Nestor Primecare Services Limited

Allied Healthcare Maldon

Inspection report

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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

This focussed inspection which was unannounced took place on 15 March 2018 in response to some serious concerns we had been made aware of from people using the service, their relatives and staff. At the last inspection in September 2017 the service was rated as Good in all areas.

The team inspected the service against two of the five questions we ask about services: is the service well led and is the service safe? This is because the service was not meeting some legal requirements in these two key questions.

No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a reablement service to adults on a short-term basis until such time as they are able to care for themselves or alternative social care arrangements are made. Placements are predominantly for people recovering from a hospital stay. This location also provides a standard domiciliary care service. There was no indication that there were any risks, concerns or significant improvement within this part of the services so we did not inspect this element of the service.

At the time of the inspection there was a registered manager, however the registered manager had just taken time away from the service for maternity leave. An interim manager was in post to cover the day to day running of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

The service was not safe. We found that a reablement service was provided to 530 people all who had been assessed as requiring social care support. We found that the majority of people had experienced missed and late calls due to insufficient staff, poor organisation and a lack of oversight. Missed and late calls had left several people at risk of harm.

Insufficient staffing levels meant that people did not receive the care that met their needs. Staff were systematically double booked for calls and unable to fulfil their rota requirements. Office staff were routinely calling several people each hour to let them know that their care call would not be taking place. Not all of these calls were being reported as missed calls so managers at Allied were not aware of the number of calls which were being missed.

Risk assessments were not up to date and those which were in place were lacking detail and in some cases,

inaccurate. This meant that people's risk rating was not appropriate to their actual level of risk. Therefore, when calls were being cancelled for low risk people, the staff could not be sure that the risk of missing this call was low and in some cases, this meant people were left at a high risk of harm.

There were insufficient numbers of staff available to carry out reviews and further risk assessments of people to ensure they received care that met their current needs. Several people were not being reviewed which meant that the service was continuing to provide a reablement service to people for much longer than they were contracted to do so. They were also continuing to take further new packages of care without the capacity to be able to do so.

Staff felt unsupported and not listened to. We found that whilst staff had raised the issues we identified, the management team had not recognised the extent of the lack of capacity and had focussed on the importance of keeping the contract going and accepting new packages of care over the safety of people using the service. During the inspection the opportunity to stop taking new packages was given and not accepted. Therefore, the Commission had to take urgent enforcement action to impose conditions on the registration of the provider in order to ensure the safety of people using the service and to support the service to implement the required improvements quickly so that the reablement service could continue safely.

At the time of writing this report the service had had some time to stabilise and recover. There has been a vast improvement in the number of late and missed calls which are now minimal. The provider has been working with the Local Authority commissioners to ensure further improvements are in place so that people receive a good quality service and are kept safe. At the time of writing this report the numbers of people using the service had reduced from 530 to under 200. This meant there was capacity to ensure people received their calls on time and for the allocated time.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

People were left at risk of harm as they were not receiving required care calls in order to meet their needs. There were insufficient staff available to ensure care was provided as required and as a consequence people did not receive the medication, food, drink and personal care they needed to keep them safe from harm.

Risk assessments were not accurate and did not ensure that risks to people were known. This meant that planning care calls did not take account of the real risk to people and people experienced harm.

Is the service well-led?

Inadequate

The service was not well led

The management team did not have the oversight of the service as a whole and therefore did not recognise the seriousness of the capacity issues and the risk this posed to people using the service

The management team had not listened to staff raising concerns and had continued to focus on medium to longer term improvements rather than resolving the immediate concerns and risk.

The culture within the service was to focus on maintaining the contract and not to focus on the safety and quality of care being provided. Staff felt unsupported and many were leaving as they felt unable to cope with the inability to change things for people using the service.

Allied Healthcare Maldon

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 was planned to check 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.

The inspection was prompted by a series of serious concerns raised by people using the service, their relatives and staff at the service in relation to a significant lack of staff and high numbers of late and missed calls. The information received indicated potential concerns about the management of risk at the service. This inspection examined those risks.

