Visionshealthcare Limited

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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

About the service
Visionshealthcare Ltd is a domiciliary care agency. The service provides personal care to people living in their own homes. "At the time of our inspection there were 4 people using the service, of which 3 received personal care.

Not everyone who used the service received personal care. In this service, the Care Quality Commission can only inspect the service received by people who get support with personal care. This includes help with tasks related to personal hygiene and eating. Where people receive such support, we also consider any wider social care provided.

People's experience of using this service and what we found
At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

Right Support:
People did not always receive care from consistent staff members at a consistent time each day. This compromised the quality of their care. Medicines were not managed safely. Individual risks were not being assessed or managed safely and accidents and incidents were not recorded safely, or lessons learnt. Care records did not always reflect people's preferences. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care:
Care records including risk assessments were incomplete meaning staff did not always have the correct information on how to deliver safe care. People's care plans did not always contain sufficient information about people's needs, preferences and routines. The care people received did not always reflect their preferences and choices. Relatives did not have access to information about what care had been provided to their family member. Daily care records had been destroyed by the provider.

Right Culture:
There were no governance systems to ensure people were kept safe and received high quality care and support in line with their personal needs. This meant the provider could not be proactive in identifying issues and concerns in a timely way. Staff did not receive the training they needed to meet people's needs and deliver a safe service. The service was not submitting statutory notifications when incidents had occurred, as required.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was good (published 14 December 2018)

Why we inspected
The inspection was prompted in part due to concerns received about a lack of responsive care and poor communication. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to risk and the safe management of medicines. We also identified breaches in relation to person centred care, good governance and ensuing statutory notifications are submitted to CQC where required.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Visionshealthcare Ltd

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 Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 2 inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. This person was also the provider of the service. They were unable to support this inspection so we met with and engaged with the providers representative who was also a director of the provider company. We have referred to them as 'providers representative' throughout this report.

Notice of inspection
We gave the service 12 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 20 September 2023 and ended on 3 October 2023. We visited the location's office on 3 October 2023. There was a delay in gathering evidence for this inspection as the providers representative told us the provider and they were out of the country and there was no one available to open the office and provide us with access to the records.

What we did before the inspection
We reviewed our systems and information we held about the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report.

During the inspection
We spoke with 2 people who used the service about their experience of the care provided. We also received written feedback from a further person and 2 relatives. We also had contact with 6 members of staff including care staff the provider and the providers representative. We reviewed the limited range of records available. This included care plans and staff recruitment records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection, the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse. A safe system had not been developed to ensure allegations of abuse were recorded, acted on, investigated and lessons learned as a result of the findings.
- Where safeguarding concerns were being investigated by the Local Authority, there were no record held at the service about the concerns, or the actions taken to ensure people were protected from the risk of abuse.

This was a breach of regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong, Using medicines safely

- Risks to people were not assessed, monitored, or managed well. There was not always written guidance or control measures in place to mitigate risks. This was unsafe.
- Care plans and risk assessments were not comprehensive and lacked detail about people's care and health needs. For example, people who had an identified risk of choking had no risk assessments in place to guide staff on how to support them to eat safely, or how to respond if they choked. This lack of information meant people were at an increased risk of harm of choking.
- People's health, care and support plans did not consistently include information on specific health issues, this meant there was a risk that people's health could deteriorate. For example, there was no specific guidance in place for one person who required support to manage their catheter. Another person had no epilepsy plan in place. This placed people at risk of harm.
- People were exposed to avoidable risk of harm as systems to ensure the safe and proper management of medicines were inadequate. We identified staff were administering medicines without appropriate records, including medication administration (MAR) charts, being kept.
- The manager was unable to provide completed accident reports where these had occurred. One accident report which had been completed had no evidence of the actions taken, if this had been followed up by the management, or if any lessons had been learned. The care plan and risk assessment had not been updated to reflect the accident.
- There were no 'as required' (PRN) medicine protocols in place. PRN protocols guide staff in safely administering medicines that are only needed for a specific situation for example pain relief. This placed people at risk of harm as staff would not know when and how those medicines should be administered leading to the potential for too much or too little medicine to be given.
- Information in people's care records about medicines was limited and did not reflect their preferences, for example how they took their medicines.

