VHM Care 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?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service:

VHM Care Limited provides personal care to people living in their own homes in the community. It provides support to older people and younger adults with physical disabilities, learning difficulties, sensory impairments, mental health and people living with dementia. At the time of the inspection 12 people were receiving personal care.

People's experience of using this service:

VHM Care Limited has been registered with the CQC for one year. The service did not start supporting people with personal care in their own home until mid-December 2018. People were often referred from hospital for a six-week period to support people with rehabilitation. People and relatives were very positive about their experiences to date. People told us that the service was very professional, and they felt confident with the care and support from staff.

The registered manager had not notified the CQC of a significant safeguarding and this is an area that requires improvement.

People's care documentation did not always record information about people's preferences in relation to their interests, hobbies, religious needs and end of life care wishes.

Opportunities to continuously learn, improve and innovate were not always evident as quality assurance systems had not been fully embedded. This included gathering feedback from people, staff, relatives and professionals about their experiences of the service to drive improvement.

People told us they felt safe and knew who to contact if they had any concerns. Systems supported people to stay safe and reduce the risks to them. Staff knew how to recognise signs of abuse and what action to take to keep people safe. There was enough staff to support people safely and the registered manager had safe recruitment procedures and processes in place. A relative told us, "The service is responsive, the staff seem nice, approachable and polite. They always check my loved one's home is safe."

People received their medicines safely and on time. Staff were trained in administering medicines. People knew what their medication was for and told us they felt reassured by the support with their medicines. People were protected by the prevention and control of infection. Staff wore gloves and aprons when supporting people.

People were supported to maintain their health and had support to access health care services when they needed to. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received kind and compassionate care. People and relatives told us that staff treated them with kindness and we observed friendly interactions when attending a care visit. One person told us, "I have never had care before and it is better than I expected."

People received person centred care that was responsive to their needs and people and relatives knew how to raise a complaint.

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

Rating at last inspection: This was the first inspection of VHM Care Limited since it was registered by the Care Quality Commission (CQC) on 13 July 2018. New services are assessed to check they are likely to be safe, effective, caring, responsive and well-led when registering.

Why we inspected: This was a planned comprehensive inspection that was scheduled to take place in line with Care Quality Commission (CQC) scheduling guidelines for adult social care.

Follow up: We will continue to monitor the intelligence we receive about this service and plan to inspect in line with our re-inspection schedule for those services rated Good.

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 Safe. Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always Well-led. Details are in our Well-Led findings below.	**Requires Improvement**

VHM Care 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

This comprehensive inspection was carried out over two days by one inspector.

Service and service type:

VHM Care Limited is a domiciliary care service, which provides personal care and support services for a range of people living in their own homes. 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:

This was an announced inspection. We gave the service 48 hours' notice of the inspection visit because it is small, and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be available.

What we did before inspection:

We reviewed information we had received about the service since it registered with the CQC on 13 July 2018. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this

information to plan our inspection.

During the inspection:

We spoke with three people who use the service, two relatives, the registered manager, director, HR and finance officer and three members of staff.

We reviewed a range of records. This included three people's care records and medication records. We looked at two staff files in relation to recruitment and staff training. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection:

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.
We sought feedback for health and social care professionals about their experiences of the service.

Good

Is the service safe?

Our findings

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

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:
•People told us they felt safe and systems were in place to ensure staff had the right guidance to keep people safe from harm.
•Staff had access to guidance to help them identify abuse and raise concerns in line with the providers policies and procedures to the local authority.
•Staff received safeguarding training and knew the potential signs of abuse. Staff told us, they would report any concerns to the manager and record in the person's diary notes. Staff were confident to call the emergency services if the person needed medical attention or if a crime had been committed.
•One person told us, "I feel very safe, the staff that visit get me up in the morning and walk behind me, offering reassurance. This makes me feel safe."

