Vera Care Limited

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Inspection report

The Old Courthouse
New Road Avenue
Chatham
Kent
ME4 6BE

Tel: 07710779182

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Vera Care provide personal care to one person in their own home. The Care Quality Commission (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 told us they received the care and support they wanted in the way they preferred from the provider. The provider worked alone for most of the time and was supported on rare occasions by a member of care staff.

We found no evidence that people had been harmed however the provider was not operating systems and processes to ensure that people always received safe, effective, well led care which reflected their needs and preferences. This was important as the provider intended to employ more staff and expand the business.

The provider and staff member did not have the skills they needed to ensure people's care was safe. For example, they had not completed training in medicines management, despite supporting people with their medicines. The provider prepared people's meals and drinks but had not completed in depth food hygiene or infection control training.

Risks to people, including oral health care, had not been assessed. People told us they had planned their care with the provider and always received their care in the way they preferred. However, guidance about how to identify some risks had not been recorded. Assessments of people's needs had not been completed to identify any changes in their needs.

Risks relating to people's homes had not been fully assessed. Support to keep people safe in an emergency had not been planned. Systems were not in operation to learn from accidents and incidents and prevent them for happening again. People had not been given the opportunity to share their end of life wishes and preferences.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; however, the policies and systems in the service did not support this practice. There was a risk that people would not always receive support to make decisions in ways which suited them best. Information about the service was not available in a variety of formats to ensure people always had the information they needed.

People told us they felt safe while the provider was in their home. The provider had not completed robust safeguarding training and there was a risk they may not identify when people were at risk of abuse.

A system was not in operation to ensure people received their care if the provider was not able to provide it

at short notice. No new staff had been recruited since the last inspection.

The provider did not have systems in operation to invite feedback about the service from people, their relatives, staff and professionals. Other systems were not in place to check and evaluate the service and the provider was not aware of the shortfalls we found. The provider did not work with others to develop their skills or the service. Plans were not in place to continually improve the service, despite the providers plan to expand.

The provider did not fully understand their responsibilities to under the Health and Social Care Act 2008. We had not been informed about changes to the provider's contact details.

People told us the provider prepared their meals and drinks in the ways they preferred. The provider identified changes in people's health and supported them to contact health care professionals and follow their advice.

People said the provider was kind and caring and they got on well with them. They told us they were listened to and the provider delivered their care and support in the way they wanted. These were underpinned by the provider's vision and values. People had shared their lifestyle choices with the provider and these were respected. People were supported to maintain their independence.

Any complaints or concerns people had raised had been addressed. The provider had a process in place to support this.

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 17 October 2018). The service remains requires improvement. The service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to staff skills and training, risk management, medicines management, planning end of life care, assessing people's needs, accessible communication, obtaining consent to care, understanding people's experiences of the service and the quality of the service, 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 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Vera Care Limited

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
This inspection was completed by one inspector.

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

Notice of inspection
This inspection was announced. We gave a short period notice of the inspection because it is a small service and we needed to be sure that the provider would be in the office to support the inspection.

Inspection activity started on 9 October and ended on 10 October 2019. We visited the office location on 9 October 2019.

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 the provider's inspection history and basic information the provider sent us about people who

used the service. We used all of this information to plan our inspection.

During the inspection
We spoke with the provider. We reviewed a range of records. This included one person's care records and medication records. We looked training records for the provider and staff member. We also looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training and induction processes and insurance certificates. We spoke with one person who uses the service.

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 requires improvement. At this inspection this key question remained the same. 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

- There was a risk that people's medicines would not always be managed safely. The provider was aware of the National Institute for Health and Care Excellence (NICE) guidance for managing medicines for people receiving care at home. However, these had not been followed. The provider did not have robust processes in operation to provide staff with appropriate training and support. The provider had not completed training in relation to medicines. The care worker had not completed medicines training since 2007.
- People's medicines were supplied in pharmacy filled 'dosette' boxes and not the original packaging. This increased the risk of errors, if people's medicines changed. The provider had not assessed people's medicines support needs to identify any risks and plan their care.
- Guidance was now in place in relation to people's when required medicines. This included the maximum dose in 24 hours and signs the person may need the medicine..
- Records of medicines administered were kept in the person's home and were accessible to other health and social care professionals. One person told us the provider showed them their medicines before they took them, so they could check they were correct. They told us they received their medicines at the correct time and in the way they preferred.

