Verity Healthcare Limited

Verity Healthcare - Waltham Forest

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 and 13 November 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The service was last inspected 28 February and 2 March 2017 when it was found to be in breach of Regulations 9, 11, 12, 13, and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Verity Healthcare – Waltham Forest is a domiciliary care agency. It is registered for personal care and treatment of disease, disorder or injury. At the time of this inspection it was providing personal care to people living in their own houses and flats in the community. At the time of the inspection it was providing a service to 12 people.

There was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found medicine risk assessments were insufficient and did not inform staff of the individual support needs and risks faced by people they supported to take medicines. Risks people faced had been identified, but the measures in place to mitigate them were not clear. Recruitment processes were not robust. Care records were not always accessible and complete. The governance and audit arrangements had failed to identify or address the range of concerns found during the inspection.

We identified breaches of three regulations. 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.

Staff received support with regular training and supervision. Staff received appraisals however appraisal records were not always robust. .

Staff and senior management had a good understanding of the Mental Capacity Act 2005 (MCA). MCA is legislation protecting people who are unable to make decisions for themselves. We saw people were able to choose what they ate and drank. There were sufficient numbers of staff employed by the service. Medicines were administered and recorded safely.

People who used the service and their relatives were positive about the staff and told us they were caring. People and their relatives told us they were involved in the planning of their care. We found that care plans were in place which included information about how to meet a person's individual needs.

Staff, people and their relatives told us senior management were approachable and accessible. The service had various quality assurance and monitoring mechanisms in place. These included surveys, audits and staff meetings.

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. Information for staff on how to mitigate risks faced by people was not always clear. Medicine risk assessments were insufficient.

The service did not consistently follow its recruitment processes.

Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Medicines were administered and recorded safely.

Is the service effective?

Requires Improvement

The service was not always effective. Annual appraisal records were not always robust.

Staff undertook regular supervision and training.

The provider met the requirements of the Mental Capacity Act (2005).

Staff were aware of people's dietary preferences. Staff had a good understanding about the current medical and health conditions of the people they supported.

Is the service caring?

Good

The service was caring. People and their relatives told us that they were well treated and the staff were caring. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Good

The service was responsive. Care plans were person centred. People and relatives told us they were involved in the planning of

their care.

Complaints and their outcomes were recorded. People and their relatives knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led. Quality assurance and audit systems had not identified or addressed issues with the quality of the service.

Care records were not always accessible and complete.

Staff, people and their relatives told us senior management were approachable and accessible.

Verity Healthcare - Waltham Forest

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 12 November 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection team consisted of three inspectors who attended the provider's office and an expert-by-experience who made phone calls to people and their relatives to gain their feedback on using the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placed people with the service, and the local borough safeguarding adult's team. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with the registered manager, the nominated individual, five care workers and one trainer. After the inspection we spoke with four people who used the service and six relatives. We looked at four care files for people who used the service, four staff recruitment records, eight staff files which

included supervision records and appraisals, a range of audits, minutes for various meetings, medicines records, accidents and incidents records, training information, policies and procedures, and complaint information.

Requires Improvement

Our findings

During our previous inspection 28 February and 2 March 2017, we found that medicines were not always managed in a safe way, recruitment processes were not always robust, safeguarding adults processes were not being followed, and risk assessments were not always robust. During this inspection we checked to determine whether the required improvements had been made. We found the service had made some improvements.

Individual risk assessments were completed for people who used the service and reviewed regularly. Records showed some of the risks considered were toileting, medicines, choking, manual handling, environment, moving and handling, falls, and epilepsy. Some of the risk assessments contained relevant information however others lacked detail and had minimal information. For example, one person was at risk of choking. The choking risk assessment had tick box answers. The choking risk assessment had been ticked 'no' to gagging on foods or liquids. Care records stated this person was diagnosed with dysphagia. Dysphagia is the medical term for swallowing difficulties. We spoke to the nominated individual about this person. The nominated individual told us the person will start foaming at the mouth when they are choking however this information was not reflected in the risk assessment or the care plan. Another example, one person was diagnosed with type 2 diabetes. The service had completed a diabetes risk assessment however it gave no guidance on how to mitigate the risk for this person. This meant risks associated with people's needs and care had not been appropriately assessed or mitigated against and they remained at risk of harm.

Medicines risk assessments were completed for people who were supported with medicines administration. However these were insufficient and did not inform staff of the individual support needs and risks faced by people they supported to take medicines. For example, one medicines risk assessment for a person gave no specific instructions, outcomes and risks involved. The same person had a medication management plan however it was not specific to that person and gave generic information about medicines. This meant people could be at risk of unsafe care and treatment as risks had not been appropriately identified or mitigated against.

