Vincentian Care Plus

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Inspection report

2 Grosvenor Gardens
London
SW1W 0DH

Tel: 02077304254
Website: www.vincentiancareplus.org.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 15 July 2016 and was announced. We informed the provider 48 hours before the inspection that we would be visiting, in order to ensure that staff would be available at the service to speak with us.

Vincentian Care Plus is a domiciliary care agency providing care and support to people living in their own homes. There were 157 people using the service at the time of our inspection. At the last inspection which took place on 1 July 2014, the service was meeting all of the regulations we checked.

The service had a registered manager. 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.

In September 2015, the provider was awarded a local authority contract to provide domiciliary care for people living in the London borough of South Westminster. After an initial period of transition and a number of issues relating to missed visits, and electronic logging in/out systems, the service continues to grow, currently providing over 2000 hours of care and support on a weekly basis.

The Director of care and the registered manager were aware that updated systems and new ways of working need to be established and embedded into practice to ensure the continuous delivery of safe and appropriate support to people using the service. The registered manager told us, "It has been a bit turbulent, there have been lots of changes and changes of staff, this has impacted on the things we do." Staff recruitment is ongoing.

The service received the majority of its referrals from health and social care professionals working in the local community. This information was used to inform and develop care plans in consultation with people, their family members (where appropriate) and senior staff members.

Where possible, initial assessments were completed before a package of care was organised. Care plans recorded people's health care needs and included contact details, information relating to personal care, medicines, communication and nutritional needs. However, we noted that reviews of people's health care needs were not carried out with sufficient frequency to ensure people were kept safe and their health and well-being promoted.

Risk assessments were either not in place or had not been fully completed in all of the care records we looked at. Where risk assessments had been completed appropriately these covered a range of issues including people's home environments, moving and positioning, equipment and mobility. For example; these included details about how people mobilised and whether they required walking aids, the support of another person or were independent. However, not all risk assessments had been reviewed and/or updated

in line with the provider's policies and procedures.

Where appropriate, specialist advice and support had been sought in relation to meeting people's needs and this advice was included in care plans. We saw advice from re-enablement teams, district nurses and community mental health teams was included in people's care records. However, staff were not always aware of or following this advice.

Where staff were responsible for prompting people's medicines, staff had completed training in medicines administration. However, we found that effective systems were not in place to ensure the administration of medicines was always recorded in a safe and consistent manner and regularly monitored for potential errors or omissions. The director of care emailed us following our visit to demonstrate that staff had been notified of changes to the way medicines administration or prompting should be recorded in people's daily logs.

Staff had a good understanding of safeguarding procedures and knew what steps they would take if someone was at risk of abuse or harm. Despite this, the provider was not always notifying the Care Quality Commission (CQC) of serious safeguarding incidents which should have been reported to us in line with the provider's registration requirements.

CQC monitors the use of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of the principles of the MCA and how this might affect the care they provided to people. Staff we spoke with understood what the MCA is designed to do and were able to describe how they supported people to make decisions.

People were asked (where possible) to provide their consent to the support being provided. Where people were not able to consent, we found that care records had been signed by a manager or a family member.

Most people felt able to make a complaint if they needed to and knew how to do so. Staff were aware of their responsibilities regarding reporting any complaints, accidents and/or incidents and systems were in place to record these.

There were protocols in place to respond to any medical emergencies or significant changes in a person's health and well-being. When required, staff supported people to attend health appointments.

Staff were aware of people's specific dietary needs and preferences and people received the level of support they required to have enough to eat and drink. Some staff told us they had completed training in food preparation and hygiene.

The provider sought feedback from people using the service. However, this was not done on a regular basis and some people had not been asked about the care they received for over 12 months.

Staff supervision and appraisal was not always taking place in line with the provider's policies and procedures and neither were staff meetings organised regularly enough to provide staff with a forum to discuss service improvements, learning and development opportunities; share good practice approaches and/or discuss any concerns they may have.

The provider had policies and procedures in place for the recruitment of new staff. Most of the people we spoke with expressed positive views about the care staff. People told us they felt safe and were supported by staff who treated them with dignity and respect.

We identified breaches of regulations in regards to safe care and treatment, person centred care, good governance and notifications and made one recommendation in relation to medicines management. You can see the action we have told the provider to take at the back of the full version of the report.

