Sevacare (UK) Limited

Sevacare - Hall Green

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Sevacare - Hall Green is a domiciliary care service which provides care to people in their own homes. At the time of the inspection the service was supporting 280 people.

People's experience of using this service and what we found
The provider had systems in place to monitor the quality of care. However, these had not always been effective.

In recent months some people had experienced missed calls. Some of the missed calls were as a result of office staff not correctly allocating calls on the provider's system. Action had been taken to reduce the risk of re-occurrence. The majority of people told us their care calls were usually on time and if they were going to be late, they were informed. Four people raised that their call times were not always consistent.

The majority of staff took regular COVID-19 tests to ensure they were free from the virus they could pass on to people they supported. Enough personal protective equipment (PPE) was made available for staff who told us they wore and changed this for every call, they had received training and additional information about COVID-19 and understood the importance of being fully protected. Relatives told us that staff followed good infection prevention control practices.

Risks associated with people's health and social care needs had been identified and assessed. We saw that most risk assessments contained clear information about key risks for people and guidance on the support they needed. However, in relation to one specific health condition the information for two people lacked detail and in one case was conflicting.

Safe recruitment and selection procedures were in place. People told us that they felt safe when the staff were in their home with them. Staff were trained in administering medicines safely. Competency checks had been completed to ensure staff were following safe practices.

People and relatives told us although they did not know who the registered manager was, they did know some of the office staff who they felt were approachable. Staff found the management team approachable.

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

Rating at last inspection
This service was previously rated Good (report published 11 May 2019).

Why we inspected
The inspection was prompted in part due to concerns received about missed and short calls, and safeguarding incidents. We undertook a direct monitoring activity which indicated regulatory action was

needed. As a result, we undertook a focused inspection to review the key questions of safe 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 has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report.

Follow up
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 well-led?

Requires Improvement

The service was not always well led.

Details are in our safe findings below.

Sevacare - Hall Green

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 completed by one inspector and one assistant inspector. An Expert by Experience also spoke with people and relatives on the telephone. 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. It also provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care

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

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider's representative would be in the office to support the inspection. Inspection activity started on 15 November 2021 and ended on 26 November 2021. We visited the office location on 17 November 2021.

What we did before the inspection
We reviewed information we had received about the service since it's registration. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this

inspection. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. We took this into account in making our judgements in this report. We used all of this information to plan our inspection.

We spoke with eleven people who used the service and with seventeen relatives of people using the service on the telephone about their experience of the care provided. We spoke with sixteen members of staff including the registered manager, regional manager, care co-ordinators and care workers. We reviewed a range of records. This included six people's care records. We looked at two 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.

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 good. At this inspection this key question has now deteriorated to requires improvement. 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.

Staffing and recruitment

● The majority of people and relatives spoken with told us that care staff stayed for the required duration. The provider had an electronic call monitoring system in place, this showed instances of short calls and some calls that were not at the expected times. The provider was aware of these and was taking action to try and ensure these did not occur in future.

● Four people told us they had experienced missed calls. The majority of people we spoke with had not experienced any missed calls. One relative told us, "They [care staff] are more or less on time and had no missed calls. Always stay his time allowed as well."

● The majority of people told us their care calls were usually on time and if they were going to be late, they were informed. One person told us, "The carers do turn up on time, they have so many people to visit, but they always get to me on time."

● Four people raised that their call times were not always consistent. One person told us, "When our regular carer was on holiday for a month, they sent out different carers who would arrive at different times." One relative told us, "There are occasions when they are quite late. They are supposed to be here for 9.15am and instead turn up at 11.00pm."

● Staff told us they had sufficient travel time to get to the care calls on time.

● Safe recruitment and selection procedures were in place. Applicants were required to provide a full account of previous jobs they had done. References from past employers had been obtained as had disclosures from the Disclosure and Barring Service. These disclosures establish if an applicant has a relevant criminal conviction or has been included on a barring list due to professional misconduct.

Preventing and controlling infection

● The majority of staff undertook weekly COVID-19 tests in line with current government guidance. However, some recently employed staff were not completing weekly testing. This meant some people were not being kept safe from COVID-19 transmission. We raised this with the registered manager who took immediate action to ensure all staff were taking the required tests.

● Relatives told us staff wore appropriate personal protective equipment (PPE) and staff followed good infection control practices when they visited. "I have been very impressed during the pandemic, the carers all wear full PPE, at first it was a bit scary for mum, but she got used to it. The office sent a letter out at the beginning of the pandemic to explain everything to us."

● Enough personal protective equipment (PPE) was made available for staff who told us they wore and changed this for every call, they had received training and additional information about COVID-19 and understood the importance of being fully protected.