The above issues with medicines and risk assessments are a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment processes were not always robust. Staff recruitment records showed relevant checks had been completed before staff had 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. However for some new staff members there were unexplained gaps in the employment history, with no recorded evidence that these gaps had been noted, explored or explained. Also it was not always clear if reference checks had been sought from the most appropriate person and those that had been received had not been verified. The references which were on file did not always support the details recorded on people's application forms. This meant the provider could not be assured that employees were of good character and had the qualifications, skills and experience to support people living at the service.

The above issues were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us the service was safe. One person said, "I have no problem regarding safety." Another person told us, "I am comfortable [and] safe with the care workers." One relative said, "My relative feels absolutely safe with the care workers." Another relative told us, "There are no issues about safety."

The service had an up to date safeguarding policy that gave guidance to staff on how to identify and report concerns they might have about people's safety. Staff told us they would escalate any concerns to the registered manager. The staff employee handbook gave information about whistleblowing. Records showed the provider was submitting safeguarding notifications to the Care Quality Commission (CQC) and the local authority.

People told us they were supported to take medicines. One person told us, "Medication is given when [staff] come to see me." Another person said, "I do it myself [administer medicine] but the care workers check that I take my medicine." A relative said, "If the medication runs out the care workers will ensure they have been to get the medication. This is over and above what they should do." A second relative told us, "Previously there were issues about medication. This has now changed."

Medicines administration record sheets (MARS) were appropriately completed and signed by staff when people were given their medicines. Monthly medicine audits were completed and records confirmed this. Medicines competency assessments were completed by staff. Records confirmed this. One staff member said about administering medicines, "Make sure you wash your hands. Wear gloves. Check you have the right person and the right medication, check the expiry date, and sign the [medicine record]."

People told us there were enough staff and they arrived on time. Staff told us they had sufficient travel time between visiting people who used the service. One person said, "The care worker is very punctual. Always on time. Does not rush. [Care worker] completes all the jobs I need." Another person told us, "Sometimes they do come late. This is due to an emergency. They do tell me." A relative said, "Usually on time. If late [care worker] will text me." Another relative told us, "No issues about timing."

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes and actions taken were recorded. For example, a person had caused injury to themselves. Records showed the care worker had called an ambulance and a safeguarding notification had been raised. Records showed the service did a yearly analysis of incidents.

Relatives told us staff wore aprons and gloves when giving personal care. Infection control training was provided to staff. Staff had access to policies and guidance on infection control which covered topics such

as personal protective equipment (PPE), hand hygiene, and the disposal of waste.

Requires Improvement

Our findings

At the last inspection on 28 February and 2 March 2017 we found staff did not always follow the legal requirements in relation to the Mental Capacity Act 2005. At this inspection we found the service was now meeting that legislation.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. Domiciliary care services must apply to the Court of Protection for legal authorisation to deprive a person of their liberty.

The senior management and staff had an understanding of the MCA and how the act should be applied to people living in their own homes. Staff explained how they supported people to make choices about their daily lives. Records showed people had been involved and consulted about various decisions and had confirmed their agreement with them.

People's rights to make decisions were documented in the planning of their care. Records showed consent to care forms were signed by people receiving a service. Useful information about people's preferences and choices were recorded.

People and their relatives told us the staff were very good and supportive. One person said, "My care worker certainly knows what she is doing. Very professional indeed." A relative told us, "[Care workers] certainly do know what they are doing."

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. The pre-admission assessment looked at people's home environment, household tasks, health information, eating and drinking, transferring, behaviours, communication, mobility, toileting, personal care and medicines. People told us they were involved with the assessment. Records confirmed this.

Staff told us they were trained and supported to have the right skills, knowledge and qualifications necessary to give people the right support. One staff member said, "I've done all the training." Another staff member told us, "We have training every week." A third staff member said, "For now we have enough [training]." During the first day of the inspection we observed a manual handling training session given to staff. The training covered health and safety, and using equipment. The training was clear and comprehensive. The provider sent us a Provider Information Return (PIR) which was completed on 7 October 2017. The PIR stated that staff received training on MCA and DoLS, equality and diversity, first aid, health and safety, medicines, moving and handling, infection control, dignity and respect, fire safety, end of life care and first aid. Additional training was also provided with regard to the specific needs of the people using the service such as dementia awareness, epilepsy, and PEG feeding. Records showed staff were supported with regular supervision sessions.

