Violet Care Agency Ltd

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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
Violet Care Agency Ltd – HSCA is a domiciliary care agency providing personal care to people in their own homes. At the time of inspection, the service was providing personal care to 187 people. This includes people being supported through the enablement service. This service provides time limited support to assist people coming out of hospital to regain as much of their independence as possible.

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
Feedback about the care provided from people and their representatives was mixed. Some people told us the care they received was not of the required standard, especially when they joined the service. Other people told us they received good care once they had settled into the service and had regular care staff.

The provider had failed to manage risk when new people joined the service, in particular when they required emergency care. Systems to monitor call times and missed visits required improvement. The provider had not always ensured people's needs were promptly assessed and staff allocated to new people had the necessary skills to meet complex needs. We received negative feedback from some professionals about staff skills and communication from the service.

The service had grown considerably in the last year. There were new staff and systems; however, this growth had not been effectively managed. Improved oversight was needed to ensure the provider understood any gaps and areas of risk. The provider was committed to resolving the issues raised at inspection and took prompt steps to address immediate concerns. They also told us they would become more involved to improve safety and increase their oversight of the service.

Care plans were detailed and personalised, however they were not always updated with information from reviews and from the new systems.

The service had enough safely recruited staff; however, improvements were needed with staff deployment to ensure people's needs were met safely and in-line with their preferences. Staff were positive about the support they received and morale was good. The provider had a focus on nurturing and developing leaders in social care. They promoted reflection and learning.

There had been recent improvements to safeguarding practice and knowledge. The provider had recently made effective improvements following concerns raised about the administration of medicines. Staff minimised the risk of infection.

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 February 2019)

Why we inspected
This inspection was prompted by a review of the information we held about this service. The inspection was prompted in part by notification of an incident following which two people using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk. This inspection examined those risks.

Enforcement and Recommendations
We have identified breaches in relation to governance and management of risk 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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Violet Care Agency 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
The inspection was carried out by 3 inspectors and 2 Experts 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.

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 were two registered managers in post. The registered provider was also a registered manager. They are referred to in the report as 'the provider'.

Notice of inspection
We gave the service 48 hours' notice of the inspection as we needed to be sure that the provider or registered manager would be in the office to support the inspection. Inspection activity started on 15 June 2023 and ended on 19 July 2023. We visited the location's office on 20 June 2023.

What we did before the inspection
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 used information gathered as part of monitoring activity that took place on 1 November 2022 to help plan the inspection and inform our judgements.

We used all this information to plan our inspection.

The inspection
During our office visit we spoke with the provider, the registered manager, the in-house trainer and other office staff. We reviewed a range of records relating to the management of the service, including eight people's care records, four staff files, training and quality assurance records. We met, called or had email contact with 13 care staff. Outside of the office visit, the provider sent us additional information by email, as requested.

The experts by experience spoke with 16 people who use the service and 5 relatives to gather their feedback on the quality of care provided.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Assessing risk, safety monitoring and management
• Processes to integrate new people into the service did not minimise risk and needed improvement. New referrals had not always been entered promptly onto the service's electronic tracking system. This meant staff monitoring the tracker had not picked up a number of missed visits, in particular where people needed emergency care at home following discharge from hospital. This placed people at risk of harm.
• After a serious incident in December 2022, the service had improved systems to track the intake of new people. However, the provider had not realised the system had failed to pick up the concerns which we found at inspection.
• The service accepted some referrals before fully understanding individual risks and needs. The provider had not ensured effective communication with stakeholders and people before care started. Some new referrals were slotted into existing rotas based on the availability of staff and before a satisfactory assessment of people's needs had taken place. For example, initial assessments had not considered the impact of a missed visit for people requiring staff support with eating and drinking.
• Professionals told us they were not confident about the standard of care people would receive. A social care professional said, "I don't use Violet Care for people with complex needs as I can't guarantee their safety."
• Feedback from some people and relatives reflected this concern. People told us, "In my first month I had a carer who did not want to care and lacked training to support me properly" and, "New carers can be a bit iffy even if they have shadowed one of the regular carers. I do absolutely feel that training could be and should be improved." A relative described how initially care staff did not have the correct information to support their family member with specific health conditions, which had placed the person at risk.
• Prior to the inspection we had concerns staff did not always respond appropriately when they missed visits due to not making contact with people. For example, they had not escalated concerns to the office, stakeholders or emergency services. This had placed people at risk of harm.
• Risk assessments and care plans were detailed. However, they were not always updated, after a review or when circumstances changed. A person's care plan had not been updated after a review of their care highlighted a change in the equipment they needed. Professionals told us end of life care plans had not been updated adequately as another person's needs changed. As a result, staff were not always aware of people's specific needs.

The provider had failed to ensure there were effective systems to minimise risk and provide safe care. This put people 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.

