CVC Care Ltd

# Liverpool Innovation Park

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Inadequate** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This inspection took place on 06 October 2017, this was an announced inspection. CVC Care was a domiciliary care agency providing care and support for people living in their own homes in the geographical area of Liverpool. The provider was registered with the Care Quality Commission for the regulated activity of personal care. This was our first inspection of the service since their registration in December 2016. At the time of our inspection we believed there were 19 people receiving a service from CVC Care.

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. The registered manager had recently left and the registered provider was managing the service.

During this inspection we found breaches of Regulation 9, 11, 12, 13, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider lacked oversight of the organisation. The processes for ensuring that staff that had been recruited were suitable for the role of working with vulnerable adults were inadequate and incomplete. We looked at the staff files for five staff members. We saw that the registered provider had failed to complete their obligations to ensure that people employed were suitable and of good character. The registered provider had also failed to obtain a full disclosure and barring service (DBS) check for some staff. A DBS check looks at any criminal records a person may have and checks to see if people have been placed on a list barring them from working with vulnerable adults.

There was no evidence that staff had been inducted or had followed a probationary period into their role or received appropriate support. The provider had no method of assessing the performance and suitability of staff in their role of supporting vulnerable adults.

Not everyone receiving a service from CVC Care had a care plan with risk assessments in place. Some care plans and risk assessments were at times vague or had information about the wrong person to who was named on the documents. We were unable to access historical care plan records and service delivery for any person. This meant that we saw no evidence that peoples care plans had been regularly reviewed.

We saw that part of the care plans for the people receiving a service had a section that said if the person had given consent to receiving care. However as the care plans were not always accurate or about the named person we could not be sure that the information regarding consent was correct.

The service had policies and procedures in place; however the service did not follow these policies, examples being recruitment and quality assurance. This meant that the polices in place were not working documents and so were not being followed. We identified through discussions that the registered provider

did not have knowledge of the policies as they did not know that they had been named as responsible for specific actions.

There was no evidence that any staff had received training in safeguarding vulnerable adults. The registered provider told us that the staff had been trained in in safeguarding when they were a previous employment/job. This was inadequate as this meant that staff were potentially providing support without being able to recognise any person who was at risk and without knowledge of who to contact in case of emergencies. This meant that staff might behave inappropriately or any potential abuse may be missed and not reported appropriately.

Following our inspection CVC Care de-registered with CQC and is no longer carrying out regulated activities.

## 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.

The registered provider failed to ensure staff being employed were suitable to work with vulnerable people.

The service did not have an effective risk assessment process in place.

Staff had not received up to date safeguarding training.

### Is the service effective?

**Inadequate**

The service was not effective.

The service had not provided their staff members with the training that is necessary for them to be effective in their role.

There was no evidence that new staff received any induction, shadow or probationary period to introduce them to the service.

Care plans were not always accurate or about the named person so we could not be sure that any information regarding consent was correct.

### Is the service caring?

**Inadequate**

The service was not caring.

Information contained within a 'service user guide' provided to people receiving care was not always clear or correct.

We observed that appropriate locked storage for confidential information was provided in the office and that computer held information was password protected.

People we spoke with told us that individual staff were caring.

### Is the service responsive?

**Inadequate**

The service was not responsive.

Not everyone receiving a service had an up to date care plan.

Care plans were, at times, vague or misleading.

The registered provider did not have an understanding of what constituted complex care needs.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The registered provider lacked oversight of the service and did not have an understanding of their legal responsibilities.

There were no effective audits in place to drive improvement.

The policies that were in place were not working documents and the registered provider did not have knowledge of what information the policies contained.

# Liverpool Innovation Park

**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 was 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 06 October 2017 and was announced. The inspection was carried out by two adult social care inspectors. The inspection was prompted in part by information of concern which we had received from a whistle-blower and from the local authority.

