Fisher Healthcare East Anglia Ltd

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Inspection report

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09 November 2020
16 November 2020

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Fisher Healthcare East Anglia Ltd is a small home care service providing personal care to people living in their own homes. 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. At the time of the inspection the service was providing care to 30 people who were receiving the regulated activity of personal care.

People's experience of using this service and what we found
The provider did not have effective oversight of the quality and safety of care being provided to people. The provider's representative whom the provider had told CQC was responsible for this task, had not conducted any monitoring or assessment of the standards of care on their behalf.

Both the provider's representative and manager demonstrated some shortfalls in their practice. This had resulted in appropriate actions not always being taken to reduce risks to people's safety.

Current systems in place to monitor the quality of care provided were not consistently effective at identifying or rectifying errors. Incidents had not always been reported for investigation and where they had been, not investigated. This is important so that lessons can be learnt to prevent incidents to people's safety from re-occurring.

Risks to people's safety had not always been adequately assessed or managed. Some people had not received their medicines correctly. Appropriate actions had not always been taken to reduce the risk of people experiencing alleged abuse or to reduce the risk of the spread of infection.

The provider had not conducted all the required checks to enable them to reasonably assess whether staff were of good character before they were employed or during their employment.

The service had experienced some difficulties recently due to several of their staff not being able to work for various reasons including having to self-isolate due to the COVID-19 pandemic. People told us they received their care visits but not always at their preferred time and on occasion, only one staff member attended a care visit when there should have been two. The provider was aware of the situation and was actively trying to recruit more staff and had sought assistance from the local authority as is appropriate.

Rating at last inspection (and update):
The last rating for this service was Requires Improvement (published 9 June 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of medicines, infection control, safeguarding people from the risk of abuse, staffing levels and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fisher Healthcare East Anglia Ltd on our website at www.cqc.org.uk.

Enforcement
During the inspection, we identified breaches in relation to risk management, infection control, safeguarding people from the risk of abuse, management of people's medicines, recruitment processes, governance and failure to notify CQC of incidents the provider is required to do so by law.

Some of our concerns required the provider's urgent attention. Therefore, we issued them with a letter giving them the opportunity to act to avoid us taking urgent action. This assurance was received and therefore, urgent action was not taken. Full information about CQC's regulatory response to the more serious concerns found during this inspection will be added to this report after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least Good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 act 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 of 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our safe findings below.

Fisher Healthcare East Anglia 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 Care Act 2014.

Inspection team
The inspection was completed by one 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 homes. The service had a manager in place. They were not registered with the Care Quality Commission but had applied to become registered.

Notice of inspection
We gave a short period notice of the inspection because the service is small, and we needed to ensure someone was available to answer our questions. Inspection activity started on 4 November and ended on 16 November 2020. We visited the office location on 4 November 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included feedback from the public and notifications from the provider. We sought feedback from the local authority. We used all this information to plan our inspection.

During the inspection visit

We visited the office of the provider on 4 November 2020 where we reviewed two people's care records, five medicine records and three staff recruitment records. We also spoke with the manager and nominated individual who is the provider's head of operations and finance. The current nominated individual took up this post on 22 October 2020 and is responsible for supervising the management of the service on behalf of the provider.

After the inspection visit
On 5, 6 and 9 November 2020 we spoke with five staff over the telephone to gather their views about the quality of care provided and the support they received from the provider. Also, on 9 November 2020 we spoke with four people and five relatives to seek their feedback about the quality of the care they received. From 9 to 13 November 2020 we requested information from the provider which was reviewed. This included various records in relation to four peoples care, staff training and supervision and how the provider monitored the quality of care people received. On 16 November 2020, we provided feedback by video call to a director of the provider and the nominated individual.

Inadequate

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 Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection the provider had failed to ensure systems were in place to robustly assess and manage risks to people's safety and to ensure they received their medicines correctly. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider remains in breach of regulation 12.

●Risks to people's safety had not been adequately assessed or managed. Incidents to people's safety had not always been reported and/or investigated to ensure people were safe and therefore, lessons had not been learnt to improve the care people received in the future. People had not received their medicines correctly.

