Heritage Homecare Services Ltd

Nelson

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of the Nelson branch on 3 March 2016. This was as a result of the Commission receiving additional information and further concerns that related to the care and welfare of people using the service. The concerns related to missed visits, administration of medication and delivery of the care provided. As a result we undertook a focused inspection to look at those concerns. This report only covers our findings in relation to those concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for the location known as 'Nelson' on our website at www.cqc.org.uk

Nelson provides care and support for people in the Burnley and Pendle area. The range of services provided includes, personal care, domestic help and shopping. The service provides support for older people, people living with a dementia, adults with physical disabilities as well as learning disabilities. The agency's office is located in the centre of Nelson. The agency was known to people using the service as Heritage Homecare.

The Nelson branch was last inspected 24, 25, 30 November and 9 December 2015. This was as a result of the Commission receiving concerning information relating to the care received by people who used the service, staff leaving and visits being missed. As a result of this inspection a number of breaches of the Health and Social Care Act (Regulations Activities) Regulations 2014 were identified. The service was rated as inadequate and was placed into 'special measures'.

During this inspection we identified ongoing breaches relating to safe care and treatment of people using the service. We are taking action against the provider and will report on this when it is complete.

As part of this inspection we visited the Nelson office as well as the head office in Lancaster where the call monitoring systems and the directors are based.

We saw evidence of missed visits taking place, the provider was in the process of transferring care packages to alternative care providers with oversight by the Local Authority. The Director of the Company could give us no assurance that people would receive the care visits that they required.

We received confirmation from the provider that staff at the Nelson branch had not been paid at the end of February. This has resulted in staff leaving and the Company's continuing ability to meet the allocated visits for people using the service at the Nelson branch.

We were told by a Director that there had been a director who had been to the office on a number of occasions. However all staff spoken with told us the directors of the company had not visited the Nelson branch for approximately three weeks.

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.

We saw evidence of ongoing missed visits taking place. The provider was in the process of transferring packages of care to alternative providers.

Staff told us the director who was responsible for the management of the Nelson branch had not visited the office for approximately three weeks.

We were told that staff had left their employment as a result of not receiving their wages.

We had no assurance from the Director of the Company that people would receive the care visits that they required.

Nelson

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of the Nelson branch and visited the head office in Lancaster on 3 March 2016 in order to speak to a Director of the company operating the service. The inspection was as a result of the Commission receiving additional information and further concerns that related to the care and welfare of people using the service. The concerns related to missed visits, administration of medication and delivery of the care provided. The inspection was undertaken by one adult social care inspector and one adult social care inspection manager.

During this inspection we spoke with members of the Local Authority Safeguarding team, the Commissioners responsible for care packages, five members of staff, a senior member of management and a Director of the Company operating the service.

We also looked at call logs records for people in receipt of care.

Inadequate

Is the service safe?

Our findings

The Nelson Branch was last inspected on 24, 25, 30 November and 9 December 2015. This was as a result of the Commission receiving concerning information relating to the care received by people who used the service. As a result of this inspection a breach of Regulation 12 of the Hearth and Social Care Act (Regulated Activities) regulations 2014 was identified. This was because the provider had failed to ensure people received care in a safe way. The service was again rated as inadequate in the domain of safe.

Prior to our inspection we had been made aware of a number of staff members that had left their employment due to concerns about wages. This had resulted in a number of people who used the service not receiving their visits as required. One member of staff we spoke with told us of seven people who had not received their visits that day. We referred these to the Local Authority Safeguarding team for them to investigate and made the Local Authority Commissioning team aware of these failures to provide care.

We spoke with five staff members based at the Nelson branch all of whom confirmed that staff had been leaving and there had be some problems with the most recent pay day. At our inspection of the Nelson branch we spoke with three staff members in the office. All staff we spoke with confirmed a number of staff had left and they told us that no visits for people using the service were being co-ordinated from the Nelson branch. We were told, "A lot of calls are going to Lancaster" and another said, "I have no idea how many staff are still working at Nelson." A Director for the Company told us that the co-ordination of care for Nelson was not being managed through the Lancaster branch. However they confirmed that the oversight of the care package transfer was being managed by a Director at Lancaster. Systems to protect people using the service were inadequate and ineffective as clear guidance was lacking on the management of care delivery. As a consequence of this people were missing their care visits and were at risk.

When asked about how the Company ensured people's care was managed safely a Director told us the staff at the Nelson branch were, "More than able to deal with missed visits or queries in Nelson." We spoke with all three staff from the Nelson branch about their skills and ability to access the call monitoring systems. We were told, "I have had minimal training for the call monitoring system. I can check who is coming to a visit and can cancel visits if requested. Most calls are going through the Lancaster office; we are not getting a lot of calls." Another told us, "I cannot get onto call monitoring system, I did in the past. I have had very little training nothing formal. If a call comes in about care I direct them to Lancaster as I can't access the system" and, "I have never had access to [name of call monitoring system] and have had no training. If someone called the office I would ask them to call head office. There is nothing to do with care at Nelson". This meant the systems to monitor and maintain safe care delivery at the location was inadequate.

During this inspection we visited the Nelson location as well as the head office located in Lancaster. A Director for the Company told us they were trying to work with the Local Authority and people using the service as they were in the process of moving to other providers. The Local Authority confirmed to the Commission the actions they were taking to move people to alternative care providers.

We asked the provider to confirm how many people were still in receipt of care from them. We were

provided with a list of people however this did not match the record that had been provided to us a number of days before our inspection. We checked the call logs provided by the service on the day of our inspection and identified further missed visits had occurred. For example one person's records we looked at identified eight visits over a seven day period that had been logged as missed. And another record identified one occasion where a visit had been missed. This meant people were at high risk of not receiving care in accordance with their needs.

The nominated person told us that the director of the company had been to the Nelson branch on a number of occasions in order to manage the service. However all staff spoken with told us the director had not visited the Nelson branch for approximately three weeks. One staff member spoken with told us the communication from the directors had, "Not been good". We spoke with the Director about this lack of management oversight at the office who told us, [Name of Director] can manage the office from anywhere, I am fully aware [Name of director] is managing the situation." However the Director was unable to provide assurance that a contingency plan was in place to ensure safe care delivery of the remaining people in receipt of care from the service was in place other than, "If I envisage issues I will speak with [Name of contracts manager at Local Authority] or the emergency duty team as soon as possible."

The provider confirmed staff at the Nelson branch had not been paid at the end of February and this had resulted in staff leaving and their ability to meet the allocated visits in the branch. The nominated person told us a number of visits had been handed back to the Local Authority for them to arrange alternative cover by another care provider.

The provider failed to protect people who used the service from the risks of unsafe care delivery. This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe Care and treatment.