Sevacare (UK) Limited

Meridian Health and Social Care - Lincoln

Inspection report

Eagle House
Exchange Road
Lincoln
Lincolnshire
LN6 3JZ

Tel: 01522690777
Website: www.sevacare.org.uk

Date of inspection visit:
28 July 2020
29 July 2020
30 July 2020

Date of publication:
30 July 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Meridian Health and Social Care – Lincoln provides care for people in their own homes. The service can provide care for adults of all ages. It can assist people who live with dementia or who have mental health needs. It can also support people who have a learning disability, special sensory needs and or a physical disability.

At the time of our inspection the service was providing care for approximately 141 people most of whom were older people. 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
The provider had a quality assurance policy in place. However, the policy did not describe a clear scheme of delegation for undertaking audits to ensure regulatory compliance. There was insufficient detail regarding monitoring timeframes and who was responsible for the quality assurance process.

There was a lack of quality assurance processes in place to monitor the quality of the service and address shortfalls. For example, the provider did not audit planned hours against actual hours delivered.

People did not always receive their visits at the times they expected, people did not always receive their hours of care in line with their care plan and planned hours of care. Staff were not deployed effectively in order to meet people's needs.

Medicine records had a lack of guidance and information for staff to safely administer prescribed medication. Medicine records were not consistently completed to show that people had received their medicines.

Communication with the office was not always effective. People told us when they raised issues, there was no evidence of action taken to resolve issues.

The care plans we reviewed contained conflicting information relating to people's needs and were not always in line with other documentation.

People did not always receive care and support in line with their preferences. There was a lack of information and guidance for staff to understand conditions associated with people's health.

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

Rating at last inspection

The last rating for this service was requires improvement (published 14 March 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing and quality assurance. A decision was made for us to inspect and examine those risks.

We received concerns in relation to the deployment of staff. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements.

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.

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.

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 Regulation 12 Safe Care and Treatment, Regulation 18 Staffing, Regulation 17 Good Governance and Regulation 9 Person Centred Care at this inspection.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Meridian Health and Social Care - 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 and an assistant inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes. at the time of this inspection the service did not have a manager registered with the Care Quality Commission. The provider is in the process of submitting a registered manager application. This means the provider is 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 would be in the office to support the inspection.

What we did before the 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.

During the inspection
We spoke with ten people who used the service and one relative about their experience of the care provided. We spoke with ten members of staff including the provider, care director, area manager, branch manager,

and care workers. We reviewed a range of documents including 16 people's care records and multiple medication records. We looked at three 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 also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records.

Inadequate

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 inadequate. This meant people were not safe and were at risk from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

Assessing risk, safety monitoring and management, learning lessons when things go wrong

- There were a lack of information and guidance for staff relating to conditions associated with people's health which put people at increased risk. One service user had Type 1 Diabetes, their care plan contained a lack of information regarding how this should be managed or guidance for staff to recognise the adverse effects of the condition.
- The provider told us they undertook a sample audit in February 2020 of service user care files. Seven care plans were examined by the provider which highlighted incomplete care plans and risk assessments. There was no evidence to show action had been undertaken to rectify these shortfalls following the auditing process.
- The provider told us during the inspection people did not always receive the hours of care in line with commissioned hours. This had been identified in May 2020 by the care director. The provider produced a 12-week action plan to address these issues. As the issues had still not been addressed a team was deployed to the service, week commencing 20th July 2020.
- Where accidents and incidents had taken place, an action stated by the provider to be taken had not been followed through. It stated on the accident and incident log, a staff member would be removed from care delivery and a competency check would be undertaken before they were reinstated to deliver care. At the time of the inspection, this action had not been taken which increased the risk to people's safety and welfare.

Using medicines safely

- On an ongoing and repetitive basis staff had failed to record the administration of prescribed medicines. We examined medicine administration records (MARs) and in each case we found instances when no entry had been made to show that a medicine had been administered as prescribed.
- There was a lack of information and guidance for staff to enable them to administer medication safely. We examined MARs and identified that named medicines and topical creams had no direction about how or when they should be administered or applied.
- The manager stated the action required was for office team to address the highlighted issues. The care director told the inspection team that they were in the process of typing up MARs to ensure all details and directions of medicine were stated on the MAR. There was no evidence to suggest these issues had been resolved in a timely manner to ensure people received their prescribed medicines or to prevent the identified issues reoccuring.

Systems were either not in place or robust enough to demonstrate safety and risks were effectively

managed. This placed people at risk of harm. 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

● Staff were not deployed sufficiently in order to meet people's needs in a timely manner. Ineffective call scheduling led to shortfalls in care delivery. Prior to our inspection we reviewed information held about the service and found there were a large number of concerns and issues raised about missed or late visits.

