Versacare Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Inspected but not rated
Is the service caring?	Inspected but not rated
Is the service responsive?	Inspected but not rated
Is the service well-led?	Good

Summary of findings

Overall summary

This report was created as part of a pilot which looked at new and innovative ways of fulfilling CQC's regulatory obligations and responding to risk in light of the Covid-19 pandemic. This was conducted with the consent of the provider. Unless the report says otherwise, we obtained the information in it without visiting the Provider.

About the service
Versacare are a specialist 24 hour live-in care provider. The service provides care workers to enable people who require 24 hour support to remain in their own home. At the time of inspection, Versacare were providing personal care to 87 people.

People's experience of using this service and what we found
People expressed satisfaction with the care and support they received. People and their relatives spoke highly about care workers and the management of the service. People also told us they were involved in making decisions about their care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. Policies and systems in the service did not always support this practice in relation to medicines, however the provider took immediate action to rectify this. We have made a recommendation about medicines protocols.

The provider had systems in place to protect people from abuse and people told us they felt safe. Risk assessments were in place to help minimise risks people faced. Infection control measures were in operation. There were enough staff employed to support people and checks were carried out on staff to verify they were suitable to work in the care sector. Steps were taken to learn lessons if things went wrong.

People told us staff were caring and respectful. Staff had a good understanding of how to support people in a way that promoted their privacy, dignity and independence. The service worked to meet people's needs in relation to equality and diversity issues.

Care plans were in place which set out how to support people in a personalised manner. People had been involved in planning their care. End of life care plans were in place for people.

People and staff spoke positively about the registered managers, saying they found them to be approachable and easily accessible. Systems were in place for monitoring and reviewing the quality of care and support provided. The provider worked with other agencies to develop knowledge and share best practice.

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

Rating at last inspection.
The last rating for this service was good (published 26 September 2017).

Why we inspected
This was a planned pilot virtual inspection. The report was created as part of a pilot which looked at new and innovative ways of fulfilling CQC's regulatory obligations and responding to risk in light of the Covid-19 pandemic. This was conducted with the consent of the provider. Unless the report says otherwise, we obtained the information in it without visiting the Provider.

The pilot inspection considered the key questions of safe and well-led and provide a rating for those key questions. Only parts of the effective, caring and responsive key questions were considered, and therefore the ratings for these key questions are those awarded at the last inspection.

Follow up
We will continue to monitor information we receive about the service until we 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?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question good. We have not reviewed the rating at this inspection. This is because we have not reviewed all of the key lines of enquiry (KLOEs) in relation to effective.

Is the service caring?

Inspected but not rated

At our last inspection we rated this key question good. We have not reviewed the rating at this inspection. This is because we have not reviewed all of the key lines of enquiry (KLOEs) in relation to caring.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question good. We have not reviewed the rating at this inspection. This is because we have not reviewed all of the key lines of enquiry (KLOEs) in relation to responsive.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

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Detailed findings

Background to this inspection

The inspection
As part of a pilot into virtual inspections of domiciliary and extra-care housing services, the Care Quality Commission conducted an inspection of this provider on 26, 27, 28, 29, 30 October and 2 November 2020. The inspection was carried out with the consent of the provider and was part of a pilot to gather information to inform CQC whether it might be possible to conduct inspections in a different way in the future. We completed this inspection using virtual methods and online tools such as electronic file sharing, video calls and phone calls to gather the information we rely on to form a judgement on the care and support provided. At no time did we visit the provider's or location's office as we usually would when conducting an inspection.

Inspection team
The inspection was carried out by an inspector, a medicines 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 specialist 24 hour live-in care provider. The service provides care workers to enable people who require 24 hour support to remain in their own home. People using the service ranged from young adults to the elderly.

The service had two managers 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
The provider was aware we would be inspecting between October and the end of November as they had agreed to participate in the pilot. Inspection activity started on the 26 October 2020 and ended on the 2 November 2020.

What we did before the inspection
Before our inspection we reviewed the information we held about the service which included statutory

notifications we had received in the last 12 months and the Provider Information Return (PIR). The PIR is a form we ask the provider to complete which gives us some key information about the service, including what the service does well, what they could do better and improvements they plan to make.

During the inspection
We spoke with three people who used the service and seven relatives. We spoke with eight members of staff including the registered managers, care workers and the recruitment manager.

We reviewed a range of records including eight care plans and risk assessments, as well as four staff files in relation to recruitment. We also looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at medicine records and updated policies.

Good

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 remained the same. This meant people were safe and protected from avoidable harm.

