Sevacare (UK) Limited

Sevacare - Stoke-on-Trent

Inspection report

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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?	**Inadequate**

Summary of findings

Overall summary

We completed an announced inspection at Sevacare Stoke-on-Trent on 16 and 17 May 2016. At the last inspection on 30 April 2013, we found the provider was meeting the required standards.

Sevacare Stoke-on-Trent are registered to provide personal care. People are supported with their personal care needs to enable them to live in their own homes and promote their independence. At the time of the inspection the service supported 75 people in their own homes.

We found that the manager shown on our records as being registered with us (CQC) had left the service three months ago and there was a new manager at the service who was in the process of applying to become the registered manager. 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 2008 and associated Regulations about how the service is run.

People's risks had not been assessed or monitored effectively to keep people safe. People were at risk of harm because records we viewed did not always match the support that staff told us people needed to keep them safe.

Medicines were not managed safely to protect people from the risk of harm. We could not be assured that people were receiving their medicines as prescribed.

Where relatives had consented to care on behalf of people, we found there were no mental capacity assessments carried out to ensure that decisions were made in people's best interests. Records we viewed did not contain guidance for staff to identify if people were able to consent to their care and staff had very little knowledge of The Mental Capacity Act 2005.

We found the systems in place to assess and monitor the quality of the service were not effective. Some of the concerns we raised at the inspection had been identified, but there had been no action taken to mitigate the risks for people who used the service.

Staff had received training and an induction before they provided care, but we found they had not received training in important areas such as; The Mental Capacity Act 2005. Staff told us that the training was not always detailed and they would benefit from further training in some areas to enable them to meet people's needs more effectively.

We found that people's preferences in care had been considered when they started to use the service. Staff knew people well, however, the records did not reflect what staff told us and had not been reviewed or updated when people's circumstances had changed.

People told us that staff treated them in a caring way and respected their dignity when they provided support.

Staff gave people choices in how they wanted their care provided. However, staff did not have the information needed to understand people's ability to make choices.

Staff and the manager understood their responsibilities to protect people from abuse and were able to explain the actions they would take if abuse was suspected.

We found there were enough staff available and staffing was managed in a way that ensured people received consistent care workers who knew people well.

The provider had safe recruitment procedures and we found that the required checks had been carried out, which ensured that staff were suitable and of good character to provide care to people who used the service.

People were referred to other health and social care professionals where concerns had been raised by staff.

The provider had a system in place to handle and respond to complaints that had been made by people who used the service and their relatives.

We identified breaches 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 the report.

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's risks had not been assessed or monitored effectively to keep people safe.

Medicines were not managed safely to protect people from the risk of harm.

Staff and the manager understood their responsibilities to protect people from abuse and were able to explain the actions they would take if abuse was suspected.

There were enough staff available and staffing was managed in a way that ensured people received consistent care workers who knew people well.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's ability to consent had not been considered and the provider was not acting in accordance with the Mental Capacity Act 2005.

Staff had received training and an induction before they provided care, but we found that they had not received training in important areas such as; The Mental Capacity Act 2005. Staff told us that the training was not always detailed and they would benefit from further training in some areas.

People were supported by staff to ensure they received adequate amounts of food and drink.

People were referred to other health and social care professionals where concerns had been raised by staff.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff gave people choices in how they wanted their care

provided. However, staff did not have the information needed to understand people's ability to make choices.

People told us that staff treated them in a kind and caring way.

People were treated with dignity and respect when staff provided support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We found that people's preferences in care had been considered when they started to use the service. Staff knew people well, however, the records did not reflect what staff told us and had not been reviewed or updated when people's circumstances had changed.

People received consistent staff who provided care at a time that they needed it.

The provider had a system in place to handle and respond to complaints that had been made by people who used the service and their relatives

Is the service well-led?

Inadequate

The service was not well-led.

We found the systems in place to assess and monitor the quality of the service were not effective. Some of the concerns we raised at the inspection had been identified, but there had been no action taken to mitigate the risks for people who used the service.

Records about people's care were not accurate and up to date.

We found there was not a clear management oversight at the service and the provider was not aware of all the issues we identified.

Sevacare - Stoke-on-Trent

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 was 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 inspection took place on 16 and 17 May 2016. This was an unannounced inspection because we had been made aware of concerns about the way the provider carried out the service.

The inspection team consisted of two inspectors.

Before the inspection, the provider completed 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. We used this information as part of our inspection planning. We also reviewed other information that we held about the service. This included notifications the provider is required to send us by law about incidents and events that had occurred at the service. We contacted local authority commissioners to obtain a view of their experiences with the service and provider.

We spoke with eight people who used the service, two relatives, six care staff, the manager and the area manager. We viewed eight records about people's care. We also viewed records that showed how the service was managed, which included six staff recruitment and training records.