Before our inspection, we looked at information the Care Quality Commission (CQC) had received about the service including notifications received from the registered provider and previously the registered manager. We checked that we had received these in a timely manner. We also looked at safeguarding referrals, complaints and any other information from members of the public.

We visited the office on 06 October 2017 and looked at records, which included four people's care records, five staff files and other records relating to the management of the service. We also visited the home of one person using the service.

During the inspection we spoke to the registered provider, and another staff member. Following this visit we made phone calls to relatives of the people who used the service and other professionals.

Inadequate

# Is the service safe?

## Our findings

We looked at the files for five staff members and had concerns about each of them surrounding recruitment processes. Employers providing a regulated activity are obligated to check that persons employed are of 'good character' and are 'fit to work'. They are required to check applicant's proof of identity and obtain evidence of conduct in previous employment relating to health and social care along with the reason why this employment ended. This is usually obtained through written references. Employers are also obligated to obtain evidence of qualifications and a full employment history of the person. The registered provider had failed to complete their full obligations for any of the five staff members we looked at. We discussed this with the registered provider who was unaware of their obligations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we also became aware that staff had completed visits to support vulnerable people in their homes without the registered provider completing or applying for a full disclosure and barring service (DBS) check. DBS checks assist employers to make safer decisions about the recruitment of staff. They consist of a check on the applicant's criminal record and to see if they had been placed on a list barring them from working with vulnerable adults. The provider had only completed a 'first check'. This was not a sufficient level of check. This meant that the registered provider could not be fully assured that these staff that had been employed, were suitable to work with vulnerable people.

We identified staff who had a DBS check carried out where it had highlighted that there had been a previous conviction. The provider had not investigated or risk assessed the staff to ensure the people they were providing a service were safe. When we spoke with the provider they were unaware of the contents of their own policies and their responsibilities to ensure a safe workforce when working with vulnerable adults.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the registered provider had not taken steps to ensure that people employed were fit and proper persons for the role.

There was no evidence that any staff had received training in safeguarding vulnerable adults. This is essential training as it equips staff members with the knowledge to be aware of and react appropriately to anything that may indicate a vulnerable adult is at risk of abuse. It also makes staff aware of their responsibilities. The provider informed us that as they knew the staff who had come from other services and had received training prior to working for CVC Care. This was insufficient as some training was some years old and the staff knowledge had not been updated. This meant that staff were potentially providing support and could be acting inappropriately. It also meant that they may not be able to recognise any person who was at risk or who to contact in case of a safeguarding concern.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff members were not equipped with the knowledge and skills to ensure that vulnerable adults were protected from abuse.

We looked at the risk assessment records for four people. The registered provider informed us that the previous registered manager had left and the service had been unable to access the password protected care records on the computer system. We were told that they were currently updating the care records following this. We looked at completed risk assessments and identified concerns. We saw that one file contained the wrong person's information this meant the risk assessments were misleading. We asked the provider and staff member if any of the people using the service had any complex care needs that were needing to be risk assessed and we were told 'no'. On visiting people in their own homes we saw that this was not correct. We saw that lifting equipment was in use and we had not been informed of this. This meant that staff were potentially using equipment that had not been properly risk assessed. This meant that the provider did not have adequate knowledge surrounding the people using the service and that staff did not always have appropriate information to ensure the service being provided was appropriate. This meant that people were at increased risk of receiving unsafe care from staff that were not aware of the risks present in people's care. This placed people at unnecessary and increased risk of avoidable harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This is because the risks to the health and safety of people using the service had not been appropriately assessed.

We were able to see that the rotas that were in place showed that the service had sufficient staff on duty to visit people and this was supported in discussion with people using the service. However we were told that sometimes staff were not always punctual. One person said "Sometimes they don't come on time".