Using medicines safely
• Guidance on how to administer 'as and when required' medicines and covert medicines wasn't always clear. People who were given medicines in this way had generalised information in their medicines care plans, that was not always personalised.
• However, the provider immediately rectified this and developed protocols to give staff more detailed information on 'as and when required' medicines and covert administration of medicines and we saw examples of the newly developed documents and protocols which had been cascaded to all staff.

We recommend that the provider continues with their work on personalising documents relating to 'as and when required' medicines and covert medicines.

• Staff were trained to administer medicines and their competence was assessed regularly.
• People were supported to manage their own medicines where possible. The assessment was reviewed regularly, and the level of support was adjusted as people's needs changed.
• The service contacted the relevant people to assess that it was in the person's best interests to have their medicines administered covertly.

Systems and processes to safeguard people from the risk of abuse
• People and their relatives told us they felt safe. One person told us, "I feel absolutely safe with [carer worker]. I can rely on them to arrive and look after me well."
• Staff had undertaken training about safeguarding and understood their responsibility to report any allegations of abuse. One staff member told us "It is crucial that I report and raise my concerns to the manager without any delay. The manager will then liaise with other authorities, such as social services to investigate the matter."
• Systems were in place to protect people from the risk of abuse. There was a safeguarding adult's policy in place. The policy made clear the service had a responsibility to report any allegations of abuse to the local authority and the Care Quality Commission.

Assessing risk, safety monitoring and management
• Risk assessments were in place for people. These set out the risks they faced and included information about how to mitigate those risks. They were detailed and personalised and based around the needs of the individuals. People had been involved in developing their risk assessments, and they were subject to regular review.
• Risks were discussed during staff handover and checks were in place to ensure information was relayed to the member of staff taking over. This included the needs of the person and whether there were any changes,

medicines, moving and handling, medicines, incidents, cleanliness and finances.
• The provider told us they had checks in place for people who were supported with their finances and we saw examples of this. One of the registered managers explained, "Nearly all our carers manage some petty cash for clients, mostly delivered by family. All cash in and out is recorded on finance sheets. We check finances at visits."

Staffing and recruitment
• People and their relatives told us they were happy with their live-in carers and any changes were communicated to them immediately. A relative told us "[Person] has one regular carer but they always make sure cover is available if needed."
• The provider carried out robust checks on staff before they commenced working at the service. These included employment references, proof of identification and criminal record checks. All forms of identification were subject to additional checks using specific technology to determine their authenticity. This meant the provider sought to employ staff that were suitable to work in a care setting.

Preventing and controlling infection
• People and their relatives told us that staff adhered to infection control and prevention practice. A relative told us, "They are very aware at the moment of hygiene and wearing gloves and aprons."
• The provider had a policy in place about infection control. This provided guidance to staff about safe practice in this area. As the service provides live-in care, staff lived in people's homes for up to six weeks at a time. The registered manager explained, "[Staff] do of course use and [are] required to wear gloves and aprons for personal care, medication, cooking etc, and this has always been the case."
• The registered managers also told us about precautions they adhered to when a new carer took over for live-in care. "We follow current government covid guidance and those who need to isolate for 14 days do so. All carers travelling by public transport have been reminded to wear face masks whilst travelling, wash hands on arrival, keep distance from all on arrival and change clothing before any close contact with current carer[worker] or [person using the service]. Our carers are really strict with one another about this, and rightly so."

Learning lessons when things go wrong
• Lessons were learnt when things went wrong. Accidents and incidents were recorded by staff and reviewed by the registered managers. This enabled them to see what caused the incident and what could be done to reduce the likelihood of a similar incident occurring again.

Inspected but not rated

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 the last inspection this key question was rated as good. We have not reviewed the rating at this inspection. This is because this inspection was carried out as part of a DCA pilot inspection and only part of this key question was reviewed.

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 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.

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. We checked whether the service was working within the principles of the MCA.

• Records documented where a person lacked capacity in their care records. We were given examples where the service worked with healthcare professionals and family when a decision about care was required in the person's best interests.
• Staff understood the importance of supporting people to make choices and were able to explain how they did this. People confirmed they were able to make decisions about their care. One person told us, "Yes they do listen and take everything on board that I say or ask of them."
• People had signed their care plans, and consent forms to agree to the care they received in line with their assessed needs.