Requires Improvement

Is the service safe?

Our findings

We found that medicines were not always managed safely. Where people needed 'as required' medicines, there was no guidance available to inform staff when these should be administered. For example; one person needed topical creams applied to ensure they maintained their skin integrity. The records we viewed did not state which topical creams needed to be applied and how staff needed to support this person with their medicines. Staff confirmed they did not have any clear guidance to ensure that they were using the correct topical creams at the correct time. Another person required the use of a medicine that helped them when they had difficulties breathing. We found that there were gaps in the Medication Administration Records (MARs) for this medicine. We were unable to identify if this medicine was needed regularly or whether it was an 'as required' medicine, because the records did not contain guidance for staff to follow. This meant that we could not be assured that people were receiving their medicines as required.

The manager told us that the gaps may be due to people being away from their home but we were not provided with evidence to show this was the reason for all the gaps on the MARs that we saw. The manager showed us a memo that had been sent out to all staff on the 13 May 2016, but there was not evidence to show whether people had received their medicines. This meant that we could not be assured that people received their medicines as prescribed and there was a risk of people receiving inconsistent care.

Records showed that people's risks were not always assessed, reviewed or updated to keep people safe from harm. Staff knew how to keep safe from harm but the records we viewed did not match what staff told us. For example; one person's care records showed that staff needed to administer their medicines. We saw that this person did not have MARs to record when medicines had been administered. Staff we spoke with told us that they no longer administered medicines and the person's relative administered their medicines. The care records had not been changed to show this change in the care to be provided. Another person experienced behaviour that may challenge and we found that the person's care records did not contain guidance for staff to follow when they supported this person. The manager told us that this person had a separate record in their home file which explained the support to be provided. Staff we spoke with told us that there was no guidance in this person's plan for them to follow to support this person safely. This meant people were at risk of inconsistent and unsafe care because up to date guidance was not available for staff to follow.

People were at risk of harm because the provider did not assess, manage and mitigate people's risks and medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe when they were supported by the staff. One person said, "I feel safe. They look after me well". Another person said, "They [the staff] are good and don't leave me until I'm settled and safe". Staff explained the action they would take if they felt someone was at risk of abuse. Staff told us that they would report any concerns that someone was not being treated properly to the manager immediately. We spoke with the manager who told us the procedures they followed if they had been made aware of suspected abuse. We saw that where there had been concerns about a person's safety this had

reported as required. This meant that people were protected from the risk of harm.

People told us there were enough staff available to support them and that they stayed for the amount of time they needed. One person told us, "I think there are enough staff and if they are running late I always get a call to let me know". Another person said, "I get the same staff every week so I know who is coming, which is good". Most of the staff we spoke with told us they felt there was enough staff available to meet people's needs. We saw that staffing had been managed in a way that meant people were supported by a consistent staff group. Staff told us and we saw that they were regularly assigned to a certain area to provide care to people.We saw records that showed the provider had safe recruitment procedures in place. Staff who were employed at the service had undergone checks to ensure that they were of a good character and suitable to provide support to people who used the service. This meant there were sufficient staff available to meet people's needs by staff who knew people well.

Requires Improvement

Is the service effective?

Our findings

The service did not always act in accordance with the Mental Capacity Act 2005 (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found that the principles of the MCA were not being applied effectively. We saw that consent forms had been signed by people's relatives on their behalf, which stated that the relatives were consenting to their care in their best interests. There was no documentation that showed whether people were unable to make their own decisions. Best interest assessments of people's mental capacity to make specific decisions had not been carried out in conjunction with other professionals. We found there was no evidence that these relatives had the correct legal decision making powers under the MCA. This meant that there was a risk that inappropriate and unsafe decisions could be made on a people's behalf.

Staff we spoke with told us they had not received training in the MCA and did not understand what the MCA meant for people. For example; one member of staff told us that they were not aware whether the people they regularly supported had the capacity to make decisions. They told us that they gave people choices and because this was not detailed in the records they tried to assess people's ability themselves. This meant that staff did not have sufficient knowledge of the MCA to enable them to recognise and report where people may need an assessment of their capacity to make informed decisions about their care.

We discussed our concerns with the manager who told us if people were unable to consent to their care it needed to be recorded on the assessment of needs and risk assessments. We showed the manager that people's ability to consent to their care had not been recorded and people's relatives were consenting on their behalf. The manager was unable to explain why people's relatives had made decisions on their behalf and whether they were the most appropriate person to be making these decisions. We found the manager was unaware of these issues prior to our inspection. When we fed back our concerns the manager said, "I agree we need to be clearer about people's capacity and we will look into this".

