Verity Healthcare Limited

Verity Healthcare - Waltham Forest

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Verity Healthcare – Waltham Forest is a domiciliary care agency. The service provides personal care and support to people from various client groups, including older people, people with physical and mental disabilities, sensory impairment and younger adults living in their own homes. Not everyone using Verity Healthcare – Waltham Forest receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection there were 59 people using the service. This provider is also registered to provide Treatment for Disease, Disorder and Injury but were not delivering this at the time of our inspection.

People's experience of using this service and what we found
We received negative feedback from people and their relatives about the service. There were numerous occasions where people who required two care workers only had one care worker and this was also confirmed when we looked at care records.

We also received negative feedback from people and their relatives that care worker punctuality and consistency was not always reliable. This had a negative impact on the quality and safe delivery of care.

People and their relatives provided mixed feedback about the management of the service, with an overwhelming emphasis on poor communication and unprofessionalism, especially in relation to one of the registered managers. Feedback about this registered manager was that they were at times aggressive and rude and this impacted their experience of using the service negatively. Feedback from professionals such as the local authority was also that one of the registered managers was aggressive and difficult to work with. As part of the factual accuracy process we were provided with a service user survey report which showed the steps the provider planned to take where the response to their survey was less than positive, albeit this was the in the minority.

We found that the registered managers were open to having discussions about our findings, during the inspection, in a professional manner. However, as we identified more concerns, the registered managers cooperation decreased. They showed a lack of accountability when we raised concerns, placing the blame on others, including service users and their families and relatives.

The provider was not routinely notifying us of notifiable events without delay.

We have made recommendations about medicines and risk assessments.

We found multiple breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 4 June 2019).

Why we inspected
We carried out this inspection due to an increase in whistleblowings, complaints and safeguardings. The inspection was also prompted in part due to the increase of concerns including concerns about the management of the service.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We have identified multiple breaches of regulation. These were in relation to staff deployment and the overall management of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements if the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our safe findings below.

Verity Healthcare - Waltham Forest

Detailed findings

Background to this inspection

The inspection
This was a focused inspection to check specific concerns we had. We received a whistleblowing in regards to the lack of management oversight, staffing levels and the support people received. Whistleblowing is the act of disclosing information about wrongdoing in the workplace. This could mean highlighting possible unlawful activities in the organisation, failures to comply with legal obligations, miscarriages of justice or reporting on risks to the health and safety of individuals or to the environment. We also received a complaint regarding concerns about the personal care of one person.

Inspection team
The inspection team consisted of three inspectors and an Expert by Experience. Two of our inspectors were on site and one was working remotely. 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 two managers 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 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
We reviewed information we had received about the service since the last inspection, including information

we received from the registered managers prior to the inspection such as their training matrix and complaints. We also sought feedback from the local authority. 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.

During the inspection
We spoke with the registered manager, the care supervisor and the office administrator. We spoke with five people who used the service, seven relatives and one friend. We reviewed three people's care records, five staff files, and five medicines records. We also looked at records relating to electronic call monitoring, safeguarding, accidents and incidents, and quality assurance documents.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed five people's care records, staff meeting minutes, staff rotas and quality assurance documents. We spoke with two people who used the service and three relatives. We also spoke with six care workers.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection the rating has deteriorated to inadequate. This meant people were not always safe and were at risk of avoidable harm.

Staffing and recruitment

- People did not receive continuity of care as the deployment of staff did not consider their needs effectively. People gave their views on staffing levels. Comments included, "There is a double up [two care staff attending one visit] however there has been occasions of no shows." Another person told us, "Two carers do not always come. Like today, I only had one [care worker] support me at lunch time as the other [care worker] was late. By the time [other care worker] had come [the first care worker] had already finished." The same person said, "Yesterday, [care worker] never came at teatime, only one [care worker] came." A relative of a person explained, "It's supposed to be a double hander, but I'm having to act as the second carer". This meant people were at risk of unsafe care as they were always supported by two care staff as required.
- We also received negative responses from people and their relatives regarding staff punctuality and consistency of care. One relative told us, "The turnover of staff hasn't been great. They are not providing care for a [care visit supported by two care workers]." Another relative said, "I have my doubts whether two staff turn up. They have been caught out." A third relative explained, "They have not been consistent with care. [Last year]seven different carers turned up in one week." A fourth relative said, "Oh my gosh! The timekeeping. There is no coordination between the agency and the staff". A fifth relative explained, "The quality of care isn't very good because they're having to rush. They haven't got enough time between visits".
- Care workers told us about their experiences of providing care where a person required two care workers. One care worker told us, "Yes, most of my calls are double up, and in some occasions, I've worked by myself". Another care worker said, "I've had to do a double up a few times on my own." A third care worker told us, "I have had to do a double up a few times on my own. I contacted the office but they couldn't get in touch with the carer that didn't turn up."
- The provider used an electronic call monitoring system (ECM) to create staff rotas and to ensure staff arrived on time and stayed the full duration of the visit. However, we found records reflected the feedback we received from people and relatives. For example, call monitoring records showed on three occasions for one person that only one member of staff had attended the visit instead of two care staff. For another person, their call monitoring records showed between 1 to 25 March 2021, out of 100 care visits, on 43 occasions they had only recorded that one carer attended for a visit that required two care staff. In addition, for this particular person, there had been a recent investigation by the local authority, and allegations of neglect and failing to provide two care workers was substantiated.