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 provider was not always managing and/or reviewing risks to people's health and safety effectively or with the appropriate frequency to ensure people were kept safe from avoidable harm.

People were not always protected against risks associated with unsafe care practices and procedures in relation to medicines management.

The provider was not always notifying CQC of serious incidents and safeguarding concerns in accordance with the provider's registration requirements.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were in the process of updating essential training such as medicines management and safeguarding.

Regular supervision sessions were in the process of being implemented but some staff had not received supervision for a number of months.

People were supported to eat sufficient food and drink.

Is the service caring?

Requires Improvement

Aspects of the service were not always caring.

People we spoke with told us they did not feel that staff always had adequate time to provide them with a person-centred service.

Staff respected and promoted people's dignity and privacy.

Staff understood the importance of protecting people's confidentiality and keeping records secure.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their family members (where appropriate) had been involved in the development of care plans. However, not all of the care plans had been reviewed and updated in line with the provider's policies and procedures.

People did not always feel that their complaints and concerns were listened to and acted on.

People using the service told us that they had difficulty contacting people in the office, particularly out of regular hours.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

People's views were not positive about the way the service was organised and managed.

The provider's quality assurance systems and processes did not ensure that they were able to effectively assess and monitor the quality of the service and mitigate risks relating to the health, safety and welfare of service users.

Vincentian Care Plus

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 14 and 15 July 2016. The first day of our inspection was unannounced. We let the registered manager know that we would be returning the following day to complete our inspection.

Before the inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and reviewed safeguarding alerts which had been made. We looked at information we hold about the service including correspondence from the provider and complaints from members of the public.

We carried out this inspection at the provider's office in Belgravia. We spoke to the registered manager, the director of care, a care manager, a field care supervisor, two administration staff and one care staff member. We reviewed the care records of 16 people using the service. We looked at eight staff recruitment files, supervision and training records, and spoke with the registered manager about the systems in place for monitoring the quality of care people received. We looked at a variety of the provider's policies such as those relating to safeguarding, medicines, complaints and quality assurance.

Following our visit we phoned and spoke with 24 people using the service, six relatives and 10 members of care staff. We also spoke with two members of the local authority safeguarding team to get their views on the service. We used this feedback to help inform our judgements.

Inadequate

Is the service safe?

Our findings

We asked people using the service whether or not they felt safe and trusted staff who cared for them. Comments included, "I'm as safe as I can be," "I trust [staff] definitely and feel safe with them." Relatives told us, "I do trust [staff]" and "I think [my family member] is safe. However, one person we spoke with felt differently and told us, "I'm at risk, I don't feel safe", and a relative told us they were concerned that staff had on more than two occasions left their family member unattended and "put her in a vulnerable position."

People were not always protected from unsafe care and treatment because the provider was failing to fully complete, review and update people's risk assessments. We looked at 16 sets of care records during the course of our inspection and saw that risks associated with environmental factors and people's activities of daily living had been identified. However, one person's records contained no completed risk assessments at all and three had not been reviewed or updated since 2013. Planned review dates were missing from all of the assessments we looked at and most contained omissions or inconsistencies, had not been signed by relevant parties and did not provide sufficient detail as to how risks could be minimized. For example; where one person required hoisting, no risk assessment was in place relating to this task and we could find no completed health and safety risk assessment for another person who had significant mobility issues following a stroke. One person was at risk of developing pressure sores. Health professionals had reviewed this person's care needs in March 2016 and provided guidance on moving and positioning and requested a two hourly turning regime and appropriate recording of this on charts provided. However, it was not possible for us to check these as none had been returned to the office for this purpose. We noted that this person's risk assessment had not been updated since September 2014 despite significant changes to this person's health and mobility. The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training in managing medicines as part of their induction and the provider had a medicines policy which outlined appropriate procedures when assisting or supporting people to take their medicines. Care records we looked at contained information relating to people's ability to manage their own medicines. The Director of care told us that where staff prompted medicines an entry relating to this task was recorded in people's daily logs. We looked at daily notes and found there were some gaps in recording when medicines had been prompted, demonstrating that there were times when medicines were not administered and/or daily logs were not completed appropriately. Details as to which medicines had been prompted or administered and at what dosage, and information as to whether people had actually been observed taking their medicines was absent. Neither did we find medicine administration records (MAR) being used (where appropriate) to document that people had taken their medicines as prescribed. We saw evidence in the daily logs that staff applied cream but were uncertain as to whether this was cream prescribed by a GP or other. One person had been prescribed eye and ear drops but we saw no evidence in the care record documenting whether staff were required to assist with these drops and no reference to this task in the daily notes. As a growing and developing service, systems must be in place to ensure best practice is followed and that people's medicines are