Assessing risk, safety monitoring and management:
•Risks to people were assessed and care plans detailed people's individual risks such as mobility, falls and pressure sores. Risk assessments gave guidance to staff on how to support the person to manage and reduce any risks to the person.
•Risks associated with the safety of peoples' homes and equipment were identified and known to staff. For example, home appliances and what to do in the event of a fire. One member of staff told us, "I check the person's environment, the fire alarms, that the doors and window are locked and any trip hazards."

Staffing and recruitment:
•There were enough staff to support people to stay safe and meet their needs. People and relatives told us, staff visited at the agreed times, they stayed for the allocated period and how they never felt rushed during their care call. Staff used an electronic system to log in and out of care calls. This meant the registered manager had assurance that people received their allocated time.
•Staff told us that changes to the rota were communicated by phone and that the office was very prompt at responding and informing staff about any changes to the rota.
•Staff recruitment files showed that staff were recruited in line with safe practice and equal opportunities protocols.
•We found that staff recruitment folders included, employment history checks, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the health and social care sector such as disclosure and barring Service (DBS).
•New staff completed an induction, this included shadowing the registered manager to ensure staff were safe and competent to work with people.

Using medicines safely:
•The provider ensured the proper and safe use of medicines by staff who were trained and competent to do

so. Staff received regular training to ensure their practice remained safe. People told us, they received the support with medication when needed.
•Staff followed policies and procedures to support the safe storage, administration and disposal of medicines. There was guidance for administering 'as and when' required medications.
•We checked the Medicine Administration Records in a person's home and found these were correctly recorded.

Preventing and controlling infection:
•People were protected from the risk of infection. People told us that staff always used personal protective equipment (PPE) such as gloves and aprons and we observed this in practice. One person told us, "Yes, they wear gloves and wash their hands."
•Staff had training in infection prevention and control and information was readily available in relation to cleaning products and processes. One member of staff told us, "I have to use the right equipment such as aprons, gloves and if I am unwell I would report to the manager so not to pass on any illnesses."

Learning lessons when things go wrong:
•Systems were in place to record and identify lessons learned and improvements were made when things went wrong.
•Incidents were discussed as they happened with staff and where appropriate additional training was sought where medication errors occurred.
•Staff understood their responsibilities to raise concerns, record incidents and near misses.

Good

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.

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
•The registered manager carried out a pre-assessment before people received care from the service. This assessment helped to form the person's care plan and to understand their care and support needs, outlining the tasks that needed to be completed at each care visit.
•People and relatives told us, they were confident that staff understood their needs, and confirmed that staff sought consent before carrying out care and support.
•People used technology to support their independence. Some people had access to technology such as tablets and mobile phones to keep in touch with friends, family and communicate with the service. Some people had other assistive technology such as a 'care pendent'. This meant that people could remain in their own homes, with the knowledge that they always have somebody to help them in an emergency.

Staff support: induction, training, skills and experience:
•Staff completed an induction and training programme, and this covered key areas such as, moving and handling, safeguarding, medication and health and safety. One member of staff told us, "We have enough training and we have opportunities to do extra training. There is always room for improvement as you need to learn and improve practice."
•The registered manager and director were hands on and supported staff at care calls to observe practice and check staff competency.
•People told us they thought staff were knowledgeable and skilled.

Supporting people to eat and drink enough to maintain a balanced diet:
•People were supported to eat and drink as far as possible and staff supported people with simple meal preparation such as, soup and microwave dinners. One member of staff told us, "I offer the person a variety of food and make sure they have enough to drink, I always make sure the person has a cup of tea and a drink when I leave the care call."
•Staff completed the persons daily notes and stated what the person had eaten and drank. People's weight was monitored, and the registered manager told us how they would engage the Speech and Language Team where appropriate, if there were concerns about people's weight.