● Not all staff had their competency to administer medicines assessed. This meant there was a risk medicines could be administered by staff that did not have the skills to do so safely.

This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People did not always have consistent staff providing their calls. This meant people did not get to know staff well and staff did not always understand people's routines and preferences. People told us that staff on induction who would be working in another side of the providers business were often sent to provide their care as part of their induction. One person told us, "Sometimes there is one carer, sometimes there are two if they are training, but it is quite a large team, so I rarely get the same people which can be a bit wearing at times."

● An effective rota system was not in place. People were not assured of continuity of care as visits often changed and this was not always communicated to them.

● The provider did not monitor people's call times to ensure they were not put at risk by variance in punctuality or call duration. The provider relied on people being able to contact them or to alert them if a carer had not arrived.

The provider did not have an effective system to monitor and identify that people received their care on time and for the planned duration This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to ensure staff were recruited safely. An effective system to ensure staff had completed all necessary checks before being employed was not in place. The provider did not have oversight of recruitment processes to ensure that fit and proper persons were employed. This failure placed vulnerable people at risk of receiving care from staff who were not of good character.

● We reviewed records where we identified legal requirements had not been met. This included ensuring staff had satisfactory references.

Preventing and controlling infection

● Most people and relatives we spoke with confirmed staff wore appropriate personal protective equipment (PPE).

● Staff told us the personal PPE they needed to prevent and control the spread of infection was available to them however, they had not undertaken infection control training.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection, the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- We were not assured that systems were in place to ensure staff were supported in their roles and had the necessary training to deliver safe care. Staff had only undertaken minimal training that did not include practical moving and repositioning, first aid, health and safety, diabetes, catheter care and infection control to name but a few.
- Induction records showed that staff completed their whole induction in one day. We questioned the effectiveness of this and the quality of training to be done in such a short space of time. Feedback on staff performance was informal and not well organised or recorded.
- Staff support was variable. Supervision records did not demonstrate a supportive conversation and sessions were held infrequently.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet

- Assessments of people's care needs had not always been completed in detail. Some care plans lacked detail around specific health conditions. This increased the risk of people not having their needs effectively met.
- People's care records were not consistently updated as staff got to know people or when there were changes in their support needs.
- Care plans outlined the support required for people to maintain adequate nutrition and hydration. However, further detail was needed to guide staff on managing dietary risks. For example, the nutritional care plan for a person who had diabetes did not contain guidance on the management of and risks associated with this health condition.
- People who were at risk of choking and required a modified diet or fluid intake did not have this information clearly recorded in their care plan to ensure staff knew how to safely support them.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- External professionals told us they found communication with the service extremely challenging with no response received from the provider to emails and telephone calls. We were also told that professionals had arranged visits to the Visionshealthcare Ltd office where they would find no one there.
- Staff told us they knew what to do if they had concerns about a person's health or if there was a medical emergency.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

● Improvements were needed to people's care records to show that they had consented to their care and support when they began to receive the service and were involved as much as possible.
● A section on people's care plans for them to consent to their care, or for a best interest's decision to be recorded, had not been completed.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection, the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls. Some people told us they did not feel well cared for.

Respecting and promoting people's privacy, dignity and independence
- We had mixed feedback about the care people received. One person told us, "There is one carer that will chat, but 9 out of 10 do not bother. It is a shame, because there is very little or no adult interaction in my day otherwise." Another person said, "They are here to do a job for me, so I am not surprised that they do not want to talk to me. Some hardly speak at all, but just get on with the job. Others can be a bit more caring."
- People had not been supported to maintain and develop their independence. People's care plans did not include guidance on how to encourage or support people to do things for themselves.

Supporting people to express their views and be involved in making decisions about their care
- People's views were not clearly recorded. Care plans did not document preferred methods of communication to enable staff to support people in expressing their views and making decisions about their care.
- Some people who used the service and relatives raised concerns that communication with staff whose first language was not English, was not always effective. They also told us that staff would visit them in pairs or threes and would talk 'over' them and not in English. This was not respectful practice and meant there was a risk that people would not receive their care as they preferred. One person told us, "They [carers] often speak in their own language and I do not know what is being said most of the time. It makes me uncomfortable, but I do not really know how to approach them about it. I do not feel I should have to."