• The above concerns related largely to emergency placements, where people required care at short notice. Where there was more time to set up care arrangements, senior staff had carried out more detailed assessments of need and risk. Following our feedback, the provider immediately changed their referral process, making sure all new referrals were assessed by a senior member of staff before care was provided. The provider also told us they would carry out a full review of existing care plans to ensure staff had current information about people's needs.
• The provider had recently arranged extra training for staff about how to respond in emergencies. Calls to staff during inspection indicated recent learning and increased knowledge about this risk.
• Prior to our inspection we received feedback from stakeholders that staff did not understand guidance around DNACPR, which stands for 'do not attempt cardiopulmonary resuscitation' and indicates whether resuscitation should be attempted if a person's heart or breathing stopped. The provider had responded well to concerns and arranged improved training and guidance. Staff were able to describe their responsibilities in this area. A member of staff said, "We have been told about this recently. If we see someone who is unwell, we have to contact someone. It might be our managers or 999, but we have to let someone know."
• Further time was needed to ensure recent improvements were embedded across the service and people could be assured they would receive safe care.

Learning lessons when things go wrong
• Incident and accidents were investigated internally and actions taken, such as increase in staffing to help a person move safely. There were some gaps in investigations, for example, why staff had not called 999 in an emergency. This meant the registered manager had not picked up the above concerns prior to the feedback received from stakeholders.
• There was a focus on mentoring and debriefing with staff after distressing incidents had occurred.

Staffing and recruitment
• We received some feedback that staff did not always have the necessary skills to support people with more complex needs. We found this largely related to the poor matching, as outlined above, where the provider had not always ensured people's needs had been fully assessed and the information used to match them to staff with relevant skills.
• Other feedback about staff skills was more positive. Staff told us they received good quality training from the new in-house trainer. A member of staff described how they had received training from a district nurse about a person's specific condition.
• People and families told us there was usually enough staff during the week but weekends were more stretched. A person told me, "A couple of times we have had missed calls on weekends. I phoned the office to be told that the carers will get to me at 11am for my breakfast visit and this will be a combined visit to cover my lunch visit as well."
• Staff told us there were enough staff to meet people's needs. A person said, "My round is manageable, I do not feel rushed, the travel time, clients and timings are good. They always cover the shifts if we ever struggle, the office staff come out."
• Staff were safely recruited. This included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
• Three people told us they did not feel safe with male staff. There were not enough female care staff, so people did not always have their preference met in this area. The provider told us they were addressing this in their ongoing recruitment.
• The registered manager understood their responsibility to raise safeguarding referrals with the local

authority and had done so on a number of occasions. We found examples however where the service had dealt with concerns but had not raised appropriate referrals. After our feedback the provider adapted their systems to prompt senior staff of their responsibility in this area.
• We had feedback from professionals prior to our inspection that staff did not recognise safeguarding and raise concerns as required. The provider had arranged additional training and guidance. All of the staff spoken said they had received training in safeguarding and whistleblowing within the past year.
• Staff were able to describe categories of abuse and stated that management involvement should be sought at the first opportunity. A member of staff told us, "It is very serious. If I notice anything, if people are not getting enough food or have bruising, I report to the manager. In my training my tutor said who to report to. I would let the social worker know if I was concerned. I also know about CQC."
• Most people told us they felt safe with care staff, in particular with established staff. A person told us, "I have felt very safe with all the carers who have come to support me. They all act very professionally."

Using medicines safely
• People told us they received their medicine safely. However, we had feedback from external professionals that some staff did not always understand more complex issues around medicines. For example, the importance of time sensitive medicines. The registered manager told us that at the time of the inspection, staff were not supporting anyone who required medicines at a set time.
• The provider had addressed recent concerns about medicines, improving training and monitoring. We met with the new medicine administrator who described effective processes to improve practice around medicine. Staff told us, "We now have someone in the office who checks the screen and is straight on the phone to us if it shows we have not administered medicines. The manager comes out and watches us do medicines, they also do spot checks" and "We have completed training and refresher training. District nurses have come in and also delivered some training about specific needs."
• People were involved in making decisions about their medicines, as appropriate. A person and their representatives had been consulted when making decisions about safe storage of medicines after an incident where they put themselves at risk.

Preventing and controlling infection
• The service used effective infection, prevention and control measures to keep people safe. A member of staff said, "Whilst [Person] is sleeping, we clean and disinfect the bathroom. We are very sensitive to infection."
• Staff used personal protective equipment (PPE) effectively and safely. A person told us, "They do wash their hands and use disposable gloves & aprons as well as face masks. They always leave my home in a clean and tidy state."