● In September 2020, staff recorded on two occasions they were concerned one person may have taken some of their medicines by mistake. The medicines were not stored securely, and the person's care record indicated they lacked insight into their own safety. The provider told us they had advised the family the medicines needed to be kept secure. In December 2020 staff raised a concern following a care visit that several tablets had gone missing and could not be accounted for. This showed the person's medicines had remained unsecure since September 2020. Although the provider told us they had spoken to the family regularly about the matter, they had not taken all reasonable steps to try to protect the person from risk of harm such as raising the issue with the local authority as a safeguarding concern. They had also failed to assess and record the risks the unsafe storage of medicines presented to the person.

●Risks associated with staff providing care when it may not have been safe for them to do so had not been assessed. Two people and one relative we spoke with told us they or their family member did not always receive the personal care they needed, as a staff member said they were not physically able to support them. This meant they had either not received the care they needed, or a family member had been required to provide the care instead.

●Staff told us the on-call phone was sometimes not answered. This was because the staff member carrying it was conducting care visits. No system had been put in place to ensure a staff member was always available to answer the on-call phone in an emergency, placing staff and people using the service at risk.

●It was recorded in one person's medication risk assessment that staff were responsible for monitoring their medicines to ensure they did not run out. This had not occurred effectively, and the person had missed some doses of two different medicines in October 2020 as there were none available. There was no record this had been raised as an incident. Therefore, no investigation had taken place to understand why the failure had occurred to reduce the risk of the same issue re-occurring in the future.

●It was recorded in one person's medication risk assessment that staff were to ensure they had taken all their medicines before they left the person however, this was not being followed. Records showed staff had been leaving medicines out for the person to take, which on occasions they had not done so. The manager discovered this when providing care to the person, but they did not act to ensure the person received their medicines correctly in the future.
●There was conflicting information within two people's medication risk assessments regarding what support they required from staff to take their medicines safely. Not having accurate information could increase the risk of staff providing the incorrect support required.
●Medicine administration records (MAR) did not show people had received their medicines as prescribed. We found several gaps in these records that had not been identified for investigation.
●Five of the nine people/relatives we spoke with told us staff did not always wear the relevant personal protective equipment (PPE) to reduce the spread of infection. One person said, "Quite a few times they have come in not wearing masks or anything. I feel it is a short call, so they feel they don't need to bother." Another person told us, "They have all been wearing masks except one. I would rather not say who that is as I don't want to cause trouble." A relative said, "The carers do wear gloves, masks and they wash their hands so there isn't a problem with that. But [the manager] doesn't wear a mask or anything sometimes."
●The provider confirmed a staff member had been attending calls without always wearing a mask as is required under current government guidance to help reduce the risk of the spread of infection, including COVID-19. The provider advised they had recently found out the staff member was exempt from wearing a mask. However, where circumstances leave staff exempt from wearing the PPE required, a full risk assessment should be completed to determine their suitability to deliver care without one. This had not taken place. Furthermore, people should be provided with a choice as to whether they are happy for this staff member to attend. This had not occurred.
●Staff did not have immediate access to eye shields when they visited people. This was because the provider had not ensured they were carrying these as part of their package of available PPE. Therefore, staff were not able to wear an eye shield as an extra precaution, if the person they visited was displaying COVID-19 symptoms such as a persistent cough. This increased the risk of staff contracting and spreading infection.

The evidence above demonstrates a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our inspection, the provider told us they had acted to ensure risks to people's safety had been assessed and managed appropriately, that they received their medicines correctly and that staff has access to the relevant PPE and wore it in line with current guidance.

Systems and processes to safeguard people from the risk of abuse
●The provider told us of several incidents where they had reported concerns of actual or alleged abuse to the local authority as is required. However, this had not happened in all cases and therefore, the systems in place were not fully effective at protecting people from the risk of abuse.
●Staff had raised an allegation claiming a member of staff had verbally abused a person using the service. This had been reported to the current nominated individual who represented the provider. They did not refer this to the local authority safeguarding team or CQC as is required.
●The nominated individual conducted their own investigation into this allegation which was not robust. They did not obtain statements from all staff present at the time of the alleged abuse or suspend the member of staff pending the investigation. They closed the investigation following their discussion with the staff member involved who denied the alleged abuse had taken place.
●Staff had received training in safeguarding. However, none of the staff involved or who were aware of the

allegation of abuse discussed above, referred the matter to the local authority safeguarding team at the time. This was despite them being concerned the matter had not been taken seriously.