We found no evidence that people had been harmed however, staff responsible for the management and administration of medication were not suitably trained and competent. Assessments of people's medicines support needs had not been completed to identify any risks. 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.

Assessing risk, safety monitoring and management

- People told us they felt safe while the provider was in their home supporting them and we did not find evidence that people had been harmed. However, the lack of guidance around some areas of care may place people at risk as the service expands. The provider was not aware of NICE guidance in relation to oral health. Care of people's teeth and mouth had not been planned to ensure they received the support they wanted.
- The provider had not improved risk assessments in relation to catheter care. No guidance had been provided to staff about how to identify any problems and the action to take. This had not impacted on people as the provider knew how to identify any concerns and report them to the community nurse.
- The risk of people developing pressure ulcers had not been assessed. People used equipment to manage these risks, but guidance was not in place about how these were used or how to identify any faults.
- Guidance was in place about the action to take in the event of a fire. However, this did not include

information about how to reduce the risk to people. Such as, closing doors between them and the fire if they were unable to move. Fire risk assessments had not been completed.

We found no evidence that people had been harmed however, some risks to people had not been assessed and guidance was not in place about how these risks would be mitigated. 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.

Learning lessons when things go wrong

● The provider had not established an effective process to manage accidents or near misses and prevent them happening again. This was important as the provider planned to expand the service. They told us, "This is something I need to take on board".

● At the inspection they were unable to show us any accidents/incident forms. A copy of a blank form was sent to us after the inspection.

● The provider told us it was their role to review any accidents and take the necessary action. This may include raising concerns with the local authority safeguarding team. However, there was no system in place to record the decisions and actions taken, and why.

Staffing and recruitment

● The provider delivered the service and provided people's personal care. They were supported occasionally by a care worker.

● The provider had not put a process in place to cover their leave or any sickness. During the inspection they said they would ask the care worker to support people. People told us their families had supported them when the provider was on leave. However, people were at risk as processes had not been established to cover at short notice or in the case of an emergency.

● No new staff had been employed since our last inspection. The provider told us they did not plan to recruit new staff in the near future.

● Processes were in place to recruit staff safely. We will check to make sure these are effective at our next inspection.

Preventing and controlling infection

● The provider knew how to manage the risk of infection. They used personal protective equipment including disposable gloves and aprons when providing personal care or preparing food and drinks.

● The provider had not completed in depth training in relation to infection control and food hygiene. The care worker had not completed any infection control and food hygiene training.

Systems and processes to safeguard people from the risk of abuse

● The provider had a safeguarding process in place. However, they had not completed in depth safeguarding training. The carer had not completed safeguarding training since 2007 and their knowledge had not been assessed.

● People were confident to raise any concerns they had with relatives who would advocate on their behalf. However, there was a risk that as the service expanded the provider and staff may not identify and act on safeguarding concerns.

● People and the provider had agreed safe processes for handling people's money.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider and staff had not completed the training they needed to meet people's needs and there was a risk they would not receive safe and effective care. For example, the provider and carer supported some people to move around their homes using equipment. The care worker had not completed moving and handling training since July 2017. Best practice guidance from Skills for Care recommend staff complete refresher training and their skills are assessed at least yearly.
- The provider had completed a one-day training course covering 11 subjects. The course had not covered all the mandatory training, including nutrition and hydration, dignity and person-centred care. The provider did not have an in-depth knowledge of the subjects covered on the course, including fire safety.
- The provider and staff had not completed training in relation to people's specific conditions to help them understand people's needs and experiences. For example, diabetes or multiple sclerosis. There was a risk the provider and staff would not understand people's experiences and make any necessary adjustments to their care.
- A process was in place to induct new staff, which included shadowing other staff and completing training. No new staff had been employed since our last inspection. We will check to make sure the process is effective at our next inspection.