Ensuring people are well treated and supported; respecting equality and diversity
- Care plans only contained basic details about people and lacked information to help staff get to know people well, including people's preferences, personal histories, and backgrounds
- The provider had not ensured that people always received a caring service. For example, appropriate recruitment checks and processes had not been completed on staff to ensure they were safe to work with vulnerable people.
- There was mixed feedback from people and relatives about continuity of care enabling them to build caring and trusting relationships with staff.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection, the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Personal care had not been planned to support people's choice and control to meet their needs and preferences.
- People did not have person-centred care plans in place to guide staff and ensure they received personalised care.
- Care records were incomplete, inconsistent, too basic or failed to guide staff about how to support people's individual needs. For example, people who had a medical diagnosis had no care plan or risk assessment to ensure they received appropriate care.
- There were limited or no daily records. The provider's representative told us they had thrown away and destroyed all of the daily care records as they were not aware they needed to keep them. This did not support the care staff to provide consistent care.

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Some people raised some concerns about the staff team's ability to communicate effectively.
- Some people reported a communication barrier between some staff and people, meaning people could not have a chat with staff. One person told us, "Staff have very little English, don't really want to engage and could certainly do with more training in basic everyday tasks."

Improving care quality in response to complaints or concerns

- We asked to look at the system to manage complaints. Whilst there was a complaints policy there was no system for recording or logging complaints.

End of life care and support

- At the time of the inspection, no one supported by the service was receiving end of life care.
- End of life care planning had not been considered with people. None of the staff had completed end of life

care training.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection, the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Working in partnership with others; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● During this inspection we identified widespread failings. The provider failed to ensure systems were in place to protect people from the risks associated with their care and support needs. This included inadequate care monitoring, management or risk and the unsafe management of medicines. We identified multiple breaches of the regulations at this inspection. These failings had not been identified by the provider prior to our inspection.
● Due to the numerous issues with visit times and lack of responsiveness from the provider the majority of people did not speak highly of the organisation. We received comments such as, "It depends on what someone wants from a service, but if they are looking to get to know their carers, this would not be for them. If they just want the support, then they can do that." Another person told us, "I really need consistency, but they do not seem able to do that. Some of the carers do not know what they are supposed to do either. I have not ever seen a care plan and I don't think they have either."
● There were no management systems in place. The provider was not undertaking any audits to ensure people's needs were met and that the service was safe. The local authority had issued the provider with an action plan to make improvements in November 2022. The provider had failed to make any progress of update the action plan in the last 11 months.
● People did not receive a service that was well-led. The provider had been away from work for an extended period of time and had not ensured the service was managed effectively in their absence. The providers representative did not have an adequate understanding of their role, regulatory requirements and lacked oversight of the service. Monitoring systems had not been effectively implemented to ensure oversight of the service.
● The provider had not ensured staff had the necessary skills, knowledge and guidance to enable them to provide consistently good quality care
● The provider was unable to provide adequate explanation for the issues identified throughout the inspection such as ineffective care plans and risk assessments, a lack of staff training and no competency assessments.
● The provider failed to communicate effectively with external agencies and there was a lack of

transparency.
● The provider had not developed systems for people to give their feedback about the quality of the service. Neither people nor their relatives had been asked to provide feedback about the service they received.

There were no systems in place to ensure adequate oversight of the service and to demonstrate good governance. This was a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider failed to ensure statutory notifications were submitted to the Care Quality Commission where required in line with their statutory responsibilities.

Systems had not been developed to ensure notifications were submitted to the Care Quality Commission without delay. This was a breach of regulation 18 (1) (2) Notification of other incidents of the Health and Social Care Act 2008 (Registrations) Regulations 2009

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 provider failed to ensure statutory notifications were submitted to the Care Quality Commission without delay.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure staff supported people's individual care needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not do all that was practicable to ensure that care and treatment was provided in a safe way as risks to people were not always identified and mitigated. Systems for the proper and safe management of medicines were not operated effectively

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of governance and oversight at the service.

The enforcement action we took:

We issued a Notice of Decision to cancel the provider's registration.