Staff working with other agencies to provide consistent, effective, timely care and supporting people to live healthier lives, access healthcare services and support:
•People were supported to maintain their health and relatives told us they were regularly updated if there were changes in their family member's health and wellbeing.
•People were supported to live healthier lives and had access to healthcare services and support to receive ongoing healthcare and staff knew what procedures to follow if they had concerns about people's health.

One person told us, "They have been so good at picking up on things, my carer identified that I may have a potential urine infection, they took a sample to the GP who confirmed it was. I was so pleased with the attention. They will do anything for me."
•The registered manager gave an example where; one person was thought to be at end stages of life and had only drank water and meal replacement drinks for many years. Through getting to know the person and asking questions, the person built up trust with the staff and started to eat a soft food diet. The registered manager engaged with the GP and the Speech and Language Team to assess the person's diet and check if there were any swallowing issues. The person has put on weight and their health and well-being has improved greatly. This demonstrates excellent partnership working which has had a positive impact on the person's health.

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.
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

•The provider had a good understanding of the Act and was working within the principles of the MCA. People were not unduly restricted and consent to care and treatment was routinely sought by staff.
•Staff received MCA training and understood the relevant consent and decision-making requirements of this legislation. We observed staff giving people choice and giving people time to respond.

Good

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

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
•People were treated with kindness and were positive about the staffs' caring attitude. We received feedback from people and relatives which supported this. One person told us, "I have a very good relationship with the staff and it means a lot to me."
•Staff had developed positive relationships with people and we observed friendly and warm interactions at care visits between the staff and people. One member of staff told us, "When I am sat doing paper work at the end of the care call, I will always engage in conversation with the person and check that they are happy."
•Staff spoke affectionally about the people they supported and knew people well, which supported them to meet their needs.
•Staff knew people's preferences and used this knowledge to care for them in the way they liked. One member of staff told us, "I Ask people what their preferences are such are how they would like me to address them." One person told us, "I never feel rushed and staff stay for the duration. Sometimes the carer may stay longer if they are helping me to wash my hair."
•Staff had an understanding of equality, diversity and human rights and people's differences were respected.

Supporting people to express their views and be involved in making decisions about their care:
•People were able to express their views and were actively involved in making decisions about their care, support and treatment, as far as possible.
•People were referred to VHM Care Service from hospital, for a six-week period to support with rehabilitation in their own home. Some people had chosen to stay with VHM Care Services after their six-week period had ended
•People and relatives were involved in developing their care plans and felt included in decisions about their care and support, involving other care professionals, such as GPs and specialist nurses, where possible.
•Staff adapted their communication to overcome communication barriers with people. One member of staff told us, "I adapt my body language, speak clearly and slowly. Moving in a little close but never shouting."

Respecting and promoting people's privacy, dignity and independence:
•People's privacy was protected. Staff gave examples of how they respected people's privacy by closing the door when supporting with personal care and kept people covered up to maintain their dignity.
•Staff supported people to maintain their independence and had a good understanding of the importance of people remaining independent. One person told us, "My carer knows what I can and can't do and encourages me where possible." Another person said, "They encourage to walk and wash the areas that I can." One member of staff told us," I always take a step back and encourage people to do as much as possible, such as washing their face.

•People's private information was secure. Care documentation was held confidentially, and sensitive information was stored securely in the office which was locked when staff were not present.

Good

Is the service responsive?

Our findings

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

People's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences:
•Assessments were carried out before providing personal care and people's care needs were recorded to ensure staff knew how to deliver care and support. For example, people's care plans outlined the tasks that needed to be completed at each visit. One person told us, "They do the little things like bringing in the milk and putting out my rubbish."
•Staff knew people well and explained how they got to know people and were led by their wishes and preferences. One member of staff told us, "I know people really well and that shows, a couple of people have gone on to stay with the service. I know peoples likes and dislikes for example, what lights they like kept on."
•People told us that they felt staff knew them and their history. One person told us, "They know a lot about me and it makes me feel like I have a good relationship with the staff."