The provider had not acted in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received an induction and training before they provided support to people. One member of staff said, "I completed training over four days and then shadowed an experienced member of staff for four days too. I felt confident to provide support to people and felt supported to understand my role". However, staff told us that they had some gaps in their knowledge such as; the Mental Capacity Act 2005, end of life care and behaviour that challenges. One staff member said, "I would benefit from end of life training so I have a better knowledge of how to support people the best way possible at the end of their life".

People told us that staff supported them with their food and drink in a way that met their preferences. One person told us that staff offered them choices and knew what they liked to eat and drink. Staff told us how they supported people to have access to sufficient amounts to eat and drink. One staff member said, "I always make sure I prepare what people want and leave drinks for them before I leave". People's care records contained details of any nutritional risks, however some of the records were out of date and we could not be assured that these were in line with people's needs.

People told us that they were supported to access health professionals when they needed to. One person said, "The staff are good, they help me to contact the doctor when I need to or they contact my family, who arrange it for me". Staff explained the actions they would take if they identified there was a deterioration in people's health and wellbeing. The records we viewed showed that staff had reported concerns and action had been taken to ensure people were supported to maintain their health and wellbeing.

Requires Improvement

Is the service caring?

Our findings

People were given choices in the support they received and they told us staff always asked them what they needed. One person said, "Staff always ask me what I want doing as my needs change frequently. I can be independent one day but then need more help another. The staff always listen to me". Another person said, "Staff listen to me and always respect my choices". Staff told us they asked people before they provided support and took account of their wishes. One staff member said, "I always make sure I give people choices, it is really important that people have control over what they want. I always listen to people and give them time to respond to any questions I ask". However, staff we spoke with were unsure of whether people understood the choices they gave them and guidance was not available to give staff information about people's ability to make choices about their care.

People told us they were happy with the way the staff supported them and staff were kind and caring. One person said, "They [staff] are very caring and very good". Another person said, "I'm very happy with the way staff treat me. They [staff] are all very nice". Relatives told us that the staff always treated people in a kind way and they were happy with the way staff cared for their relative. One relative said, "I have no complaints, the staff are very good and are caring towards my relative".

People and their relatives told us that they were treated with dignity and respect when staff were supporting them. One person said, "The staff are always sensitive to my feelings and give me the amount of privacy I need". Another person said, "Staff treat me with dignity. They always speak to me politely. I feel dignified when they help me". A relative said, "The care has always been provided in a dignified manner. Staff make my relative feel comfortable". Staff told us they always made sure that people's dignity and privacy was protected when they were providing care and support. One staff member said, "I treat people in a way that I would want to be treated myself. I respect their decisions and make sure they feel comfortable". Another member of staff said, "I always ask if people are happy for the support to be provided and speak to people in a caring and dignified way".

Requires Improvement

Is the service responsive?

Our findings

People told us that they received their care in a way they preferred. On person said, "The staff know how I like my care to be provided. They know the clothes I like and the food I like to eat". Another person said, "Staff know me well now and they do things the way I like. If I have different staff I have to tell them what I want, because they don't know me as well". Staff we spoke with knew people's preferences and were able to describe how people liked to be supported to maintain their independence. However, we found that improvements were needed as the care plans we viewed did not match what staff had told us and did not contain people's up to date preferences in care. For example; staff told us how one person's independence fluctuated and they liked to do things for themselves when they were feeling well, but the records did not reflect this. Staff told us what another person liked to eat, but the records did not contain these details. This meant that people were at risk of receiving inconsistent care that did not meet their needs if different or new staff provided support to these people.

We found that reviews of people's care needs were out of date and we saw that care plans and risk assessments had not always been updated to reflect any changes in people's needs. For example; one person's skin care needs had changed and the support staff needed to provide had changed. However, the person's care records did not record these change. Another person's care needs had changed after a review had been undertaken by their social worker. The care records had not been updated to give staff guidance on this person's change of needs and the support required. Most staff were aware of the changes in people's needs because they knew people well and people had consistent staff, but newly employed staff would not have this information available to them. This meant there was a risk of people receiving inconsistent care because the records did not contain up to date guidance for staff to follow.

People we spoke with told us that they received consistent staff at a time that they needed it. One person said, "I have the same staff, which is good as I know them well. I do get different staff sometimes if my regular carers are on holiday or sick". Another person said, "I've had the same staff for eight years and they know me well. My needs vary but staff always know how to help me". People told us staff usually arrived at their preferred time and they were contacted by the office if the staff were going to be late.

People and their relatives told us they knew how to complain if they needed to and they were comfortable raising concerns. One person said, "I have no complaints but I know I could speak to the staff if I needed to". Another person told us they had complained about their care and they were happy with the outcome and the action that had been taken. The provider had a complaints policy in place and we saw there was a system in place to log any complaints by the registered manager. The complaints we viewed had been acted on and a response sent to the complainant. This meant that the registered manager acted on complaints received to improve the quality of the service provided.