Inspected but not rated

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 the last inspection this key question was rated as good. We have not reviewed the rating at this inspection. This is because this inspection was carried out as part of a DCA pilot inspection and only part of this key question was reviewed.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us they were well treated and supported. They had good relationships with the care workers who supported them. Some of their comments included, "I think they are excellent carers. They work very hard and don't cut any corners at all" and "They are very kind and caring people."
• Staff understood the importance of promoting people's privacy, dignity and independence. A relative told us, "I think they do treat [person] with dignity, they never rush her, they let her take her time and are very patient with her."

Supporting people to express their views and be involved in making decisions about their care
• People were able to express their views and be involved in decision making. People and their relatives where appropriate, were involved in the initial assessment of their care needs and the subsequent development and review of care plans. People told us staff asked them what they wanted and what was important to them. This was reflected in care plans.

Inspected but not rated

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. We have not reviewed the rating at this inspection. This is because this inspection was carried out as part of a DCA pilot inspection and only part of this key question was reviewed.

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

• Care plans were personalised and detailed and set out people's needs and included information about how to meet them. Care plans covered needs related to mobility, personal care, relationships, religion, medicines and eating and drinking as well as including detail about people's life history.

• People had been involved in developing care plans so that they reflected what was important to them. People told us the registered manager met with them to discuss their needs, and records showed care plans had been signed by the person or their representative. Care plans were subject to regular review. This meant they were able to reflect people's needs as they changed over time.

• The registered managers and recruitment manager took time to match people with care workers who shared similar characteristics or interests, to enhance the development of relationships.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's care plans contained specific details about their communication needs. This included how people should be given information.

End of life care and support

• Care plans included information about people's end of life wishes and where appropriate Do Not Attempt Resuscitation documentation was in place.

• All staff had received training in end of life care. One care worker told us, "Yes I have supported a person at the end of their life. The way I treat them with dignity is to talk to them, speak with them respectfully, keep a caring and positive attitude and continue to ask them how they want to be cared for."

Good

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 remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People, relatives and staff spoke positively about the registered managers and said they were accessible. A relative told us, "All the office staff are very good, easy to get hold of and very helpful."
• The provider promoted an open and positive culture at the service. One member of staff told us, "At Versacare they care about their staff." Another member of staff said, "A friendly company to work for, well organised and they are always willing to assist."
• The provider engaged with staff on a regular basis via telephone calls and meetings and staff told us they felt supported. The registered managers sent out monthly newsletters to staff highlighting good work and spotlighting topics to learn from. Recent examples included a series on dementia, a heatwave guide, and general health and wellbeing guidance for all during the coronavirus pandemic.
• To help achieve good outcomes for people, care was provided in a person-centred way. People were involved in developing and reviewing their care plans. This helped to ensure that they covered what was important to the person.

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;
• People told us they had good relations with the registered managers and that there was effective communication. One person said, "Yes, they keep me informed and I call them if I need to ask them something in particular."
• The registered managers and staff undertook regular training. This continuous learning helped staff to gain relevant knowledge and skills to improve care.
• The registered managers were knowledgeable about their regulatory requirements. For example, they were aware of what issues they had a duty to notify the Care Quality Commission about, and the service operated within the conditions of registration imposed upon it by the regulator.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Working in partnership with others
• There were two registered managers in place and the service had clear lines of accountability. Staff were aware of who they reported to, and who they could report to if they were unable to go directly to their line manager.
• Staff were provided with a job description, and there was a set of policies and procedures which helped staff to be clear about their role and the expectations of them.

• Various quality assurance systems were in place. These included audits of medicines and regular reviews of care plans and risk assessments.
• The provider worked with other agencies to develop knowledge and share best practice. For example, they were affiliated with Skills for Care and the UKHCA (The United Kingdom Homecare Association) as well as being 'I Care' ambassadors. One of the registered managers explained, "There are several of us who have signed up to be I Care ambassadors. This is where we help deliver activities and talk about what it is like to work in care and encourage the next generation in schools and colleges."
• In addition, the provider demonstrated their good working relationship with the CCG (Clinical Commissioning Group), social workers and health professionals such as occupational therapists, which we saw examples of within correspondence and care plans.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care
• The provider engaged with people using the service to seek their views and get feedback from them. An annual survey was carried out of people and their relatives and completed surveys contained positive feedback. A staff survey was also recently carried out containing positive feedback.
• The registered managers carried out spot checks and observations at people's homes. This enabled them to check staff were working appropriately, and also to speak directly with people to see if they were happy with the care provided.
• People's equality characteristics were covered in their care plans. The provider had a set of policies which provided guidance about equality and diversity. We saw good practice in relation to employment with regard to equality and diversity, for example through the staff recruitment practices.