The evidence above demonstrates a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

●The provider had not conducted all the required checks to enable them to reasonably assess whether staff were of good character before they were employed or during their employment.

●The nominated individual who recruited the manager, had not obtained a reference from the manager's last employer. Two-character references had been received from colleagues of the manager when they worked for a different provider. These references had not been independently obtained as they had been emailed directly to the manager. They had also been written over three months prior to the date the manager had been employed and therefore, the accounts were not timely. Another reference from a previous employer had been received, but this was dated after the manager had started their employment.

●A DBS had been performed for one staff member in August 2018. This showed the staff member had been convicted of a criminal offence in 2016. No assessment of the risk this may pose to people was conducted. A further DBS was performed in October 2018. This again identified this conviction, but any risks associated with this were not assessed. The second page of the DBS was missing. This contains information the police may wish to make provider's aware of such as pending investigations. This staff member continued to work for the service providing care to people, until they were incarcerated in October 2020 for a criminal offence that had occurred in August 2018.

The evidence above demonstrates a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us during the inspection, they had not been made aware at any time this staff member was being investigated for a criminal offence.

●We received mixed feedback from people regarding staffing levels. One person told us, "The carers are very polite and friendly, they come when they are supposed to." Another person said, "They do always show up eventually and that is good enough for me. They mostly come when they are supposed to, and they do ring to let me know if they are going to be late." However, another person told us staff were often late which meant they had needed to change the time they ate their evening meal to accommodate the care visit. A relative told us, "They (staff) come about an hour later because they have been given extra calls to deal with. Sometimes they have turned up just as I am about to dish up lunch so we have to wait for our lunch so they can do personal care."

●The staff we spoke with also gave us mixed views regarding staffing. Most told us they did not miss any care visits, but some said two staff did not always attend a call where this was needed. We reviewed the records for October 2020 where two staff were required to visit people. These showed that in the main, two staff had attended and where they had not family had been able to step in and safely assist the one staff member.

●We spoke with the nominated individual and manager about staffing levels. They told us they had experienced challenges over the last few months to ensure people had their care visits covered. A number of staff employed by the provider had been unable to work for various reasons such as self-isolating due to COVID-19, long term sickness or maternity leave. Existing staff had stepped in to pick up several extra care visits. Office staff, the manager and nominated individual had also covered care visits. The nominated individual confirmed they had recruited several new staff to try to help with the situation and were continually recruiting new staff. The use of agency staff had been considered however, the manager said

these had not been available to support the service.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated 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; Continuous learning and improving care; 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

At our last inspection the provider had failed to ensure systems were in place to robustly monitor the quality and safety of care provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider remains in breach of regulation 17.

- The governance structure in place was not effective at monitoring the quality and safety of the care provided. The director of the provider told us the manager was solely responsible for monitoring the service was meeting the fundamental standards of care. The nominated individual was not supervising the management of the regulated activity as is required by CQC. Therefore, the provider had no effective oversight of the quality of care being provided.
- The nominated individual demonstrated shortfalls in their knowledge and practice by not making appropriate referrals to the local authority safeguarding team or the CQC when it had been appropriate to do so. This was despite them having written the provider's policy on safeguarding which they had not followed. They had also not conducted enough checks to assure themselves staff were of good character before employing them as is required.
- The provider had been alerted on 1 October 2020 to allegations that some staff had not been wearing appropriate PPE when delivering care to people in their homes. They failed to act on this urgent concern to ensure people were safe from the spread of infection during the pandemic until our inspection over a month later.
- The system in place for recording incidents was not effective. The nominated individual advised any concerns raised should be recorded as an incident on the electronic APP. This would generate an email to alert the manager and themselves a concern had been raised. However, staff including the manager were not always raising incidents when appropriate, despite being advised of the need to utilise this system in July 2020 during a team meeting.
- The manager told us they reviewed the electronic APP each week to monitor if people had received their calls correctly and in line with their needs. This monitoring had not identified that some incidents had not been reported for investigation or where they had been, had not been appropriately investigated. No record of this weekly audit along with any issues found or actions taken had been made.