● People did not always receive the hours of care they required in line with their care plan and planned hours of care. During the inspection we looked at call monitoring logs to identify when visits should have been undertaken and when they had been completed. We found people's visits were not provided for the duration they were assessed or commissioned for. We also found people's visits were not provided at a consistent time and on some occasions had been up to two hours late.

● We analysed call monitoring logs and found a member of care staff had been allocated twelve calls in one day with no travel time in between calls. This resulted in all twelve service users losing a percentage of their allocated call time.

● A service user had been assessed to require three calls per day and required support with personal care, meal preparation and administration of medication. Records highlighted that they received only 37% of their allocated call duration over a two week period. This service user told us, "I am supposed to get help with personal care and meals, but I often do it myself, sometimes I struggle doing things myself."

● A staff member described a situation where a person using the service was allocated a call at 21:05pm. They said, "I was running late, I spoke to out of hours [the provider's out of hours service], asking for support, I was told to attend, which resulted in me waking [service user] at 23:53pm to check medicines had been taken."

Staff were not deployed sufficiently in order to meet people's needs in a timely manner. Ineffective call scheduling increased risks to people's safety and welfare. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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 people concerned did not have criminal convictions.

Preventing and controlling infection

● People told us staff reduced the risk of spreading infection by wearing single use disposable gloves and aprons when carrying out personal care or preparing food. Staff confirmed they were provided with this.

● Training records showed staff received training regarding infection control as part of their initial induction.

Inadequate

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 now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Continuous learning and improving care

- There were a lack of effective quality assurance processes in place to monitor the quality of the service and address shortfalls. We requested documents regarding how the care delivery was monitored and were informed by the provider, no formal audits had taken place, only informal checks had been undertaken which were not documented. The provider failed to monitor and mitigate risk relating to health, safety and welfare of service users, due to a failure to establish and implement systems and processes within the service.
- Systems to monitor, check and audit regulatory compliance were not effective. The provider had a policy relating to governance, however this did not describe a clear scheme of delegation for undertaking audits to ensure regulatory compliance. The policy gave no clear description of timeframes, intervals and failed to specify who was responsible for completing audits.
- The provider completed a service user file audit in November 2019. This identified risks relating to falls, a lack of evidence of consent and limited information regarding care and support needs in care plans. However, in the audit tool used by the provider, a 100% compliance rating was documented. This demonstrated clear issues with the auditing processes within the service.
- The provider was in the process of conducting a service user satisfaction survey, the previous formal service user satisfaction survey was completed in March 2019, this identified 37% irregular carers attending calls, 10% of service user were less than satisfied when contacting the office for support. There was no evidence of actions taken to address these issues or and when they were reviewed to ensure satisfactory improvements had been made.
- The provider had conducted an MAR audit which reviewed a range of MARs from June 2020. This highlighted that on several occasions staff had failed to record the administration of prescribed medicines, however there was no evidence to demonstrate the actions to improve this aspect of people's care.

The above concerns demonstrated a failure to ensure effective systems and processes were deployed to monitor and assess the quality and safety of the service and was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- The provider had a system in place to obtain the views of people using the service by sending out an annual survey

● At the time of the inspection there was no registered manager in position at the service. The care director informed us they planned to submit an application to Care Quality Commission during the inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People did not always receive care and support in line with their preferences.

● People and relatives told us the service was not well led. We were consistently told communication was poor and the persistent lateness of staff, resulted in an adverse effect for people. For example, a relative told us, "[service user] becomes distressed when staff turn up late", resulting in a negative effect on their emotional well-being."

● One person's care record stated they did not wish to receive care and support from a male carer during calls involving personal care. When we spoke to the service user, they told us on many occasions the provider had sent male carers, they had refused to be supported by them. There were occasions where the provider re-sent a female member of staff but others where they could not do so leaving the person without the care they needed.

● When we spoke to a service user, they told us, "I had spoken to the office staff about preferred carers but they keep sending ones I don't know, on many occasions they have tried sending unknown carers and I send them away or tell the office I don't want them". The service user told us they had decided not to have a call on these occasions.

The above concerns demonstrate a failure to put in place reasonable adjustments and ensure care and treatment is personalised specifically for the people using the service. This was a breach of Regulation 9 (Person Centred Care) 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

● The provider understood their regulatory requirements and ensured they notified us about events they were required to by law.

● Our previous ratings were displayed on the providers website and in the office location as required.

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 9 HSCA RA Regulations 2014 Person-centred care There was a failure to put in place reasonable adjustments and ensure care and treatment is personalised specifically for the people using the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate safety and risks was effectively managed. This placed people at risk of harm.

The enforcement action we took:

We issued a warning notice to the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to ensure effective systems and processes were deployed to monitor and assess the quality and safety of the service.

The enforcement action we took:

We issued a warning notice to the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed sufficiently in order to meet people's needs in a timely manner.

The enforcement action we took:

We issued a warning notice to the provider.