We recommend the provider take into account 'The handling of medicines in social care' by The Royal

Pharmaceutical Society of Great Britain.

The provider had a safeguarding policy which had been reviewed and kept up to date. The policy contained details on how to protect people from abuse and the steps to take, should abuse be suspected. Staff we spoke with were able to explain to us the different types of abuse, the signs to look out for and any actions they would take to report this. Staff told us, "Safeguarding is about protecting the clients and yourself and noting and informing the office of any problems."

We checked safeguarding records held at the service and found that information was well maintained and updated with any further developments regarding each concern. We spoke with the local authority, who told us there had been a number of safeguarding concerns at the service ranging from errors with medicines and missed calls and that these were currently being dealt with alongside the provider. We checked information provided to CQC against information held by the local authority and found some discrepancies. At the time of our visit we had been notified of four safeguarding concerns relating to allegations of theft and had received no notifications in relation to missed medicines or missed visits. This demonstrated that the provider was not always notifying CQC of serious incidents and safeguarding concerns in accordance with their registration requirements. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Care records identified where staff were responsible for shopping tasks. Financial transaction sheets were in place to record purchases, monies received and monies returned. We looked at one person's 'cash record' sheets and noted that for 11 consecutive days in March 2016 there was a record of total sums of money spent but no information as to what money staff had received or returned following purchases and no receipts of purchase. This may have meant that people were vulnerable to financial exploitation. In light of the four allegations of theft of monies and/or personal property, we would expect the provider to be operating more robust procedures to ensure any risks of financial abuse were minimized and where possible, people's personal belongings were kept safe and secure.

There were enough staff who had been safely recruited to meet people's needs. We looked at the staff files of eight staff members who worked for the service and found that adequate pre-employment checks had been carried out by the provider. These checks included photographic identification, proof of address and the right to work in the United Kingdom, at least two reference checks from previous employers to confirm their satisfactory conduct and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. This meant the service followed safe recruitment practices to help ensure only suitable and appropriate staff members were employed.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff who were fully supported to carry out their roles effectively. The registered manager told us that staff received an induction before starting their employment with the service. Induction training covered mandatory areas including safeguarding, medicines management, health and safety, first aid and moving and positioning. The induction was designed to equip staff with the skills and knowledge to carry out their duties and responsibilities effectively. Newly appointed staff shadowed other experienced members of staff until they and the provider felt they were competent and confident in their role. We asked to see records of staff training and were provided with a training matrix that was not populated. We discussed this matter with the registered manager who told us they had decided to refresh essential training for all staff members since there was some confusion about what training had been provided to staff in the past. Staff we spoke with confirmed that they had undergone induction training and had recently completed refresher training in safeguarding and medicines management.

Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. In staff personnel files we looked at, we found supervisions were not always being carried out on a regular basis. For example, one staff file we looked at recorded supervision as having last taken place in April 2015. In another staff file, we found records of supervision dating back to May and June 2015. Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their roles. We found records of appraisals dating back to 2013/14 and 2011/12 but none for the period 2015/16. Feedback from staff and the registered manager confirmed that opportunities for staff development including regular supervision and annual appraisal were not yet in place. This meant the provider was not providing adequate support to all staff to enable them to carry out their roles and responsibilities effectively. The above relates to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. The application procedures for this in domiciliary care services are to be made to the Court of Protection. We found the service to be acting within the Mental Capacity Act 2005 (MCA) legislation. Staff we spoke with were able to describe the main principles behind the MCA 2005. In care records we looked at, we saw that people had signed service contracts (where this was possible), demonstrating people had consented to receiving care and support from the provider. Where people were unable to sign to give their consent, documents were signed by senior staff and family members on their behalf where appropriate.

