Sage Care Limited

# Sagecare (Lincoln)

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Sagecare Lincoln is a domiciliary care service that provides personal care and support for people in their own homes. The service can provide care for adults of all ages and covered Lincoln and surrounding areas. At the start of our inspection there were 181 people using the service, but this was changeable throughout the inspection period.

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

People's experience of using this service and what we found
Systems and processes were not always effective in sustaining improvement at the service. Quality assurance systems did not always identify and act on issues and concerns.

The provider monitored care call data which identified continued staffing deployment concerns. There was no action plan in place to address these issues and this directly impacted on people's care.

Medicines were not always managed safely. We found concerns with how medicines information was recorded.

Risks to people were not always managed effectively. Relevant information was not always recorded by staff and lessons were not always learnt following incidents.

Staff recruitment was not always safe, as work history was not always recorded; however, staff did have other up to date safety checks in place.

People told us some staff did not always wear appropriate person protective equipment (PPE). The provider had taken some action to address staff not wearing PPE.

Staff did not always feel engaged by the provider. Some people and relatives felt the service communicated with them effectively, but others did not.

Some staff were not always aware of provider whistleblowing procedures. Safeguarding systems were in place to protect people and staff knew what signs to looks out for to protect people from abuse. People and relatives told us they felt the service was safe.

The service worked closely with other agencies to support people.

People were supported to have maximum choice and control of their lives and staff supported did them in

the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 21 December 2021) and there were breaches of regulation. At this inspection we found the provider remained in breach of regulations and remains rated requires improvement. The service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We also undertook this inspection to check whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met.

The overall rating for the service has remained requires improvement based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report. The provider has taken some action to mitigate the risks outlined in this report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

Enforcement
We have identified breaches in relation to medicines, risk management and governance at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## 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 well-led findings below.

# Sagecare (Lincoln)

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 02 November 2022 and ended on 03 January 2023. We visited the location's office on 02 November 2022.

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 who work with the service.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
During the inspection we spoke with the registered manager and two operations managers. We also spoke with 9 staff members

We spoke with 18 service users and 6 relatives. We reviewed 19 service users' care plans and records. We also reviewed a range of other records including 5 staffing recruitment files.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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.

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Using medicines safely

- Medicines were not always managed safely. People did not have protocols in place for 'as needed' (PRN) medicines and this was not in line with best practice. It is best practice for each person to have a protocol in place for each PRN medicine they are prescribed. Staff, therefore, did not have specific information on what PRN medicines were for and when they should be given. Staff also did not record why PRN medicines were given, so it was unclear if people were receiving PRN medicines as prescribed.
- We found staff did not always record medicine administration safely. For example, one person was prescribed a pain relief patch which needed to be changed every 7 days. Staff had recorded this patch had been changed on medicine administration records (MARs), but then recorded in care notes that this patch would be changed at a later care call. This put the person at risk of a medicines error if the same staff member was unable to attend the later care call.
- Staff did not always follow provider processes to raise concerns about medicines. One person was prescribed a drink supplement due to concerns about their dietary intake. In records we reviewed, this person frequently refused this drink, but staff failed to always notify the office of these concerns with the relevant communication form. This meant the risk to the person was not always highlighted to the office to follow up these concerns.
- Following a conversation with inspectors highlighting concerns around PRN protocols, the registered manager took some action and showed evidence of PRN protocols being put in place. The registered manager had also identified the other above concerns during the inspection and had recorded relevant actions to support staff with medicines practices.

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

- Risks to people were not always managed safely. Staff failed to document relevant information to help manage risk. For example, one person with a skin integrity risk required support with washing in the evening. However, staff had recorded on several occasions that this had been completed by others, with no further

information in their care notes as to who had completed this task. Staff we spoke with also raised concerns that this person was not receiving appropriate support in the evening, increasing the risk to their skin integrity.
● Risks were not always managed effectively following accidents and incidents. For example, we reviewed an incident where a person had fallen from their wheelchair. Despite this known risk, there was no information to inform staff to encourage this person to use their lap belt to reduce the risk of re-occurrence and keep them safe.

Medicines and risks to people were not always managed safely and this placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the above concerns, we did see some evidence of lessons learned following incidents such as medicine errors.
● There was also some good practice in managing medicines, such as a time-critical medicines audit, which supported people to receive medicines at the right time of the day.
● People and their relatives told us they felt safe using the service. Speaking of staff, one person told us, "I do feel safe with them, they know what they are doing." One relative also told us, "I am sure [my relative] is safe with them, [staff] are often still there when I go, and they are being very nice to [my relative]."