Assessing risk, safety monitoring and management

● Staff told us how they supported people safely and understood people's risks.

● Risks associated with people's health and social care needs had been identified and assessed. We saw that most risk assessments contained clear information about key risks for people and guidance on the support they needed. However, in relation to one specific health condition the information for two people lacked detail and in one case was conflicting. This put people at risk of not receiving the health care they may need. The registered manager assured us they would ensure this was rectified.

● Some people needed support to move, including the use of hoists. Information in their care records was detailed about how any risks should be managed and the equipment needed. One person told us, "I need hoisting so have a double up call and they [staff] expertly hoist me safely from my bed to chair, so yes, quite safe with them."

Systems and processes to safeguard people from the risk of abuse

● Systems and processes were in place to ensure people were safeguarded from avoidable harm. The registered manager had fully investigated any concerns raised.

● People told us that they felt safe when the staff were in their home with them. One person told us, "The carers make me feel safe, they talk to me, I don't like people who just come in to do a job; they don't, as they come in and help me and chat to me too."

● Staff understood their responsibilities for keeping people safe and knew how to report any concerns they had. One care staff told us, "Any issues I will report to the office, for example bruising", another care staff told us, "Safeguarding is my priority."

Using medicines safely

● Staff had training in medicines, and this was updated regularly. Staff competencies to administer were also routinely assessed by observations by supervisors.

● Medicine records indicated people had received their prescribed medicines.

● People told us they received the support they needed with their medicines. One relative told us, "Mum has tablets in a blister pack and the carers give the tablets at morning and at lunchtime, they always remember to give mum her tablets and always take them from the blister pack in date order."

Learning lessons when things go wrong

● Staff understood they needed to report and record any accidents or incidents that occurred when they provided people with support.

● The registered manager had reviewed any incidents and complaints to see if any lessons could be learned to help them from re-occurring in the future.

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 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.

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

- A system was in place to check that all staff undertook weekly COVID-19 tests. However, an administrative error meant that several new staff had not been added to the spreadsheet that was used to monitor the tests. This had not been identified until we brought to the registered managers attention. Immediate action was taken to rectify the issue.
- The provider was taking action to ensure care staff stayed for the required duration of a call. In recent months a new monitoring system had been introduced that identified individual staff who did not stay for the required time. New ways of working had been introduced and we saw that action had been taken to discuss any issues with staff. This new monitoring system required more time to become embedded into working practices, to ensure consistency and sustain the improvements being made.
- There had been some incidents of missed calls. These were investigated by the registered manager and in some instances had resulted in staff disciplinary action. Some of the missed calls were as a result of office staff not correctly allocating calls on the provider's system. Action had been taken to reduce the risk of re-occurrence.
- Checks had not identified that some risks assessments lacked detail, clarity and guidance for staff.
- Unannounced spot checks were carried out on staff by their supervisors, to ensure they were meeting people's needs.
- Arrangements were in place to ensure staff training was up to date. Staff received feedback on their performance and were kept informed of changes and updates through supervisions, meetings and communication.
- The latest CQC inspection report rating was on display in the reception area of the service and on their website. The display of the rating is a legal requirement, to inform people, and those seeking information about the service and visitors of our judgments.
- The provider had taken account of the findings of our last inspection and improvements had taken place regarding the recording of consent in care records. The registered manager also showed she was aware of the needs of people using the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others;

- People using the service, their relatives and staff said they were able to give their views about the service, although a small minority did not feel listened to. One relative told us, "They send out a survey once a year, in the earlier days we did make a comment about the number of carers mum was having, and they did listen

to us."
● People and relatives told us they did know some of the office staff who they felt were approachable. One relative told us, "If we need anything at all we just call the office, they are friendly and just sort things out straight away."
● Staff found the management team approachable. One member of staff told us, "I do feel supported, they understand me, and I have a good relationship".
● The service continued to work in partnership with health and social care professionals such as GP's, district nurses and the local authority.

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
● A duty of candour incident is where an unintended or unexpected incident occurs which result in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.
● The management team understood their responsibilities to be open and honest when things go wrong. They knew what they needed to report to CQC and other relevant agencies, such as the local authority. Where things had gone wrong we saw an apology had been given.
● Any notifications that the registered manager and provider were obliged to make such as those alleging abuse, had been made to the CQC and local authority.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Most people and relatives contacted told us they were happy with their carers who they found to be respectful, kind and caring.
● The provider's policies and procedures were kept up to date to ensure the service delivery would not be interrupted by unforeseen events. The business continuity plan took account of the COVID-19 pandemic to ensure people continued to receive the care they needed.
● There was evidence of learning from incidents and improvements made to mitigate future reoccurrences.