Where possible, initial assessments were completed before a package of care was organised. Care plans recorded people's health care needs and included contact details, information relating to personal care, medicines, communication and personal care needs. Care plans also included information relating to food

and fluid intake and highlighted where people had been identified as being at risk from dehydration and/or malnutrition. Some staff told us they had received training in food hygiene and preparation. People told us that staff prepared simple meals for them or heated up their pre-prepared meals. Staff recorded people's meal and drink choices in daily logs but we noted that where it was perhaps important to record specific food and drink choices, for example; where people had been diagnosed with diabetes or were losing weight, information in daily logs was non-specific with comments such as, 'served lunch' and 'meal heated up.' This meant that it would have been difficult for family members and health professionals to monitor people's food intake in the event of any deterioration.

Requires Improvement

Is the service caring?

Our findings

People we spoke with were positive about their regular care staff and told us, "The carers are mostly helpful, pleasant and kind", and "staff are very nice and very good, and well trained." Relatives told us "Carers do a very good job", "The care has been exemplary", and "I can't speak highly enough of the carers, they are sensational; their care and concern, they go the extra mile."

Some care plans (but not all) specified what support people required with personal care. One person had requested a bath twice weekly. We checked this person's daily notes to see if they were receiving this assistance and were unable to find any information relating to bathing in the two week period we reviewed. People we spoke with told us they did not feel that staff always had adequate time to provide them with a person-centred service. For example; we were told, "My carer is supposed to do an hour but sometime leaves early", and "[Care staff] did the work in 15 minutes and then left, I'm supposed to have an hour, I pay for it." Another person told us, "I have to go to hospital on Wednesdays, If only they could come on time, it would make my life so much more pleasant."

We were told that where possible, the provider attempted to ensure continuity of service by ensuring people were visited by the same team of staff. However, people told us that this did not always happen. People told us, "I have a different carer every day and I have to explain everything all the time and another person told us they had made a formal complaint about being supported by 17 different carers in a 16 day period. Staff told us that travel time was not always factored into their timetables which made it very difficult for them to arrive and leave on time.

Staff understood the importance of ensuring people's privacy and maintaining their dignity. One care worker told us that they knocked on doors before entering and made sure curtains or blinds were pulled before delivering personal care and that there were plenty of towels available to hand. One person told us, "[My carer] knows what to do, when washing me [they say] "I won't leave you" and I feel safe." Staff told us they always asked people for their verbal consent before they began to deliver personal care, so that people felt consulted and respected at all times. One person using the service told us, "My carer is a dear; [they] always ask me, if they are doing something different, they let me know, I trust them and feel safe with them."

Staff completed daily notes after each visit and returned completed daily notes to the office on a monthly basis. We reviewed copies of returned notes and found that staff were recording a brief summary of tasks undertaken and noting when someone was not feeling well, or where items such as incontinence pads were unavailable, food stocks were low and/or where medicines had not been delivered. It was unclear whether this information was then passed on to the relevant services and/or health and social care professionals in a timely manner so that any necessary action could be taken. We noted that the language used to record people's continence issues was not always sensitive or respectful of people's dignity.

Care plans were held securely in the office and another copy was kept within people's homes. Staff told us, "I always read care plans to keep my memory jogged and to see what people might need especially if they are new to me." Staff understood the importance of protecting people's confidentiality and keeping records

secure.

Requires Improvement

Is the service responsive?

Our findings

People using the service and their relatives told us they knew how to make a complaint if they were unhappy about anything. The provider had systems in place for recording complaints which included recording the nature of the complaint and the action taken. People we spoke with told us they had complained about the reliability of the service in regards to visit times and communication between themselves and office staff. People's comments included, "Every day I have to ring them to know who's coming over the weekend. They tell me they're going to get back to me but they never do", and "You ring the office and they never get back to you. No-one answers the phones in the evenings" Relatives told us "I'd love to make a complaint but I don't think it's fair on staff", and "It's very topsy turvy in the office, we should have been notified about changes to management."

Visit times were discussed as part of the initial assessment process and people and their relatives confirmed that they had been given a choice about what time they wished to be visited. Staff were provided with a mobile hand set which was used to log in and out of people's homes via a simple scanning mechanism attached to people's care plan folders. People we spoke with confirmed that care staff logged in and out each time they visited. Visits were monitored by staff based in the main office.