Staffing and recruitment
● Staffing levels were not always safe. Although electronic call monitoring (ECM) data indicated calls were not cancelled, people told us about staffing pressures causing calls to be delayed, cut short or cancelled. One person told us, "[Sagecare] say to me 'We've got nobody to come' at a weekend, and I've said 'You will have to find someone ,I pay for this' and [Sagecare] say 'You've got [access to other support]' but [my other support] can't do personal care or my pills and that's what I need."
● Continuity of carers was limited, and people and relatives were concerned about not knowing which carers would attend care calls and how this impacted them. One person told us, "I've been on and on at [Sagecare] for a rota but it's always changed, and we never know who is coming. We do get a regular carer for the first call of the day through the week and after that it's just anybody." Another person told us, "[Carers] should come between 10:00am and 10:30am. Which if it's my regular carer it is, but if it's someone different it's getting on for 12:00pm."
● Staff told us they had experienced last-minute changes to their rota due to staff shortages and sickness. One staff member told us, "The rota can change daily and can change throughout the day." People were also concerned about this, with one person telling us, "I am so sorry for the carer when they are here. [Sagecare] are constantly changing their visits or the time. [Sagecare] are changing 40-minute care calls into 20-minute care calls or no care call at all. The poor carer doesn't know what's going on."
● The provider told us that current sector pressures meant that staff recruitment and retention was challenging but they felt this did not compromise people's safety. The registered manager also told us that staff were only changed at short notice to cover staff absence.
● Staff recruitment was not always safe. One staff member's recruitment file we reviewed did not include a full record of the staff member's employment history. However, staff recruitment files did include up to date Disclosure and Barring Service (DBS) checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement.

This meant the service management and leadership was inconsistent. Systems and processes did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider had failed to ensure the service was well-led. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Systems and processes had failed to improve staffing deployment since the last inspection. As outlined in the safe section of this report, staffing levels had a negative impact on both staff and people.
- Electronic call monitoring (ECM) data showed staff were not given sufficient travel time between calls. Staff were also concerned about travel time, one told us, "[Staff] are not always getting appropriate travel time. I am cutting calls short to fit more in. I may say to the client, 'I can't do this [task] today as I've only got half an hour'." The registered manager had identified the lack of scheduled travel time and addressed this in a team meeting with care co-ordinators.
- The provider did acknowledge staffing pressures, and had offered staff incentives to work at weekends, but they failed to have an effective system to address these concerns. Provider care audits we reviewed identified that care calls were often not punctual, and their duration cut short. There were no recorded actions to address this and there was no wider action plan in place to improve staff deployment. The registered manager told us they felt there was an issue with the provider system used to calculate this data, but this issue had not been addressed.
- Governance and quality assurance systems were not always effective in identifying concerns.
We found audits delegated by the registered manager, such as care audits and medicines reviews, failed to identify issues with care records. For example, inconsistencies between people's medicine administration records (MARs) and currently prescribed medicines lists were not always identified. Although audits completed by the registered manager were more effective in identifying issues, these were spot checks and did not check all records covered by delegated audits.
- The provider failed to ensure records were up to date. People's care plans and risk assessments were not updated following changes to people's care and contained outdated information about risks to people.

Systems had also failed to ensure that recruitment information was always in place for all staff.
● Provider systems were ineffective in driving improvement to enable them to achieve a good rating. This was the fourth consecutive inspection where the service was rated requires improvement.

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

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

● Care was not always person-centred. Although people told us staff were kind and caring, issues with staffing pressures and deployment impacted on the service's ability to provide person-centred care. One relative told us, "I have refused a few carers in the past for various reasons and they have tried to send them again and I have said, 'no'. I have really had to put my foot down and I shouldn't have to do that, you end up feeling like you are at fault."
● Staff members also gave examples of where staffing pressures impacted on person-centred care. One staff member said, "[A person's] call time keeps getting pushed back. [The person] is not happy. This happened because Sagecare took on a new client." Another staff member spoke about care calls getting shortened, "They have shortened [a person's] dinner call. We need to hoist them, get lunch and get them back into their chair. Why has it been lowered? We have raised it and raised it."
● People gave mixed views on engagement from the provider. Some people and relatives felt they were contacted by the office when needed. However, others felt the communication was not sufficient. One person told us, "I don't mind if the time varies, but they need to tell me. Mostly they don't, and I have to ring up to find out." A relative also told us, "They need better communication, I understand they can be short of staff, but it could be better organised. You could be included in decisions more and told more."
● Most staff we spoke with felt the registered manager was approachable and responsive to requests and concerns, but they were not always accessible. Some staff felt when they had raised concerns to the office staff, these were not always listened to. Staff were also not always comfortable feeding back to the office through the staff survey as staff told us this could not be completed anonymously.
● The provider had recently developed a new people survey system to better capture people's views and were in the process of gathering initial responses. The survey was now quarterly instead of annually and the registered manager told us they felt this would be more personal and better capture people's views about the service and drive improvement.

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; Working in partnership with others
● The registered manager contacted people and their relatives to apologise when things went wrong.
● The provider worked with other agencies to ensure support was in place for people. In one instance, the provider worked closely with a family and day centre to help avoid a potential medicines error. We saw evidence of staff contacting healthcare agencies, such as district nurses, when there were concerns with people's health needs.
● The provider also worked closely with the local authority, as commissioner, to support people to have appropriate support in place.

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<br><br>Medicines and risks to people were not always managed safely and this placed people at risk of harm. |

**The enforcement action we took:**

Notice of Proposal to impose conditions.

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. |

**The enforcement action we took:**

Notice of Proposal to impose conditions.