Staff were not effectively deployed to ensure they could safely meet people's care and support needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager followed safe recruitment procedures to make sure staff were of a suitable character to work in a care setting.
● Staff recruitment records showed relevant checks had been completed before staff worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. A care worker told us, "They did a DBS and they requested references."

Assessing risk, safety monitoring and management
● Risks to people's health and wellbeing were assessed, managed and regularly reviewed. They were for areas such as personal care, medicines, food and drink, environment, falls, epilepsy, mental health and skin integrity.
● The risk assessments included information about risks associated with people's health needs and instructions for staff to follow to meet those needs safely. However, we found these were not always sufficient. For example, one person living with epilepsy did not have clear information on how their health condition affected them and what staff should do to support them during and after a seizure.
● We also found risk assessments were not appropriately completed and easy to follow. For example, three people's falls risk assessment scorings were not clear as control measures seemed to have increased their risk of falls instead of reducing them.

We recommend the provider consider current guidance on risk assessments.

Using medicines safely
● Medicines were not always administered safely. The provider had various medicines management policies in place. However, we found staff were not always following their 'Recording the Administration of Medication Policy and Procedure.'
● One person required medicines support at lunchtime however this was not always recorded on their daily care plan for lunch time support, in line with the provider's policy.

We recommend the provider consider current guidance on the medicines administration record keeping.

● Staff were trained in medicines administration and their competency assessed before they supported people with medicines.
● Medicines risk assessments were comprehensive. These assessments included information such as a picture of the medicines packaging, why the medicines were prescribed, side effects, and what route to take the medicines.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt the service was safe. A relative said, "[Person] is physically safe. The [care workers] are sweet and caring, but the management isn't great".
● There was a safeguarding and whistleblowing policy in place which set out the types of abuse, how to raise referrals to local authorities and the expectations of staff.
● Staff and management we spoke with had a good understanding of their responsibilities in safeguarding people. One member of staff said, "If I had safeguarding concerns, I will let the care coordinator know."
● Staff completed safeguarding training to provide them with knowledge of abuse and neglect. Records confirmed this.
● The registered manager was able to describe the procedure they would follow when they received safeguarding alerts which included reporting to the Care Quality Commission and the local authority, however we found that we were not always notified.

Preventing and controlling infection

● The service followed safe infection control practices to ensure people and staff were protected against the risk of the spread of infection.

● The provider ensured an adequate supply of PPE was available to staff. Hand sanitisers, gloves, face masks and aprons were available for staff to collect from the office. One staff member told us, "We have enough PPE. Gloves, masks, apron and shoe covers. Hand sanitizer as well." Another staff member said, "We have enough PPE."

● The majority of people and their relatives told us staff wore PPE correctly and followed infection control procedures whilst providing personal care. Comments included, "Everyone wears gloves and aprons", "[Staff] good with bringing gloves and aprons with them", and "[Staff] wear gloves, the whole lot."

● Staff completed training in infection prevention and control. Staff told us, "[They] Ensure that we use PPE such as gloves, mask and apron. Also handwashing or disinfecting with hand sanitizer."

● The provider's infection prevention and control policy was in date and included reference to COVID-19.

Learning lessons when things go wrong

● The provider recorded accidents and incidents. The registered manager told us there had been no accidents and incidents for this year and one for 2020. Records included information about the incident and actions taken.

● After the inspection the provider sent us some examples of how they recorded lessons learnt.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection the rating has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

● One of the registered managers was also the nominated individual (A nominated individual is responsible for supervising the regulated activity on behalf of the provider). The nominated individual for this service failed to demonstrate they were of good character, honest, trustworthy, reliable or respectful (we acknowledge that since the inspection the provider has changed the nominated individual. References to the nominated individual in this report relate to the nominated individual at the time of the inspection).

● We saw examples of these failings where the nominated individual was unprofessional in their conduct during meetings, as well as within email exchanges with the CQC and other professionals.

● People who used the service and their relatives also told us that the nominated individual was often rude. Comments about the nominated individual included that they 'yelled' and that they were 'dismissive'.