Inadequate

Is the service well-led?

Our findings

Systems in place to monitor medicines were not effective. During the inspection we identified concerns with the way medicines were recorded and managed. For example; 'as required' protocols were not in place to give staff guidance and staff told us that they were sometimes unclear of when to give as required medicines. We also found that the Medication Administration Records (MARs) contained gaps in recording and there was unclear information regarding the dosage required. An audit of medicines had been completed by the manager in April 2016, which stated "all okay". We viewed the Medication Administration Records (MARs) that had been audited and saw that these Medication Administration Records (MARs) contained gaps in recording, and we could not see how these had been picked up or investigated by the manager. The manager told us some of the gaps were because the person was in hospital or a day when they were out, but this was not clear on the audits. This meant that the system in place to audit the medicines was ineffective and medicines were being managed unsafely. The manager and area manager told us they had identified that the Medication Administration Records (MARs) audits were not undertaken regularly enough to identify concerns with recording and had implemented a new audit which started on the day of the inspection. Therefore, we were unable to assess whether this method of auditing was effective and whether this would be sustained to make improvements to the service provided.

We found that records were out of date and did not correspond with the care that was being provided. For example; staff knew people's risks and were able to explain how service users needed to be supported, but the records we viewed did not always record how people's risks should be managed. Staff we spoke with told us they felt the records did not give them enough detailed information about the support people required. We found that people's care records had not been reviewed regularly or when people's needs had changed. We saw the provider did not have an effective system in place to regularly check care records to ensure they were up to date. This meant that service users were at risk of inconsistent care because the provider did not keep an accurate and complete record of people's care needs.

We found the manager had not acted in accordance with the Mental Capacity Act 2005 as people's ability to consent to their care had not been taken into account. People's relatives were consenting on their behalf and the manager had not recognised that this may put people at risk of harm. This meant that the manager was unaware of their responsibilities to protect people from the risk of inappropriate and unsafe care.

We saw that an audit of the service had been carried out in April 2015, which contained actions to be completed to make improvements to the service provided. We saw the actions that had been identified had not been completed. We saw there was an action plan in place , which stated that the action needed to be completed by an area manager by the 15 May 2015. We found that none of the required actions detailed on the action plan had been signed off as completed. For example; we saw concerns had been identified within people's files, such as recording, reviews, medication guidance and assessment updates. The concerns we identified at the inspection had also been identified in the audit, but steps had not been taken to improve the quality of the care provided. The area manager was unable to explain why these action had not been completed. This meant that the system to assess, manage and make improvements to the quality and safety of the service were not effective.

We found there had not been a registered manager at the service for 3 months, which is a condition of your registration with us and we had not been notified of this change. A new manager had been appointed who was in the process of registering with us (CQC). We were told by the manager that they were currently looking at the actions that were needed to monitor the service but these had not been implemented at the time of the inspection. We found that the leadership and oversight of the service had been infrequent and the area manager had only recently become involved with the service. The area manager told us that the provider had started to implement new paperwork across the organisation and concerns had been identified with medicines, but these had not been implemented at the time of the inspection. This meant we were unable to assess the effectiveness of the new systems and whether the recent change in the management structure would be sustained.

We received varied comments about the management at the service. Some staff told us that they were able to approach the manager if they had any concerns. However, some staff told us that the managers were not always approachable. Comments included; "I can approach the office staff and manager if I need to and they are helpful" and "I don't find the management that supportive. The management feels disorganised and needs improving". One member of staff told us they had concerns about their knowledge to support people effectively and felt they needed further training, but they felt unable to tell the manager about their concerns. We asked staff how they felt improvements could be made to the service and we were told that the records needed updating and the communication between staff and the office staff could be improved. We did not see evidence that staff had been asked for feedback or suggestions on how the service could be improved. We spoke with the manager about the concerns raised and they told us they felt they were approachable and they would look into the concerns raised to make improvements to the relationships between care staff and the office staff.

This meant the provider did not have effective systems in place to ensure that the quality of service people received was assessed and monitored. The provider did not maintain accurate records to ensure that staff had sufficient guidance available to support people effectively and safely. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

We served a warning notice to the provider telling them to make immediate improvements to the quality of care.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm because the provider did not assess, manage and mitigate people's risks and medicines were not managed safely.

The enforcement action we took:

We served a warning notice to the provider telling them to make immediate improvements to the quality of care.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to ensure that the quality of service people received was assessed and monitored. The provider did not maintain accurate records to ensure that staff had sufficient guidance available to support people effectively and safely.

The enforcement action we took:

We served a warning notice to the provider telling them to make immediate improvements to the quality of care.