their own home.

Requires Improvement

Is the service caring?
The service was caring.

Staff were kind, considerate and treated people in a dignified manner.

People, or their representatives, were involved in making decisions about their care.

People's dignity was respected. Staff respected people's individuality, and acted upon their likes and dislikes with regard to the way they preferred their care to be provided.

Good

Is the service responsive?
The service was responsive.

People's needs were appropriately assessed and regularly reviewed.

People's care was individualised and their preferences for the way they liked to receive support and care in the own homes was respected.

People knew how to complain and appropriate action was taken to resolve dissatisfaction with the service provided.

Good

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

A registered manager was not in post.

Requires Improvement

Summary of findings

The manager was aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and applied that knowledge appropriately with regard to providing a service to people in their own homes.

Staff had the managerial support they needed to do their job.

There were systems in place to audit the quality of people's care.

Sevacare - Northampton

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 announced inspection was carried out by an inspector and took place over two days on the 5 and 6 March 2015.

Before our inspection, we reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about important events which the provider is required to send us by law.

'48 hours' notice of the inspection was given. We needed to be sure that when we inspected the manager was in the agency office. We do this because in some community based domiciliary care agencies the manager is often out of the office supporting staff or, in smaller agencies, providing care.

During this inspection we visited the agency office. We spoke with eight staff, including the manager, two team leaders, and five care workers. We reviewed the care records of six people who used the service. We looked at eight records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service by the provider and the manager. This included the findings of the 2014 'Annual Service User Satisfaction Survey'.

We visited six households with people's prior agreement, met with eight people living there, including two relatives. With people's permission, we looked at the care records maintained by the agency staff that were kept in people's own homes. We spoke with 17 people on the telephone. We asked all the people we spoke with about their experience of using the service.

Good

Is the service safe?

Our findings

People were protected from harm arising from poor practice or ill treatment. There were clear safeguarding procedures in place for care staff to follow in practice. For example, care staff were familiar with the 'whistleblowing' procedure in place to raise concerns about people's treatment. They understood the risk factors and what they needed to do to raise their concerns with the right person if they suspected or witnessed ill treatment or poor practice. Care workers understood the roles of other appropriate authorities that also had a duty to respond to allegations of abuse and protect people.

Staffing levels were maintained at a level that safely met people's needs because day-to-day scheduling took into account vacancies for care workers; unexpected absences due to sickness, and planned holiday leave. This helped ensure that people received safe care, however people were not always advised of staff changes or delays in staff arriving to care for them; for some people this impacted on their sense of safety.

People were safeguarded against the risk of being cared for by unsuitable persons because care workers were appropriately recruited. For example, all staff, including those who were office based, were checked for criminal convictions; references from previous employers were taken up. Recruitment procedures were satisfactorily completed before care workers received induction training prior to taking up their care duties. Newly recruited care workers 'shadowed' an experienced care worker before they were scheduled to work alone with people receiving a service.

People had care plans kept in their homes, with an up-to-date copy held at the agency office. Care plans contained an assessment of the person's needs, including details of any associated risks to their safety that their assessment had highlighted. Individualised care plans and risk assessments were in place that ensured people were supported in an effective way. A range of risks were assessed to minimise the likelihood of people receiving unsafe care. Individual plans of care were reviewed on a regular basis to ensure that risk assessments and care plans were updated regularly or as changes occurred.

Care plans provided care workers with the guidance and information they needed to provide people with safe care. Where agreed in their care plan support was provided for people needing help to safely manage their medicines, for example prompting them to take their medicine at the times prescribed.

Where pertinent people's care plans accurately provided care workers with up-to-date information about their healthcare needs, their mobility, and other factors that had to be taken into consideration so that safe care was provided. For example, suitably secure arrangements were agreed and put in place to enable care workers to access a person's home when they had physical difficulties opening their front door. One person said, "Getting to the door leaves me out of puff; it's a real struggle. Knowing they [care workers] can let themselves in is a big help and means I don't have to worry about not getting the help I need because I can't get to the door in time." In such circumstances, for example, care workers had been issued with a code that enabled them to access a small wall mounted safe that contained the person's front door key. There were precautionary arrangements in place to prevent people's security being compromised by any unauthorised use of codes.

Requires Improvement

Is the service effective?

Our findings

The arrangements in place to advise people that their care worker was 'running late' usually worked well but were reliant upon timely communication. For example, care workers were expected to keep office based staff advised if they had been delayed so that the next person scheduled to be visited could be promptly contacted. This had not always happened.

There was a telephone operated system for monitoring when care workers arrived and left a person's home, although not everyone had agreed for this to be used in their home. This system was designed to promptly alert office based staff to a 'missed' or 'late call' and was an additional safety precaution. When in use this system worked well and protected people against the risk of not receiving the care they needed.