●When staff had indicated they had raised an incident by either ringing the office or the on-call duty staff member, a contemporaneous note of the action taken had not been made. For example, staff had reported a concern about a person's health condition. Office staff had taken appropriate action by requesting medical advice but no record of this had been kept.
●There was no effective system in place to monitor that people did not run out of their medicines. People's medicines were not being counted which would enable the provider to quickly identify any potential issues.
●In February 2020, the local authority had conducted a quality visit and had identified some shortfalls in the provider's recruitment processes. They had requested the provider audit all their existing staff files which the provider advised had been completed in October 2020. At this inspection we found continuing shortfalls in the staff recruitment process which demonstrated this audit had not been effective at identifying issues with the existing recruitment process.
●Two breaches have been repeated since the last inspection in March 2019. An action plan was received from the provider following that inspection detailing what steps they would take to improve. This had not occurred, and the quality of care provided had deteriorated with more breaches of regulation found at this inspection.
●The provider had failed to assess risks associated with one staff member's health to ensure they were supported and able to deliver care to meet people's needs and keep them safe.

The evidence above demonstrates a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The nominated individual (NI) told us the system in place to monitor if people received their medicines correctly involved the auditing of their medicine administration record (MAR) each month. However, they said this had not occurred as required. We found some MARs had not been audited since March 2020. The NI had identified this issue and had employed a staff member to catch up on the audits which they were doing during the inspection.

After the inspection, the provider told us they had reviewed their governance structure and plans were in place to provide staff with extra training in incident reporting and investigation. They also told us they monitored the quality of the care provided through the conduction of staff supervisions, questionnaires and reviews of people's care.

●The provider had not ensured CQC had been notified of important incidents as is required by law. For example, CQC had not been notified that a person had been found during a care visit covered in bruising or of the alleged verbal abuse that occurred in September 2020.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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
●People told us they were happy with their carers who they described as polite, caring and approachable. However, seven of the nine people/relatives we spoke with told us they had some form of issue relating to the running of the service. A relative told us, "The office is supposed to ring and let me know if they are running late but they never do. I wouldn't recommend this service. Since the new management I have not been very happy. They are told things but never follow it up." A person said, "I do have a problem with the office. I am not told who I am getting, and they are constantly changing the rota. I must do the ringing around to find out who is coming and what time they will arrive." Another person said, "The call times have

gone out the window, they seem to turn up when they want to. The service does occasionally ring to let me know that they will be late but not often and sometimes they tell me who is coming that evening and then someone completely different turns up."

●A poor culture had developed within the service. One of the five staff we spoke with told us they felt fully supported in their role. However, four staff said they did not feel this way. They stated they did not feel listened to or valued and that concerns they raised were not investigated or taken seriously.

●The provider had supported some staff to shield during the pandemic for their safety. The nominated individual told us they had discussed risks to staff with them on an individual basis. However, the staff we spoke with told us no discussion had occurred to give them the opportunity to review risks from COVID-19 to them or their families. There were no records on staff files to demonstrate this risk has been assessed.

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 Commission had not been notified of incidents of alleged abuse to a service user. Regulation 18 (1), (2) (e).

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 Risks to service user's safety had not always been assessed. Incidents in relation to service user's health, safety and welfare had not always been raised or investigated to mitigate risks to service user's. Service users had not always received their medicines correctly and staff had not always acted appropriately to prevent and control the risk of the spread of infection. Regulation 12 (1), (2), (a), (b), (g) and (h).

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not effective at protecting service users from the risk of abuse. Investigations into allegations of abuse were not robust. Regulation 13 (1), (2) and (3).

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective at assessing, monitoring or improving the quality and safety of service provided or mitigating risks to service users health, safety and welfare. Contemporaneous records in respect of each service user's care and treatment had not always been made. The provider had not acted on feedback received from other bodies for the

	purpose of evaluating and improving the service provided. Regulation 17 (1), (2) (a), (b), (c) and (e).

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Robust processes were not in place to ensure staff employed were of good character. Regulation 19 (1) (a).

The enforcement action we took:

We imposed conditions on the provider's registration.