

Vincentian Care Plus

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Inspection summary

CQC carried out an inspection of this care service on 11 August 2017 and 14 August 2017. This is a summary of what we found.

Overall rating for this service

Inadequate ●

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?

Inadequate ●

Vincentian Care Plus is a domiciliary care agency that provides care and support to people living in their own homes. At the time of the inspection there were 141 people using the service.

This inspection took place on 11 and 14 August 2017 and was announced. We told the registered manager 48 hours before the inspection that we would be visiting. This was to ensure the registered manager would be available to take part in the inspection.

At the previous comprehensive inspection on 14 and 15 July 2016 we identified breaches of regulations in regards to person centred care, safe care and treatment, good governance, staffing and notifications. We made one recommendation in relation to medicines management. We rated Vincentian Care Plus as requires improvement overall. We asked the registered provider to send us a plan to tell us what they would do to meet legal requirements. The plan detailed what actions the registered manager and staff would take to meet legal requirements. You can read the report from our last inspection, by selecting the 'all reports' link for Vincentian Care Plus on our website at www.cqc.org.uk.

At this inspection we followed up on the breaches of regulations to see if the registered provider had made improvements to the service. We found that the registered provider had taken some action to meet the regulations. The improvements we found were in relation to staffing and notifications.

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.

We found people were at risk because the service did not have effective systems in place to manage missed and late visits. During and after the inspection we requested a log of missed and late visits but at the time of writing this report this was not received as requested. There was a system for people using the service and staff to contact a manager outside of regular office hours. However, people using the service and staff said that their call was not always answered when they contacted the out of hours telephone number.

People were at risk of not receiving their medicines safely because there were not effective systems in place to monitor and audit medicine administration. The registered manager did not have systems in place to ensure that people had their medicines as prescribed in a safe way.

The service did not have effective systems in place to ensure that care records were accurate and up to date. We found that people's care records contained gaps in them and were not always updated. People had an assessment of their needs before using the service. Care reviews of people's health care needs were completed on a regular basis. However we found following a review, people's care plans were not updated to reflect changes in need or level of service. This meant that people's care records did not always reflect their current needs.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. The registered manager and staff did not understand the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Records showed that a person's medicine was hidden within their home and appropriate steps had not been taken to assess their capacity to make this decision and to ensure that the decision was made in their best interests.

People had the opportunity to provide feedback about the service. People provided mixed views about the service and the quality of the care they received. The registered manager had not taken action to manage the concerns raised by people.

People said that their regular care worker was caring and understood their needs. They commented that they were treated with dignity and their privacy respected when they were receiving care and support.

Risks to people's health and wellbeing were assessed. There was a plan in place for the identified risks and guidance for staff to manage them. Staff understood the registered provider's safeguarding procedures and knew what action to take if a person using the service was at risk of abuse or harm.

People were supported by health care services. When people's care and support needs changed staff sought appropriate advice from health and social care professionals.

People gave their consent to the care and support provided. A relative gave consent on behalf of their relative if they were unable where they had the legal authority to do this.

There were effective systems in place for people to make a complaint. The registered manager dealt with complaints about the service. We saw records that showed the registered manager had

acted on complaints and responded appropriately.

People had meals that supported their requirements and personal choices and preferences. Staff completed shopping and meal preparation for people as required.

Staff had support from the registered manager. Staff completed an induction, supervision, training and appraisals on a regular basis. Staff had the opportunity to discuss their personal and professional development needs. These were recorded and the registered manager supported staff to achieve self-identified goals.

The registered provider ensured there were enough staff deployed. This ensured people received their care and support from a member of the care team as required and in line with the care assessment. The registered provider followed robust recruitment processes. This ensured suitable staff were employed to provide care and support to people.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We identified continued breaches of regulations in regards to person centred care, safe care and treatment, and good governance. We are considering what further action we are going to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

You can ask your care service for the full report, or find it on our website at www.cqc.org.uk or by telephoning 03000 616161