We found no evidence that people had been harmed however, the provider and staff had not completed training suitable for their role. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● The provider did not fully understand the principles of MCA. They had not completed training in relation to MCA and their role and responsibilities to ensure they fully understood the Act and follow guidance in the code of practice.
● Where people had capacity, records had not been maintained that they had consented to all areas for their care, such as the holding of personal confidential information.
● The provider was not aware that it was their responsibility to assess people's capacity to make day to day decisions in relation to their care, including what support they were offered and when. One person with capacity to make all decisions around their care told us the provider followed their instructions and provided their care in the way they preferred. However, there was a risk people would not always be supported to make decisions in the best way for them.
● The provider did not know the Court of Protection had the authority to restrict people's liberty in their own home where they were at risk. There was a risk the provider would not identify when people were at risk and share information with the relevant authorities.

We found no evidence that people had been harmed however, the provider did not understand the principles of the Mental Capacity Act. This placed people at risk of harm. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider did not know about recognised assessment tools, such as pressure ulcer or oral health assessments. Other assessment processes were not in operation and people's needs were not regularly assessed. People told us their needs had not changed. However, there was a risk that as the service expanded the provider would not identify changes in people's needs.
● The provider had an assessment process in place to help them understand people's needs before they were offered a service. We were not able to review how effective this process was as no new people had started to use the service since our last inspection. We will check to make sure the process is effective at our next inspection.

We found no evidence that people had been harmed however, the provider did not have processes in operation to assess people's needs and preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us the provider prepared food and drinks as they preferred.
● The provider described to us how people preferred their meals and drinks prepared and the support they needed to eat and drink. Information was available to staff to refer to in people's care plans about their preferences and support needs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to remain well. The provider contacted people's GP or community nurse when they identified signs that people may be unwell. They followed up referrals when necessary to make sure people received care and treatment in a timely way.
● People were supported to follow their health care professional's advice, such as taking short term medicines to aid recovery.
● Where people receive care from more than one care service informal arrangements had been put in place to share information about people. The provider told us they left notes about people's homes to update

other carers and other carers did the same. One person told us they were happy with the arrangement.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
- People told us the provider was kind and caring. They told us they were treated with respect and the provider listened to them.
- The provider knew people well and spent time chatting with them or watching films together. One person told us they laughed and joked with the provider and "We tease each other rotten".
- People had opportunities to tell the provider about their lifestyle choices, sexual orientation and gender identity and their choices were respected.

Supporting people to express their views and be involved in making decisions about their care
- People led their care and told us the provider followed their wishes and preferences. People described to us how they preferred their care to be provided. This reflected the provider's descriptions of people's preferences, including how they liked their meals prepared.
- People made decisions about all the care they received. If people needed support to make decisions the provider encouraged them to discuss these with their relatives. When people wanted, the provider purchased items for them, such as groceries. People told us the provider always purchased the items they chose.
- People told us the provider had time to spend with them and they were never rushed. The provider was flexible to the people's needs and provided additional visits when people requested them.

Respecting and promoting people's privacy, dignity and independence
- The provider supported people to remain as independent as possible. They had as much choice and control as possible in their lives. This included checking tasks had been completed to the standard they expected.
- People told us they had privacy and were treated with dignity. One person told us they would recommend the service to others.
- The provider kept people's personal information secure.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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 people's needs were not always met.

End of life care and support

- People had not been given the opportunity to share their end of life wishes and preferences. Such as any cultural and spiritual needs, where they wished to be cared for and who by. No one was at the end of their life, however, there was a risk that people's end of life needs and preferences would not be met.
- The provider had not completed training in caring for people at the end of their lives.
- When people had returned from hospital with advanced decisions, such as do not attempt cardio pulmonary resuscitation, the provider had supported them to successfully challenge this.