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.

•The registered manager understood their responsibilities around AIS and people's communication needs were identified, recorded and highlighted in their care plans if appropriate.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them:
•The registered manager told us, how they encouraged people to pursue activities in the community and have provided people with information about local organisations and how some people are supported to go out for a coffee.

End of life care and support:
•Staff supported people at the end stages of life. People were supported to make decisions about their preferences and wishes for end of life care.
•People were supported by staff who understood their diagnosis and were skilled and competent to support them.
•People's wishes for resuscitation was recorded and known to staff. This is known as a 'DNACPR' which means; Do Not Attempt Cardio Pulmonary Resuscitation.

Improving care quality in response to complaints or concerns:

•People and relatives knew how to make a complaint and told us that they would be comfortable to do so if necessary.
•People had a copy of the complaint's procedure in their home and told us they would be happy to make a complaint if they needed to.
•The registered manager had systems in place to responded to complaints promptly and told us they had not received any complaints since the service registered.

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

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:
•The registered manager had failed to notify the CQC of a safeguarding concern that happened earlier this year. This was discussed at the inspection and the registered manager had misunderstood their responsibilities to notify the CQC of safeguarding concerns. The registered manager gave reassurances that this will not happen in the future and felt clearer about their responsibilities. they took action to make sure this did not happen again, the concerns had been reported to the safeguarding team at the local authority.
•Staff understood their roles and responsibilities and spoke highly of working for the service. The registered manager told us, "When new staff register with us, we tell them about what our expectations are. We discuss expectations and responsibility in supervision and have group supervisions to talk about the company's policies and behaviours. For example, reiterating professional boundaries." The registered manager also told us how they carried out spot checks to ensure that staff were behaviour accordingly and to check staff understanding.
•Each staff member was given a 'staff handbook' which included key information, such as the values of the service, policies and procedures to support staff in understanding their role and responsibilities. Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people:
•Documentation did not always record information about people's preferences to show their interests, hobbies, religious needs related to protected equality characteristics and end of life care wishes. Whilst there were sections in the care plan to record this information the registered manager did not always facilitate these conversations with people to ensure person-centred care was promoted. This is an area of practice that requires improvement.
•The registered manager was also the provider and placed high value on providing good quality care. One member of staff told us, "A very caring service, managed well and we have enough time to get between calls."

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

•Due to the service only being in operation for a short time, quality assurance systems had yet not been fully embedded to gather feedback from people, staff, relatives and professionals about their experiences of the service. This meant that it was too early for quality assurance questionnaires to identify areas for

improvement. The registered manager told us, that they were in the process of developing a feedback form which will be sent out later in the year.
•The registered manager told us that feedback is sought verbally with people at care calls and people are asked to complete a feedback form shortly after they started receiving a service. Initial feedback from people was positive.
•Staff attended regular team meetings and told us there was good communication.

Continuous learning and improving care:
•Improvement plans to monitor overall actions and future developments, following accidents, incidents and near misses, had not been fully embedded to ensure sustainability within the service because there had not been any issues to date.
•The registered manager carried out monthly audits of care plans to ensure that people's care and support needs were reflected when they changed.

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:
•The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.
•Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had.

Working in partnership with others:
•The registered manager and staff worked in partnership with healthcare professionals to promote positive outcomes for people. A health professional told us, "I did some joint working with VHM, they were very prompt in assessing and starting the care and I had positive feedback from the customer. I observed a real rapport with the day to day carers on my visits and they did a good job supporting the person in relation to pressure care to avoid further input from the district nurse. There were on-going safeguarding concerns with this customer and they were good at alerting me to any new incidents or risks within the home."
• A business continuity plan was in place to consider the actions required in the event of an emergency, such as office staff being unable to attend the office.
•The registered manager kept abreast of local and national changes in health and social care, through Skills for Care, the Care Quality Commission (CQC) and government initiatives.