However, we heard many comments relating to late visits, missed visits and lack of information and updates regarding delays and scheduling errors. These issues appeared to worsen over the weekend and during school holiday periods. For example, people told us, "I'm very unhappy. I was left waiting for care on Sunday", "I'm very worried about the holidays coming up", and "Nobody turned up until 10:40 for an 8.00 o'clock appointment, this lack of care is making me very poorly." We heard that one relative had asked for changes to be made to the time their family member was visited in order for them to arrive at their place of education on time. Following this request, we noted that staff had arrived late over 12 times in a recorded three week period.

We looked at the care records of 16 people and found evidence that people and their family members (where appropriate) had been involved in the development of care plans. Care records we looked at contained brief details about people's life histories, current interests and personal preferences. Reviews of people's care and support needs took place either through meetings in people's homes or via telephone discussions with people and their relatives (where appropriate). Not all care plans had been reviewed and updated in line with the provider's policies and procedures. Some people who used the service told us there were no regular reviews of their care and support needs. One person said; "My care plan is out of date, it doesn't apply, they're working in the dark. It hasn't been updated since October 2015." Another person told us, "No-one comes round to see me or ask about me, they should come round to see us." The issues described here and above relate to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents or incidents were being recorded in line with the provider's policies and procedures. In We saw evidence in people's daily logs that staff had contacted emergency services in a medical emergency. Staff told us they contacted senior staff members in the office to inform them of any emergency situation who in

turn contacted family members. The service had procedures in place for when staff were unable to access people's homes which included checking with neighbours and the main office for advice or contacting the police if necessary.

Requires Improvement

Is the service well-led?

Our findings

We heard many negative comments from people using the service, relatives and staff about the management and organisation of the service. People told us, "There is a real admin problem in the office", and "I wish I'd stayed with my other care service, they were much better managed. The carers are mostly pleasant; it's the management that is lacking." Relative's told us there had been issues with new systems and communication with the office, but that "things are slowly improving." Staff complained about last minute changes made to their rotas and unrealistic expectations in relation to travel time between visits. One member of staff told us, "We are always rushing from one place to another", and another staff member told us, "Sometimes we're scheduled to be in two places at the same time."

The service had a registered manager in post. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Staff told us that the Director of care and the registered manger were supportive but that at times they didn't feel listened to. Staff told us they attended meetings but that these were not held on a regular basis.

Standards of record keeping were observed to be inconsistent. We saw evidence that care plans and risk assessments were not always accurate or up to date. This meant that staff did not always have access to up to date and complete records in respect of each person using the service, which potentially put people at risk of harm.

Spot checks and staff observations were conducted to ensure the effectiveness and quality of the care and that staff were appropriately dressed, had their identification present, treated the person with dignity and respect and completed paperwork appropriately. However, these checks were not being carried out on a regular basis.

The provider's quality assurance systems and processes did not ensure that they were able to assess and monitor the quality of the service and mitigate the risks relating to the health, safety and welfare of service users. Six monthly service reviews had not been completed and auditing systems in place to monitor the quality of daily records or medicines were inadequate.

The Director of Care and the Registered Manager recognised that the service had encountered issues at the start of the new contract awarded and demonstrated a commitment to improving standards, process and procedures to ensure people were safe and happy with the care they received. Despite this, we found there was a lack of management oversight, inconsistent supervision for staff members and ineffective quality assurance systems at the time of our visit. These shortfalls relate to a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider must notify the Care Quality Commission of any important event that affects people's welfare, health and safety so that where action is needed, action can be taken. Regulation 18 (1), (2) (e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that care and treatment was appropriate, met people's needs and reflected their preferences. Regulation 9 (1) (a), (b), (c)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that risks to the health and safety of service users were regularly assessed and that these risks were mitigated. Regulation 12 (1) (2) (a), (b)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems

to monitor and improve the quality and safety of the services provided, to monitor and mitigate the risks relating to health safety and welfare of service users.
Regulation 17 (1), (2) (a), (b), (c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not adequately support staff to carry out their roles and responsibilities. Regulation 18(2)(a)