Virtue Care Ltd

42 Alexandra Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
42 Alexandra Road is a domiciliary care agency which was providing personal care to 19 people on the day of the site visit. Staff provide people with either care calls or 24 hour live-in care. The provider's office is located in Farnborough and they provide care to people living in Hampshire, Bracknell and Hounslow. They provide care to both younger and older adults, who may have a disability, a mental health diagnosis, a learning disability or who may be living with dementia.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People did not always receive their medicines safely. The provider had not ensured all staff understood their medicines training and were fully competent at managing people's medicines safely. Staff did not always have the required guidance to direct them in the administration of medicines prescribed for use, 'as required.'

There had been a failure to fully mitigate potential risks to people from shortened care calls or to maintain accurate and complete records of the delivery of people's care. The provider had failed to submit to CQC two notifications of events at the time they occurred.

Staff had completed safeguarding training and understood what to report. The provider co-operated with safeguarding investigations, but was not able to demonstrate their response to identified issues had always been fully effective in ensuring the required changes were made.

The provider had assessed potential risks to people and where risks had been identified, measures were in place to manage them. Some relatives did report specific issues in relation to risk management, which they felt created potential risks. There was evidence staff meetings had been held when things went wrong, in order to share information and learning from incidents.

Overall there were sufficient staff for their role. Not all staff had the required level of competence and skill to provide people's care safely. Staff had received relevant infection control training and followed relevant guidance to protect people and themselves from the risks of acquiring an infection.

People and their relative's reported although they liked the registered manager, they were not always consistently effective at leading the service and ensuring people experienced good outcomes from their care. Not all staff understood the fundamental need to provide a quality service.

The provider audited various aspects of the service and used their audits to identify potential areas for

improvement. The provider overall worked collaboratively with external partners.

Rating at last inspection
The last rating for this service was good (published 28 April 2021).

Why we inspected
We had received concerns in relation to medicines, safe care and the quality of care provided. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 42 Alexandra Road on our website at www.cqc.org.uk.

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

We have identified breaches in relation to safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

42 Alexandra Road

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided

Notice of inspection
We gave the service a short notice period of the inspection activity, because it is small, we needed to be sure they would be available. Inspection activity started on 1 October 2021 and ended on 22 October 2021. We visited the office location on 18 October 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information during the inspection. We reviewed information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We sought feedback from commissioners about the service. We used all of this information to plan our inspection.

During the inspection
We spoke with three people and six relatives about the care provided. We also spoke with the registered manager who is also the provider and two members of staff. We reviewed five people's care records and

their medicines records. We also reviewed two staff recruitment records.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- The provider had not ensured the proper and safe management of medicines at all times.
- Staff had not always documented the administration of a person's medicine on their medicine administration record (MAR), in accordance with the provider's policy. One staff member when asked about whether they always recorded a person's medication on their MAR, told us, 'I was a bit relaxed'. A second staff member, said they recorded the administration of a person's medication in their daily records, but not always on the MAR. National guidance requires the administration of a person's medicines is always recorded on their MAR.
- One staff member told us they had not completed the provider's medicines training. They and a second staff member also told us they had not had their medicines competency assessed. Although records showed all staff had been medicines trained and had their medicines competency assessed, it was not fully effective. The provider had since taken action regards one staff member and another has since left the provider's employment.
- One person's electronic MAR showed on three occasions, their medications had not been administered at the time of day prescribed. The registered manager said staff may have administered the medicine at the correct time but then not completed the MAR until later. Medicine records should be completed as soon as the medicine has been administered, with no undue delays.
- One person had a missed call, which resulted in their medicines not being administered. These included a medication prescribed to prevent the formation of harmful blood clots. Although the person did not experience harm, there was a risk they may have done.
- Two people were prescribed medicines to be administered 'as needed.' There was a lack of written guidance for staff to enable them to understand when the person might require the medication or how long should be left between doses. National guidance requires 'robust processes' should be in place for 'as required' medicines.

We found no evidence people had been harmed, however, the failure to ensure peoples' medicines were managed safely placed them at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Staff had all completed safeguarding adults training and had access to the provider's safeguarding guidance. Staff spoken with understood their responsibility to report any safeguarding concerns to the provider.
- There had been two recent safeguarding's raised, following concerns about aspects of people's care. The

provider had co-operated with these enquiries. However, they were not able to demonstrate they had effectively addressed all of the concerns which arose from one safeguarding alert. This meant one of the issues carried on and was not fully addressed for the person, who is no longer receiving care from the service.

Assessing risk, safety monitoring and management

● The provider had assessed potential risks to people and where risks had been identified, measures were in place to manage them. Risks related to people's moving and transfers, falling, wheelchair use, bathing, skin integrity, fire and their home environment had been assessed. A professional told us how the provider had identified and reported to them an environmental risk with the provision of one person's care, they had identified when the care commenced.

● People and their relatives did report some specific issues in relation to risk management. A relative told us they had found on one occasion staff had left the person's key safe on the code which opened it, this placed the person at risk of unauthorised access to their property. Another relative told us a medical device their loved one used to prevent swelling, had not been referenced in their care plan to guide staff.