Inadequate

# Is the service effective?

## Our findings

In the five staff files we looked at there was no reference to any training being provided by the agency. This included essential core training that all care staff are expected, as best practice, to receive near the start of their role as outlined by Skills for Care; the government appointed body for setting standards of training in the care sector. Examples of necessary training include understanding your role, duty of care, moving and handling, communication, safeguarding vulnerable adults, fluids and nutrition, privacy and dignity, health and safety and infection prevention and control. The registered provider told us that they knew the staff and that they had received training in their last place of work. However, the provider had no record of how recent staff had been trained or when any subject needed updating.This was inadequate as there was a risk that staff were working unsafely, inappropriately or outside the provider's own policies and procedures. One person we spoke with said "They're not trained".

We also saw that there was no evidence that new staff received any induction or shadowing period to introduce them to the people being cared for and ensure they were suitable for the role identified. The lack of induction and training meant that the registered provider could not be sure that staff members were able to effectively or safely carry out the duties they had been employed to perform.

There was very little evidence of on-going support in the five staff files we looked at. We did not see evidence of supervision or appraisal meetings. These are meetings when concerns about areas of their performance had been addressed by the registered provider and they offer the staff member the opportunity to give the employer feedback about their job. There was no structured method used by the provider of assessing the performance and suitability of staff in performing their role of supporting vulnerable adults.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff had not received appropriate training, support and professional development to enable them to carry out their duties effectively.

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 MCA. We checked whether the service was working within the principles of the MCA. There was no evidence that any staff or the registered provider had been provided with any awareness training with regard to the MCA. We saw that part of the care plans for the people receiving a service did have a section that said if the person had given consent to receiving care. However as the care plans were not always accurate or about the named person we could not be sure that the information regarding consent was correct.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because it was not clear if the service had obtained people's consent to their care.

We saw that care plans contained information regarding nutrition, fluids, likes and dislikes. However as the care plans were not always accurate we could not be certain that staff were aware of people's dietary requirements. One care plan said for staff to 'encourage adequate amounts of diet and fluids to prevent dehydration and malnutrition' however it was not clear what was classed as 'adequate' for the person or if the person refused food.

Inadequate

# Is the service caring?

## Our findings

People's we spoke with and their relatives told us that individual staff members had a caring approach. One relative told us "They do their job and they're quite pleasant" and another said "They just seem to care". The people we spoke with also said that their dignity was respected by the care staff who attended them.

CVC Care provided a 'service user guide' for each person who was receiving a service from them. This included information about the service that was to be provided however the service had not always followed their own processes. The service user guide stated that staff had received CVC Care mandatory training and inductions; however there was little evidence to support this. We also saw that the document said that care was to be reviewed one month after the start of care being provided and then on a six monthly basis thereafter. This had not happened. The service user guide also held information about the previous registered manager. The service user guide was printed in a way that was difficult to read and those people who had eyesight issues and/or other health needs such as dementia would have found it very difficult to read the information. This meant that the majority of the information held in the service user guide was misleading so people who were receiving a service from CVC Care did not have appropriate information.

We saw little other evidence that the provider provided information effectively in any other way to people using the service or their relatives. The service user guide stated that there was a service user forum however there was no evidence that this had taken place.

We observed that appropriate locked storage for confidential information was provided in the office and that computer held information was password protected. However, the provider did not have access to the password which had been held only by the previous registered manager who had left the service. This meant that staff could not access and essential records in order to provide a service to people, such as care plans and risk assessments.

We were told that no one was currently receiving end of life care and we did not see any evidence that people's end of life wishes had been discussed with them. We asked the registered provider if they had any processes in place to support people at end of life; they were unclear about their own processes and were unable to give specific information.

Inadequate

# Is the service responsive?

## Our findings

The registered provider told us that there had been significant problems accessing the online care records following the registered manager leaving the company. We asked if the registered provider had 'backed up' any documentation or held paper copies. This had not happened. This meant we were unable to access historical care plan records and service delivery for any person. This meant that we saw no evidence that peoples care plans had been regularly reviewed.

The agency had, since the computer records were not able to be accessed, started to carry out new care planning with people receiving a service. However, not everyone had been assessed and the ones who had had plans which were not always clear. We also saw how in some instances the wrong names were on documentation. This made the care documents that were meant to hold information about an assessed persons care needs were of little use to staff.