One person said, "Usually they [care workers] are very good. Weekends and when [care worker] is on holiday is when I start wondering if they will forget to come. They [care workers] have never actually done that though, but now and again I have had to ring them up and ask them if someone is actually coming. To be fair they are usually on their way by the time I do that. That's still a bit unsettling when you are on your own." By contrast, another person said, "Yes, I do feel safe. They [care workers] more often than not get to me bang on time and if they are held up they let me know so I don't worry."

The manager and staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005). Staff had received the training and guidance they needed in caring for people who may lack capacity to make particular decisions. People's care plans contained assessments of their capacity to make decisions for themselves; for example in circumstances where a person still lived alone but had dementia care needs.

People's needs were met by staff that were effectively supervised by the manager. The competence of staff to do their job was regularly appraised and staff received the guidance, managerial support and training they needed to provide people's care. Care workers had been supported to attend training courses which had increased their knowledge of the care and support people required, such as people handling skills and managing medicines. Care workers had been appropriately supervised and met with their manager at regular intervals throughout the year to discuss their training needs and job performance.

Team leaders also carried out regular unannounced 'spot checks' to observe and assess if care workers were doing their job safely, for example using personal protective equipment such as aprons and gloves. One person said, "Their 'boss' asked me if they [care workers] had shown their 'badge' [identity] when they first visited me. They had. I know them all now but if a new one [care worker] comes they always show it [identity]." Team leaders also checked with people living alone that the care worker had appropriately secured the front door before they left the person's home.

Care workers had a good understanding of people's needs and the individual care and support that had been agreed. Timely action had been taken if there were concerns about people's wellbeing, raising these directly with family members or, where appropriate and with people's consent, to external professionals such as their GP or community nurse.

Good

Is the service caring?

Our findings

People said the care staff were kind and friendly. They also said that the care workers were familiar with their routines and preferences. One person said, "They [care workers] are ever so kind and cheery even though they have a hard job to do. They make us smile, they really do."

Care plans included people's preferred name. Another person said, "They [care staff] call me [name] once I get to know them and ask them to call me [name]. It's friendlier that way. I don't just like to be called [title] [surname]. They [care workers] are coming into my house to help me after all." A relative said, "My [relative] has had the same [care worker] for a good while now. [Care worker] has got to know [relative] and knows when [relative] is a bit down and needs cheering up. It's not quite the same when [care worker] is away but all the [care workers] are kind."

People's privacy and dignity were respected by care workers. One person said, "They [care workers] help me have a shower. That was a bit embarrassing for me but they [care workers] were really sensitive to that and made sure I felt comfortable with what they needed to do to help me."

People said that although care workers were there to support them with their assessed needs they still felt encouraged to manage as much as they could for themselves. People were treated as individuals that have feelings, especially with regard to having anxieties about needing help in their own home just to manage their daily lives. One person said, "It's difficult for me to do certain things but they still encourage me to try. They don't just 'take over'." A relative said, "It's got so that [relative] can't do much now but they [care workers] always ask [relative] to try, but nicely. They [care workers] don't expect [relative] just to 'get on with it'. They just make the effort to involve [relative], try to keep [relative's] self-respect even though they know [relative] will need their help."

Care workers were mindful of the sensitive nature of their work and respected confidentiality. People said that care workers never gossiped about other people they visited. One person said, "I wouldn't like that. If [care workers] spoke out of turn about others what would they say about me? They [care workers] never do that though and that's very reassuring."

We heard office based staff respond to telephone queries in a helpful manner, with explanations where this was appropriate. One person said, "At the start [of the service] there were a few 'hiccups' and I had to phone them [the service] a few times to get things sorted. They were always very apologetic. Although they [the service] had made the mistakes they made me feel what I said mattered, that they were listening and wanted to get things right; which they did."

People were given the information they needed about the service; for example, office contact numbers, and a copy of their agreed schedule of visits that included the name of their allocated care worker. One person said, "If my regular [care worker] is away I like to know who is coming in their place. For a while this was a bit 'hit and miss' but I get this [information] now. There's nothing worse than not knowing who to expect."

Good

Is the service responsive?

Our findings

People's care and treatment was planned and delivered in line with people's individual preferences and choices. Care plans were regularly reviewed and updated to reflect changes made to the way people received their care. Relatives, such as a person's partner or other main family carer, were encouraged to participate in reviews as long the person concerned had no objections. This was confirmed by the relatives we spoke with when we visited people at home. One relative said, "When they check up on us to see if my [relative] is getting the help [relative] needs I 'sit in' on it [review]. I can tell them if we are not managing but my [relative] can't really so they listen to me and what our regular [care worker] thinks. We get more visits now because of that and that helps a lot." The outcome of reviews were acted upon and where appropriate other professionals, such as care managers from the Local Authority, were involved in decision making and allocating 'extra' domiciliary care support.