Staffing and recruitment

● Not all staff had the required level of competence and skill to provide people's care safely. A relative told us the staff member providing end of life care to their loved one lacked sufficient knowledge. Although records showed the staff member had completed training in this area, when we spoke with them they could not recall this training. The provider has since taken appropriate action to re-train this staff member.

● Overall there were sufficient staff for their role. However, one person told us, on occasions only one care staff was provided instead of two as commissioned. Although the person told us when this happened "they could manage," they had been assessed as requiring two staff to provide their care. Not all care staff could drive and they were dependent on either public transport or the provider to get to people's calls. A staff member told us this was not a problem if they were based in the same geographical area for the day, but it could be an issue if they needed to travel between areas. A relative reported they were concerned if the provider was not available, to transport staff.

● The provider had policies and processes in place to ensure staff's suitability for their role. Their staff pre-employment recruitment checks included a Disclosure and Barring Service (DBS) check and other relevant checks upon staff's suitability for their role.

Preventing and controlling infection

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of their office.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

● Staff meetings had been held when things went wrong, in order to share information and learning from incidents. Following a recent safeguarding, a meeting had been held with staff to share the outcome and to reinforce the provider's expectations by ensuring staff were reminded of the relevant guidance.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- We found two examples where people's care calls were shortened. One person's relative told us their loved one's care calls had been shortened, which records confirmed. They said the person was living with dementia and was therefore, "not getting the interaction [person] needs." The person's daily care notes documented the physical care staff had provided, but did not demonstrate time had been spent with the person, socially stimulating them. People had not always received calls of the length commissioned to fully meet their needs.
- The provider did not have effective systems to mitigate the risk of missed calls. One person's relative told us how staff had failed to arrive for a planned care call and they were not informed, this person would not have received their care if their relative had not supported them. The provider had not ensured staff followed their policies around appropriate actions to take if staff were unable to gain access to people's homes. The provider had not ensured guidance was detailed in the person's care records. National guidance requires a person's risk assessment should state what should happen if a visit is missed.
- Daily care records for two people were incomplete and not all daily records for a third person were readily available. The provider advised this was due to problems with internet reception in some areas, which meant staff then had to complete handwritten records. However, these had not yet been collected from people's homes to provide a complete record or to enable them to be reviewed.
- One person's records contained the name of a person who was not their relative and another person's risk assessment, noted their gender incorrectly. One person's key safe was not mentioned in the person's care records for staff's information. Staff had noted on one person's electronic daily records, they had input another person's notes. There was variance in the quality of people's daily notes. One person's notes were very detailed, whilst two people's notes contained minimal detail of the care provided. The provider had not ensured people had accurate and complete records.
- Two people's relatives told us their loved one's care plan records covered their care needs but were rather 'basic' and said they had to supplement them with their own instructions for care staff about their loved one's routine. Records confirmed one person was living with dementia, but their care plan lacked sufficient detail about how staff should meet their needs for social stimulation.

The provider had failed to fully mitigate the risks relating to people's safety and welfare or to always maintain accurate and complete records. These were breaches of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to notify CQC of two recent notifiable incidents at the time they occurred as legally required. This meant the commission were not aware of relevant information in relation to these two events to enable us to monitor the service provided and to consider if any regulatory action was required. The provider immediately submitted the two notifications once this omission was brought to their attention.

Continuous learning and improving care

● The provider had in place processes to audit the quality of the service provided. They completed monthly audits of people's records, medicine records and staff recruitment. The provider's September 2021 records and medicines audits, had identified issues in relation to daily records, staff accessing the electronic records system and medicine records completion. Actions to address these issues had been identified. It will take further time for the provider to be able to demonstrate the effectiveness of their planned actions.

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

● People and their relatives were positive overall about the care provided and most liked the registered manager who was also the provider. Some people told us they knew the registered manager as they often provided their care. However, they did not all consistently feel they were fully effective at leading and managing the service. One relative reported they had to raise issues on several occasions and said communication was not always good. Another described their experience as, 'Appalling.' Another relative told us although the issues they raised had been addressed, this had taken time.

● Two relatives spoken with felt the care provided had not achieved good outcomes for their loved ones. A relative reported their loved one's calls were shortened and their care needs were not always fully met. They did not feel these issues had been adequately addressed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● No-one had experienced a notifiable safety incident. The registered manager understood their legal duties in the event anyone experienced such an incident.

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

● Some people and their relatives told us they did not have a copy of their care plan or could not access their records. The provider was due to complete a survey with people to gather their views on the service.

● Not all staff understood the fundamental need to provide a quality service. Records showed one member of staff had five observations of their practice during the four months of their employment, they have since left and appropriate action had been taken in relation to a second staff member.

Working in partnership with others

● The provider was commissioned to provide care by both health and social care commissioners across two counties and one London borough. They worked with a number of partner agencies, two of whom expressed concerns about aspects of the care provided to two people.

● The provider was responsive and co-operative with partnership agencies when issues were raised.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure peoples' medicines were managed safely which placed them at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to fully mitigate the risks relating to people's safety and welfare or to always maintain accurate and complete records.