● The nominated individual should also demonstrate that they have appropriate knowledge of applicable legislation including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relevant best practice and guidance and understand the consequences of failing to take action on set requirements. For example, the nominated individual had not ensured specific care set out by the local authority to re-able a person over a specific time frame had been fulfilled. This resulted in a complaint by the person's family and the care was then withdrawn by the provider.

● The nominated individual refused to work collaboratively with the local authorities and the CQC, and we found that they refused to acknowledge improvement was needed and were instead very defensive and rude, placing blame on others, in particular on service users and their families. We saw various examples of this in email exchanges, one example was when a person who used the service had made a complaint about high staff turnover, the nominated individual accused them of 'treating carers in an unacceptable manner'.

●We also found that the nominated individual had a lack of understanding of consequences especially in relation to their conduct during meetings, which was often aggressive.

The registered person did not take all reasonable steps to ensure that the nominated individual was of good character. This was a breach of regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Registered managers are expected to be of good character, honest, trustworthy, reliable and respectful. The information we acquired before, during and after our inspection showed that the registered manager did not demonstrate these characteristics.

●We were not assured that the registered manager acted in good faith towards people, their relatives or

professionals and we saw examples of this in email exchanges and at meetings where the registered manager was defensive and aggressive and refused to be accountable when things went wrong. We found that they were not receptive to suggestions for improvement.

This was a breach of regulation 7 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; Working in partnership with others

● The provider failed to ensure there was effective management in place. They had a lack of oversight of how the service was being run. The service had two registered managers who also managed another service with the same provider. This meant they were sharing management roles and responsibilities at both services. As a result we found that communication from the two registered managers was inconsistent.

● The provider had failed to ensure people received staff to support them as per their agreed care plan. The provider's electronic call monitoring records showed staff did not always complete the daily care records, they did not always record when they arrived at people's home to provide care and these gaps had not been identified by the provider. This meant the provider did not have robust systems to ensure people always received care as per their agreed care plan.

● The provider's quality assurance systems were not always effective to ensure the quality and safety of the service. They had not identified the issues we found during the inspection. For example, the concerns relating to medicine administration records, risk assessments, care records and staff deployment.

●The provider did not always keep contemporaneous records. A relative of a person who used the service sent us her mother's risk assessment which showed another person's name and address and information about her mother that was not true, for example that she was partially sighted and required a hoist. Although this person is no longer using the service, this information formed part of our rationale to carry out a responsive inspection.

● The service worked with the local authority and local health services, however feedback from local authorities was not always positive about the management of the service. One of the registered manager's was often described as being aggressive and unprofessional and not always willing to be accountable when things went wrong or when suggestions for improving the service were made. This meant that this particular registered manager did not have the characteristics required to provide a professional or caring service.

Systems were either not in place or robust enough to ensure the service was effectively managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The quality of the service was monitored by speaking with people, regular meetings, and annual surveys to monitor whether they were happy with the service. Annual surveys had been sent out for this however they had not been analysed yet.

● Equality characteristics were considered during the care planning process. This included people's sexuality, ethnicity and spirituality. Records confirmed this.

● The service held staff meetings regularly. Records confirmed this.

● Staff were positive about the management of the service. Comments included, "The registered manager is very approachable", "I have supervision with the care coordinator. She is good. There is good support", and "[Management]" are supportive."

● Staff understood their individual responsibilities and contributions to service delivery.

● Spots checks on staff were completed and helped to monitor their performance.

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; Continuous learning and improving care;

● Evidence from safeguarding alerts and complaints suggested the provider did not accept responsibility when issues were raised and was defensive in their responses to people and any relevant professionals or representatives. This meant they did not demonstrate accountability towards people who used the service in line with duty of candour principles.

● We saw examples of this when looking at email exchanges between the provider and other professionals whereby they refused to take responsibility for when things went wrong and blamed other people instead, and then resorted to cancelling the care package.

● We received concerning feedback about the management of the service from people and relatives and some reported that one of the registered managers was particularly unprofessional. One relative told us, "I called up [registered manager] and [they] yelled at me". Another relative said, "I find [registered manager] to be very unprofessional. On one occasion [they said] 'Can you stop messaging me…' [They are] so dismissive." A third relative said, "Manage the business is what they could do better".

The registered manager did not act in an open and transparent way. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● It is a legal requirement for providers to notify the Commission without delay when incidents happen whilst services are being provided. We found the provider had not routinely ensured all notifiable events had been reported. The failure to notify the CQC of incidents puts people at risk of receiving poor care on an ongoing basis. We are considering what action is to be taken.

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 6 HSCA RA Regulations 2014 Requirements where the service provider is a body other than a partnership The provider did not take all reasonable steps to ensure that the nominated individual was of good character.

Regulated activity	Regulation
Personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager did not always demonstrate they were of good character.

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 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to ensure the service was effectively managed.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered managers did not act in an open and transparent way.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to ensure they could safely meet people's care and support needs.

The enforcement action we took:

Warning Notice