We asked the registered provider if anyone's care plans identified that they had complex care needs. We were told no;, however we identified that this was incorrect on visiting and speaking with people. We raised this with the provider who did not know that the peoples care and health needs would mean that significant care planning would be needed.

Some guidance for staff was vague. This meant that care staff did not have the necessary information to be confident in providing the correct and safe care for people. One person's care plan stated 'Any falls please liaise with GP to review' and 'Any concerns in regards to mobility transfers or falls please liaise with GP.' There was no other information regarding the risk of falls held in the care plan.

People's care plans did not outline what medication a person was taking or the reasons why they were taking it. If medication was mentioned it was only briefly to note that staff were to support a person to take it. One care plan instructed staff to 'Prompt medication from a blister pack and to order medications in a timely manner to prevent any episodes of running out of prescribed medications'. There was no other information about the persons health or medication needs contained in the care plan. We saw no evidence of medication training or competency checks. This meant that there was a risk that untrained staff had responsibility of prompting and ordering medication for a person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people's care planning was inadequate and did not equip staff to be able to meet people's needs.

People we spoke with did not have any complaints about the service although one person told us they were intending to find a new service provider. The 'service user guide' held information on who to complain to if the need arose, however the style of writing was difficult to read and there some contact information was incorrect. The service had a comprehensive complaints procedure in place and had not received any complaints. However, on looking at the policy and procedure we identified incorrect information regarding who to contact in case of a complaint. We asked the provider if they were aware of their responsibilities

regarding complaints and we were told "Not really".

Inadequate

# Is the service well-led?

## Our findings

There was no registered manager in place as they had recently left the service and agency was being managed by the registered provider. During our inspection we saw that the registered provider lacked oversight of the service and the care that was being provided to the people it supported.

We asked to see the audits of the service that should be carried out to drive improvement in the service. We did not see any evidence of effective auditing practices in place. This meant that the quality of the service was not being monitored and improvements were not being made.

CVC Care had a number of policies in place that covered subjects such as health and safety, safeguarding, recruitment and complaints. On reading the policies we saw that the registered provider was named as being responsible for various processes and we asked if they were aware of their responsibilities and did they know that they were named in the policies. We were told "No". The registered provider demonstrated that they did not have knowledge of their legal responsibility as a service provider and that they had little oversight of the service. This meant that the polices in place were not effective documents as they were not used to inform how the service should be managed and run and the provider had little knowledge of them..

We saw that the service had not recruited or inducted people safely and did not have a robust system of support and training for the staff they employed. We also saw no evidence of other staff communication such as staff meetings or competency checks. This meant that the people being supported in the community were at risk of receiving care from untrained staff.

We saw that people's risk assessments and care plans were sometimes vague, did not contain information appropriate to the person who was named on the care plan and that the registered provider did not recognise when a person had a complex care need.

We asked to see how the agency asked people their opinions on the service; we were unable to see evidence that the agency had formally asked people their opinions. This meant that people did not have an opportunity to voice their opinions.

These examples were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not maintained systems or processes that allowed them to assess, monitor or improve the quality and safety of the care being provided.

We discussed our findings with the registered provider who admitted that they had not researched their responsibilities and had relied and trusted overly heavily on the previous registered manager.

Following our inspection CVC Care de-registered and is no longer carrying out the regulated activity of personal care.

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<br><br>This is because people's care planning was inadequate and did not equip staff to be able to meet people's needs. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>This is because it was not clear if the service had obtained people's consent to their care. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>This is because the risks to the health and safety of people using the service had not been appropriately assessed. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>This is because staff members were not equipped with the knowledge and skills to ensure that vulnerable adults were protected from abuse. |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider had not maintained systems or processes that allowed them to assess, monitor or improve the quality and safety of the care being provided. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>This is because staff had not received appropriate training, support and professional development to enable them to carry out their duties effectively. |