New staff joining the service completed the care certificate. The care certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting. Relatives told us new care staff were shadowed by more experienced carers.

Appraisals were being completed and staff confirmed this. However records of appraisals were not robust and unclear at times. For example, one appraisal covered the period of 1 January 2017 to 31 December 2017 however this period had not yet ended. This appraisal was dated and signed on 27 September 2017. Another appraisal, which again covered the period of 1 January 2017 to 31 December 2017, was dated and signed on 20 July 2017. In a third example, the start date for one employee was 7 March 2016 however the appraisal covered the period 25 February 2016 to 25 February 2017. This meant it was not clear staff's appraisals records were accurate and up to date. As part of the factual accuracy process the provider informed us that the appraisals that were carried out months before the end of the appraisal period were [sic] 'post 6 month appraisals'.

People and their relatives told us they were well supported with meal preparation. One person said, "They [staff] warm [food] correctly." A relative told us, "I will provide the food. The care worker will prepare the meals. We do not have any issues with this." Records showed people had a nutritional risk assessment completed when they started to receive a service and this was reviewed regularly. Care plans gave guidance on who had the responsibility of supporting people with meal preparation. Care plans recorded people's likes/dislikes and preferences. For example, one care plan stated, "I prefer fried eggs. My [relative] will prepare this for me. I need you to assist me by cutting up the food into smaller pieces. I eat [culturally specific] meals only."

People's care records in people's homes included the contact details of their GP so staff could contact them if they had concerns about a person's health. Where staff had more immediate concerns about a person's health they called for an ambulance to support the person and support their healthcare needs. Records confirmed when people needed medical attention the care staff contacted an ambulance.

Good

Our findings

People and their relatives told us they had a caring relationship with staff members. One person said, "My care worker is so nice. Always going the extra mile. I feel so fortunate." A second person told us, "They [care workers] are pleasant, they are kind, really helpful." A third person said, "[Care workers] very good to me." A relative said, "[Care workers] are absolutely brilliant. They understand my relative. They are so caring. They are like family to my relative." Another relative told us, "[Care workers] are marvellous with my relative. They sing together. Always laughing. It is great to hear the happiness with my relative."

Staff told us they got to know people by reading their care plans and talking with them and their relatives. One staff member said, "Clients tell me they are very happy with me." Another staff member told us, "I get to know the [people who used the service] by talking to them." Staff we spoke with had a good understanding of the people they cared for.

Staff told us how they made sure people's privacy and dignity was respected. They said they explained what they were doing and sought permission to carry out personal care tasks. One staff member told us "Treating [people who used the service] like you would want to be treated. Closing the door when giving personal care. Respecting their religion and their wishes." One relative said, "[Care workers] respectful and kind."

Care plans contained detailed information about people's communication needs and preferences. This helped give staff the information they needed to build rapport with people in order to establish positive relationships with them. For example, one care plan stated, "I like you to ask how I am feeling. Please do not rush me. I get nervous when I am rushed." In another example, one care plan stated, "My toothbrush is blue in colour and can be found in a blue cup. I like [specific brand] toothpaste." Care plans captured if people had a preference for care workers of a specific gender and records showed this was respected.

Care plans also contained information about people's background and personal history. For example, there were details about where people lived, relationships, their family history, favourite football team, and hobbies. The service captured information on people's religious and cultural needs and preferences in their care plans. This enabled staff to understand people's background history and provide personalised care.

Good

Our findings

At the last inspection 28 February and 2 March 2017 we found care plans were task focused and did not reflect people's preferences. Also people told us staff were late and did not always come at a time that suited them. At this inspection we found the service was now meeting this regulation.

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's needs. The care plans covered personal care, engagement, medicines, health management, manual handling, epilepsy, communication, night care, and religious and cultural needs. The care plans were person centred. For example, one person needed support with personal care. The care plan stated, "I need you to apply the lotion that my [relative] has bought me and I will like you to ask [relative where lotion is stored]. Tell [relative] I like the lotion that smells like lavender. It makes me feel fresh." Another example showed one person needed support with dressing. The care plan stated, "To assist with dressing, I will like to start with the right side of the body. I will like the right sleeve of the dress to be slotted into my right arm." Records showed care plans had been reviewed regularly or as the person's needs changed. One relative told us, "We have a good relationship with management. We have together discussed the review [and] care plan." Another relative said, "We have discussed the care plan together [with senior staff]." Detailed care plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

At the last inspection people told us staff were late and did not always arrived at a time that suited them. People and their relatives told us staff punctuality had improved and they had consistency with the care workers that supported them. One person said, "I have a team that comes in. I have two care workers that come at the same time." One relative said, "There is consistency hence why my relative has a wonderful relationship with the carers." Another relative told us, "Two care workers come each time."