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Continuous learning and improving care

• The provider did not have sufficient oversight of risk and safety across the service. In August 2022 there were 56 people using the service. By June 2023 this had risen to 187. There were new staff and numerous systems had been developed. However, this had not been managed effectively. The provider had not ensured the registered manager was on top of all the new systems and staff were working safely.

• Prior to the inspection there were a number of incidents where people had not received safe care. Individual actions were taken after each incident. The provider had made some changes to address issues across the service, such as improved training and developing systems to track new referrals and prevent missed visits. However, they had failed to recognise gaps in the system and where people remained at risk. In particular, when staff were sent to provide care before an assessment of people's needs and risks had been carried out.

• We requested data from the service around visit times but the information sent to us was difficult to analyse. An electronic system recorded staff arrival and departure times. However, 40% of call times had been manually inputted by staff who had recorded they had completed visits exactly as planned. According to these staff records none of these hundreds of visits had been shorter than planned or delayed by traffic. As a result, we were not assured the provider was using their system to effectively monitor call times. For example, to address the concerns around punctuality, missed visits or whether time-sensitive medicines were given at the planned time.

• Although there were systems in place to record accidents and incidents, they did not provide effective oversight. Information was not always easily to access as there were two different spreadsheets with different information. Although senior staff had recorded actions and learning, they had not always gone back to check whether actions had been effective. As a result, the provider did not have oversight of whether improvements had worked, such as the new systems set up to prevent missed visits to at the start of services.

The provider's systems and processes to assess, monitor and mitigate risks across the service were not always effective. This was a breach of Regulation 17 (2) (a) (b) [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• There were a number of parallel systems which needed fine tuning to prevent duplication. Staff roles had been assigned to different tasks and communicated frequently. Improved oversight was needed to ensure they were working and communicating more effectively.

• The provider told us saw their role as being one of "developing people to be leaders in adult social care," rather than being involved in the day to day running of the service. After our feedback, they assured us they understood the importance of ensuring safety and quality across the service. They told us they would increase their involvement to support the registered manager to improve the service.
• The provider promoted a good culture around reflection and learning. When we raised concerns at our office visit, we observed the provider bringing key staff together to so.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Feedback from people and their representatives was mixed. We were told staff needed more training on supporting people with dementia. A relative said, "Staff just handed my family member an orange but didn't realise they had forgotten how to peel it. Person will stop eating if no one is there to encourage them, and the staff don't always do this." Professionals told us they had feedback from people that some care staff did not engage with people, spending time on their phones.
• We received positive feedback from many people about how consistent staff helped them achieve good outcomes. A relative told us, "I feel my family member is 100% safe with the carers. [Person] has dementia and their regular carer makes them laugh." Some people told us the service was improving. A person said, "I had about 16 carers before now so it's nice to have the same carers."
• Staff spoke warmly about the relationships they had developed with people they supported regularly. A member of staff said, "Most of the time we do extra things like vacuuming, we are like a family and if they need help, I help." They described the support in detail, demonstrating a good knowledge of their specific needs and preferences. Care plans were person centred and respectful.
• People told us they felt involved and consulted about their care when being supported by their usual care staff. A person said, "They do ask my consent before doing my shower for example and they encourage me to do as much as I can for myself such as cleaning teeth and washing my own face."
• Despite the concerns outlined above with the monitoring of visit times, where calls had been logged correctly on the provider's electronic system, there was evidence visits were punctual, well planned and monitored. This reflected the above positive feedback regarding the care provided to some people at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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
• Although there was an open culture, communication was not always effective, with some people describing how confusing contact with the office could be. A relative said, "When I complained about poor care, I kept getting different managers and staff phoning and apologising." We also had feedback that although people felt able to complain, it could take quite a long time for issues to be resolved.
• Although most people said they did not know who the manager was, they told us they received regular calls or feedback forms from the office to ask them about the quality of the service.
• The staff we spoke to were enthusiastic and committed. They told us they felt well supported. A member of staff told us how they had been given more travel time between visits after they had raised concerns about their rota. There was a focus on promoting staff wellbeing. A member of office staff told us it was their job to ring staff regularly to carry out a wellness check.

Working in partnership with others
• Prior to the inspection we attended a meeting with health and social care professionals where we received feedback that communication with the service was not always positive. We were told the registered manager did not always engage pro-actively with other professionals or escalate issues, such as where support was not being provided as planned. The provider told us they were employing additional staff to

support the registered manager in their role.
• We found examples of positive partnership-working where the service had established relationships with professionals, particularly around the long-term care for known people. Staff had worked well with district nurses to ensure people received the health care they needed and with occupational therapists to request equipment.
• The provider and registered manager worked positively with CQC during their inspection. They were open and responsive to the feedback when things needed to improve.

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 there were effective systems to minimise risk and provide safe care. This put people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes to assess, monitor and mitigate risks across the service were not always effective.