We found no evidence that people had been harmed however, the provider did not have processes in operation to design people's end of life care to meet their needs and preferences. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider did not know about AIS. They had not arranged for information to be given to people in alternative formats such as large print or spoken.
- This had not impacted on people using the service. However, there is a risk that any new people would not have access to information they needed in ways they understood.

We found no evidence that people had been harmed however, the provider did not have processes in place to enable and support service users to understand the care choices available to them. This placed people at risk of harm. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People had planned their care with the provider, including their preferences. One person told us the provider delivered their care in the way they preferred.
- People's care plans did not contain detailed guidance for staff about how to provide people's care. However, the provider knew people well and provided consistent care in the way they preferred.
- People's care was flexible to their changing needs. One person told us if they needed additional support

on occasions, the provider would arrange for a staff member to work with them.
● The provider kept records of the care they had provided in the person's home. These were available to people, their relatives, other carers and professionals, so they knew what had happened and about any changes.

Improving care quality in response to complaints or concerns
● People were confident to raise any concerns had with the provider. One person told us, "If I have a problem I tell [the provider]. This usually resolves things, but I may have to them things a couple of times".
● The provider had a process to receive, investigate and respond to complaints. No complaints had been received. Minor issues had been addressed to people's satisfaction.

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 has 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.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they were involved in planning their service and the provider made changes to their care at their request.
- The provider did not have a process in place to gather the views of, people, their relatives, staff and professionals of the service. They told us, "Since they still want me to be there, I must be doing something they like".

We found no evidence that people had been harmed however, the provider had failed to establish systems to seek and act on feedback from service users and others to improve and develop the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- The provider did not complete any checks or audits of the service. They had not arranged for any external parties to complete checks to support them to identify the shortfalls we found and make improvements. We found the service had not improved since out last inspection.
- The provider had some systems in place to check the quality of the service provided by staff once they were employed. However, these were not comprehensive and did not cover all areas of the service. The provider told us, "I have everything in place to develop a quality process".

We found no evidence that people had been harmed however, the provider had failed to establish quality assurance systems with the aim of improving the quality and safety of the services. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The provider was not working with external stakeholders and other services to share information and keep up to date with best practice. They told us they had previously attended local registered managers forum but had not attended for at least four months. This was a concern as the provider planned to expand the service but was not aware of best practice guidelines.

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

● Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of changes to important information about the service. This is so we can always contact the registered persons. Before the inspection we found the provider had not notified us of changes to their phone numbers as soon as possible. We gave them guidance about how to do this, but this was not followed promptly. We received the notification 20 days after it was requested.

● The provider was not aware they were required to tell us about important events that happen in the service, like a serious injury. This is so we can check that appropriate action had been taken. They were aware they needed to tell us about other events including safeguarding allegations.

● The provider employed one staff member who did not work for them often. They planned to employ more staff to expand the service and had job descriptions for these roles. We will check to make sure the provider has effective systems in place support staff to understand their roles at our next inspection.

● The provider had displayed the CQC quality rating in their office. The provider's website was not operational at the time of our inspection. People and those seeking information about the service were not able to look there for information about our judgments.

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 was not clear about their responsibilities under duty of candour. We found no evidence that people had been harmed and the provider had been required to act on their duties.

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

● The service had a person-centred vision and values which included, equality, privacy, dignity, and independence. The provider told us, "We don't take anything away from them". People confirmed the service was provided in line with the provider's vision.

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 The registered persons had failed to carry out assessments of service user's needs and preferences. The registered persons had failed to enable and support service users to design their end of life care to meet their needs and preferences. The registered persons had failed to enable and support service users to understand the care choices available to them. 9(3)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons had failed to operate effective processes to ensure service users care and treatment was only provided with their consent. 11(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to ensure staff responsible for the management and administration of medication were suitably trained and competent.

Regulation 12(1)(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to establish effective systems to assess, monitor and improve the quality and safety of the service. The registered persons had failed to establish effective systems to seek and act on feedback from relevant persons, for the purposes of continually evaluating and improving the service. 17(2)(a)(e)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to ensure they and staff received appropriate training to enable them to carry out their duties. 18(2)(a)