

Veraty Care Solutions Ltd

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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

Veraty Care Solutions is a domiciliary care service providing personal care to people living in their own homes. At the time of the inspection 51 people were receiving the regulated activity of personal care.

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

People's medicines records had unexplained gaps in recording and there was limited monitoring or audits of systems to manage people's medicines. This meant people could be at risk of not receiving their medicines as prescribed.

Limited quality monitoring systems were in place, and those that were being used were not fully embedded. This meant the provider had limited oversight of the service which placed people at risk of harm of receiving inconsistent care.

People told us they felt safe when staff supported them, and staff knew how to recognise signs of abuse and how to report any issues.

People were supported by trained staff who had been recruited safely. People were supported in line with government guidance around COVID-19.

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 good (published 8 April 2019)

Why we inspected

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about lack of notifications. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with people's safety around medicines, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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 have identified breaches in relation to 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 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?

The service was not always safe

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Veraty Care Solutions Ltd

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 one inspector. An Expert by Experience made calls to people and their relatives. 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.

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 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection and sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection

We spoke with eight people who used the service and six relatives or friends about their experience of the care provided. We spoke with eleven members of staff including the registered manager, deputy manager, service manager, office manager and carers.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. 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. We looked at training data, care plans and medication records.

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.

Using medicines safely

- Medicines were not always managed safely. Medicine administration records (MAR) did not state the full medication name or dosage and had not been signed at the beginning of the medication cycle to confirm stock levels received.
- Multiple gaps in recording on MARs were observed. For example, some people's MARs had not been signed multiple times during one month, and correct codes were not being used to explain why medications had not been administered. This meant when accurate records were not being kept when people refused their medicines.
- MARs had not been audited by the provider for over 6 months. This meant the provider did not have oversight of people's medication which could place people at risk of not getting their prescribed medicines when they needed them.
- From the records we looked at and the people we spoke with we did not identify any incidents where people had not received their medicines. One person told us, "My memory is not what it was... they do my tablets because I am sure I would forget them sometimes and I know I do need them."

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Safeguarding incidents had been reported to the local safeguarding team; however, these had not always been sent to the CQC in a timely way as required. This was raised with the registered manager who was able to demonstrate a new system that had been put in place to ensure this would happen consistently going forward.
- Staff were able to tell us about the different types of abuse and what actions they would take if they were concerned about a person. One staff member told us, "If I saw a bruise or someone not acting the way they usually do I'd call the office and log it in notes as it may mean something is not right."
- The registered manager was able to show us how any issues or concerns were logged on the electronic system and followed up where necessary, however consistent analysis wasn't being undertaken to learn from these when things had gone wrong.

New paragraph

Assessing risk, safety monitoring and management

- People told us they felt safe with staff when they were being supported. One person said, "I feel that the staff do everything they can to keep me safe."
- Care plans and risk assessments were in place and contained enough guidance for staff to follow to provide support and to keep people safe.
- Staff knew people well and were able to tell us what support people needed and their personal preferences. One staff member said, "Care plans and risk assessments are good and give me information

about the person and we do have lots of training, especially around monitoring people's behaviour. We had some specific training about how to look out for triggers that could make people anxious or upset."

Staffing and recruitment

- The majority of people we spoke to were happy with the support staff provided and the times and duration of their calls was what was required. Some people told us consistency of staff was sometimes an issue but they were usually informed if someone different was attending their call. One person said, "Timings can be a bit of an issue sometimes especially on a weekend, but if they are running late they ring and let us know so we are not hanging about waiting." And a relative told us, "My [family member] is never rushed, there is plenty of time to do the care. The thing I really like is if we need to alter times of calls it never causes a problem for them."
- The registered manager told us they were having problems with staffing levels and were actively recruiting but this was proving difficult, they said, "Like a lot of providers, we are struggling to get staff and due to some of our clients living in rural areas it makes it difficult to recruit." There were sufficient staff to ensure people's needs continued to be met.
- Agency staff use was high as these were being used to cover the most rural packages of care but a consistent staff team was used. At the time of the inspection the deputy manager was completing care calls to help out until more staff could be recruited.
- Checks were carried out on staff to check their suitability to work with people who use the service. These included DBS checks and references from previous employers.

Preventing and controlling infection

- People and relatives told us that staff wore suitable Personal Protective Equipment (PPE). One person said, "They have masks and gloves on and are very careful due to the pandemic and made sure we didn't have too many different carers."
- Staff told us they had enough PPE and had received training so they that they knew how to use it safely.

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 good. At this inspection this key question has now deteriorated to requires improvement. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The registered manager did not have consistent oversight of the service. On the first day of inspection they were unavailable to support the inspection but informed us all documents and systems would be accessible. We were not able to access all people's current care records as some were electronic and some paper copies in people's homes and not viewable from the office. Office-based staff, including the deputy manager were not able to access all of the systems and this meant that they may not be able to access important care information if the Registered Manager was not available in the office. A follow up visit was conducted whereby the registered manager was able to demonstrate systems in use.
- The systems in place were not embedded into the service, with many audits either not being completed or documented fully. People's daily records were not being checked. This meant the registered manager did not have oversight of the day to day running of the service. We saw staff were reporting instances of ill health or other issues to the office and these were being followed up, but actions taken were not always recorded and not audited for any trends.
- Audits for medication had not been taking place for a period of six months or more which meant incomplete records of medicines and missed signatures to acknowledge administration on medication administration records we found had not been identified.
- Some care plans had not been reviewed or audited since they were implemented, although carers were able to tell us people's support needs and correct support was being provided.

We found no evidence that people had been harmed. However, due to poor oversight risks to people's care and support were not always sufficiently monitored and placed people at the potential risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The electronic call monitoring system was checked daily to monitor that calls were being completed and on time.
- Notifications were not always submitted as required. A notification is information about events that by law the registered persons should tell us about. The registered manager had been contacted prior to the inspection to discuss notifications and we were informed some were outstanding. These had still not been sent to the CQC at the time of the inspection but have since been received. The registered manager was able

to demonstrate a new process that was being implemented to ensure these were submitted in the future.

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

- We saw evidence of actions being taken where problems had been identified. For example, we saw where an issue had been identified the registered manager had made a home visit to the person to discuss the issue and also made a follow up visit to check there had been no further issues.

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

- People and their relatives told us that the registered manager or office staff did ask them for feedback about the service and they would be happy to raise concerns if they needed to. One person said, "I have had contact with the office over the last year, they rang me nearly every week just to check that I am ok and do I need anything, it is quite reassuring for me especially as I live on my own." And another person said, "If I need to get in touch with someone there's never a problem, someone always answers the phone and if they are not available they always ring me back."
- Records showed that the provider had sought support from other health professionals including GP's and district nurses.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Poor oversight meant risks to people's care and support were not always sufficiently monitored and placed people at the potential risk of harm</p>