Where practicable scheduled support visits were organised to fit in with people's daily routines, such as when they attended a day centre. People, who required support to get up in the morning, or to retire to bed, received their care at a time to suit them. This was not always possible, however, and sometimes a compromise had to be agreed with people, particularly when it was essential that they received this support. One person said, "I'm not able to get myself up in the morning without their [care worker] help. I would like them to come a bit earlier but we had to agree a time they [care worker] could realistically get to me, so I'm fine with that until they are in a position to offer me an earlier call [visit]."

People were encouraged to make choices about how they preferred to receive their care. Choices were promoted because staff engaged with the people they supported at home. One person said, "They [care workers] always ask me how I like things done." Another person said, "They [care workers] come in to help me with my [relative's] care so they [care workers] always check with me as my [relative] likes things done in a certain way. They [care workers] never just make assumptions and [care workers] always read my [relative's] care plan in case I forget to mention something that has changed."

There were appropriate policies and procedures in place for complaints to be dealt with. There were arrangements in place to record complaints that had been raised and what had been done about resolving the issues of concern. Those acting on behalf of people unable to complain or raise concerns on their own behalf were provided with written information about how and who to complain to. People said that care workers encouraged them to speak up if they were unhappy or worried about anything.

When people received an agreed service they, and their representatives, were provided with the information they needed about what do if they had a complaint. One person said, "They [care worker] said I should always complain if I wasn't happy with anything. They explained what I needed to do. Mainly I have just had little grumbles about late visits that always get sorted out but at least I know if I had real worries I would know what to do." A relative said, "I have complained in the past about a 'mix-up' when my [relative] didn't get a visit. It was a genuine mistake though, but they [office staff] listened and appreciated I was annoyed. It got sorted and I haven't had to complain again, but at least I know it [complaints procedure] works."

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post when we inspected, and the unregistered manager had been in post for several months. An application had originally been completed by the manager when they had been appointed but because of an oversight the application had not been submitted to the Care Quality Commission (CQC) in a timely way by the agency's head office.

We found that the manager was approachable and encouraged people, including relatives, and healthcare professionals to provide feedback, verbally, or in writing regarding their perception of the quality of care provided by the agency. Team leaders, for example, regularly gave feedback to the manager on people's experience of using the service. Positive as well as negative feedback was shared with care workers at meetings and where people had criticised the quality of service action was taken to put things right. For example when people had complained about not receiving their weekly schedules in good time the manager reviewed the procedures for sending these out and people received the timely information they needed.

People had their say about their experience of using the service. There were systems in place to audit the quality of care provide, such as regular surveys. A randomly selected sample of people using the service received an annual 'Consumer Satisfaction Survey' questionnaire. In November 2014, for example, 60 survey questionnaires were sent out to people and the responses were then analysed and improvements to the service were made where these were identified as needed. The sample was designed to give a balanced reflection of the quality of the service provided to people whose needs ranged from low to high dependency. For example, improvements were identified as being needed to ensure that people regularly had support from the same care workers. The survey indicated that over half the people that responded 'quite often' received their support from a care worker that had not regularly visited them at home. The manager acted upon this information and the aim to provide people with care workers that regularly visited the same people had been prioritised. One person said, "I used to get a bit 'fed up' having someone [care worker] different nearly every time. Now I know them [care workers] and they come to me regularly. I realise, though, that sometimes I'll still get someone [care worker] I haven't met before but I know my regulars [care workers] will come back to me."

People benefited from receiving a service from care workers that were empowered by a manager who provided them with guidance and support. The manager had an 'open door' policy so that care workers did not feel dissuaded from seeking advice on how best to provide care. The manager also used regular supervision and appraisal meetings with care workers constructively so that they reflected on the way they did their job and, where appropriate, made changes to their work practices.

Quality audits were regularly carried out. These included 'spot checks' carried out by Team Leaders who visited people at home. The records maintained by care workers in people's homes were checked to establish that they were accurate and up-to-date. People said that the records reflected the care and support they had received on the day the record was made. Records were kept of what was discussed at meetings and care workers were encouraged to express their views about how the service could be improved.

Records relating to the day-to-day management of the agency were up-to-date and accurate. Staff recruitment and training records were fit for purpose. Training records showed that new care workers had completed their induction, that experienced care workers received regular 'refresher' training. Where care workers had received training prior to working at the agency they were required to provide a copy of their training certificate.