There was a complaints process available to people. People were given a 'service user guide' which explained how they could make a complaint. We looked at the complaints policy and we saw there was a clear procedure for staff to follow should a concern be raised.

People and their relatives knew how to make a complaint and knew that their concerns would be taken seriously and dealt with quickly. One person said, "Management are good with me. They come to see me. They listen to me." One relative told us, "I did previously make a complaint about timing. This has improved." Another relative said, "My [relative] had to complain. They are better now." There were systems to record the details of complaints, the investigations completed, actions resulting and response to

complainant. The provider sent us a Provider Information Return (PIR) which was completed on 7 October 2017. The PIR stated the provider had nine complaints in the last 12 months. We found the complaints were investigated appropriately and the service aimed to provide resolutions in a timely manner.

Requires Improvement

Our findings

At the last inspection 28 February and 2 March 2017 we found quality assurance and audit systems had not identified or addressed issues with the quality of the service. People and staff gave us mixed feedback about the leadership of the service. At this inspection we found some improvements had been made.

Care records were not always accessible and complete. During the inspection we asked for various documents which were not in people's care files. We found care files were not accurately maintained with the most up to date information and were not easily accessible. For example, one care file had a blank manual handling risk assessment. We asked the nominated individual why the assessment was blank and he told us there was an updated version. The nominated individual came back to us 30 minutes later with a completed manual handling risk assessment. The nominated individual told us the service had records stored on multiple systems such as an internet cloud, memory stick, a computerised and a paper based system. This meant there was a risk that the most up to date information was not always available to care and office staff.

The provider had various quality monitoring systems in place. The nominated individual and the registered manager told us they had conducted spot checks in people's homes. The provider had analysed the spot checks and created a report. The spot checks observed punctuality, personal appearance of the care workers, politeness, respect for people who used the service, respect for the property, abilities to carry out care tasks and knowledge and skills. The analysis report stated the provider had completed 32 spot checks over the past few months. However the specific review period was not clear as the analysis report was not dated and did not give the dates when the spot checks took place. The spot analysis report rated each of the observations as excellent, good or satisfactory however there was no opportunity to explore if a staff member's performance was unsatisfactory.

Systems were not robust to ensure the delivery of high quality care. During the inspection we identified failings in a number of areas. These included managing risks, medicines, recruitment and record keeping.. These issues had not always been identified by the provider which showed there was a lack of effective quality assurance systems in place.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives gave us positive feedback about the leadership of the service. They felt it had

improved since the last inspection. One person said, "I do know [nominated individual]. He comes to see me. He is good." Another person commented, "They provide a really good service." One relative told us, "[Nominated individual] is very generous with his time. Physically comes to see us. Very good, now listening to us." A second relative said, "Since [nominated individual] has taken more control things have moved on. Things are good now. Relationship is very good. He does speak to his staff if any issues." A third relative told us, "[Nominated individual] has taken more of a role. This has made a great difference."

There was a registered manager in place. However the nominated individual told us they (the nominated individual) had taken a more proactive role in the running of the service since the last inspection. This was confirmed by staff, people and their relatives we spoke with. The nominated individual advised us that he would be applying for the registered manager position.

Staff told us the registered manager and nominated individual were supportive and accessible. One staff member said, "If I have a question I can call them." Another staff member told us, "Managers supportive and understand what it was like to be a carer." The same staff member said, "If there is a problem you call the office. They are very good at sorting out everything." A third staff member said, "[Registered manager] knowledgeable as a manager."

Records showed staff had regular meetings where they were able to raise issues of importance to them. We saw the minutes from these meetings which included topics on accidents and incidents, medicine recording, recruitment, care plans and staff punctuality. Regular senior staff meetings were held. Topics included spot checks and quality monitoring.

The provider had a system in place to obtain the views of people who used the service. The provider had last sent out an annual survey to people in 2017 and this was analysed in a report dated September 2017. The survey made comment on staff punctuality, length of visit, consistency of care staff, and accessibility to the out of hour's number. Overall the results were positive. Comments from people included, "happy with the service" and "the staff were friendly."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been assessed and measures in place to mitigate risks were insufficient. Regulation 12 (2) (a) (b)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People who used the service were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems and records, designed to enable the registered provider to regularly assess and monitor the quality of the service provided. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not always check if staff had the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (a) (b)