This inspection took place on 15 March 2018 and was unannounced. We visited the office location on 15 March to see the manager and office staff; and to review care records and policies and procedures. On the same day a team of inspectors made telephone calls to people using the service and their relatives.

The Inspection team consisted of an Inspection Manager, two Inspectors on site and 3 inspectors who made telephone calls to people and their relatives. We spoke to 35 people who used the service, seven staff members, the interim manager and two members of the regional management team. We also spoke to the commissioners at the Local Authority and the quality improvement team who had also undertaken a visit to the service.

Inadequate

Is the service safe?

Our findings

Allied Healthcare Maldon provided a reablement service to people that have been assessed as having personal and social care needs that they are unable to provide for themselves or need significant support to do so. At the time of our inspection this service was being provided to 530 people. We found that people's needs were not being met in a safe way due to a severe lack of capacity in staffing and poor logistical organisation of service provision. We found that during the week commencing 5 March 2018, 1320 visits had been cancelled or missed to these 530 people. For some people this had meant one call out of their daily calls had been missed but for some people we found that they had a series of missed calls which had resulted in them missing medication, not receiving food and drink and not having the support they needed to carry out personal care. On the day of inspection were told by several staff members and observed in records that missed visits were continuing at a high level each day and that the level of missed visits was not decreasing.

We also found that a number of visits had been recorded as 'cancelled by client' and not classed as a missed visit. When we analysed these visits, we found that the majority had been cancelled by the client following a call from the service to advise that their support worker was sick or running very late and they were asked if they would be ok without receiving a call.

We looked at the data provided from the call monitoring system in relation to the visits that had taken place and found that most care calls were being cut significantly shorter than they were scheduled to be. For example, on Friday 9 March 2018, a person should have received a 30 minute visit between 07:00 and 07:30. The carer arrived at 7:53 and stayed for 7 minutes. Another person was due a 45 minute call at 07:00 to 07:45. The carer arrived at 11:17 and stayed for 7 minutes. The service commissioned for these people included support with personal care including medication, washing, dressing and food/drink preparation. There were no notes or feedback to the office as to what the carer did in the short amount of time they were with the people and no system to provide assurance to the managers at the service that their care needs had been met. The reduced care call times were due to carers being given up to 14 calls to deliver in any one shift with no paid time for travel between people. This was confirmed by staff we spoke to and also confirmed in an email shown to us from a recruitment manager at an agency used to provide further support staff.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: staffing.

We found that whilst risk assessments were carried out by staff when a person was first assessed for the receipt and suitability of reablement care, these risk assessments were lacking detail, not regularly reviewed and therefore could not be considered an accurate reflection of the risk to a person. Risk Assessments resulted in people being assigned a vulnerability rating to each person receiving care. There were three levels of vulnerability, Red, Amber and Green. We were told by staff, the location manager and the area director that in an emergency situation, when visits cannot be made due to lack of staff they are prioritised based on the service users assigned vulnerability. We were told by the location manager that service users with a vulnerability score of Green could miss a visit with minimal risk, however a service user with a

vulnerability score of Red would be at high risk if a visit was missed.

We looked at the care records for people with a Red vulnerability score and found that several people had missed visits due to the lack of staff which had left them at risk of harm. For example, a person who had been assessed as requiring two carers to support with personal care due to mobility issues, Alzheimer's and continence issues had been called on two days to say that none of the four calls required those days could not be fulfilled due to lack of staff. There was also an occasion where a carer had arrived at this person's home to support with personal care but had to cancel as there had been no second carer arrive and the person required two carers to support them to mobilise from bed to their chair. This person was left without the care they required even when they scored as a high risk red rating on the vulnerability index.

We spoke to a person who told us that they had used the service for six weeks and had experienced frequent missed calls. This person told us that they were diabetic but also had Rheumatoid Arthritis and were therefore unable to prepare their own food. They told us that the missed visits meant they had been without food and had experienced Hypoglycaemic symptoms. The person told us that they had made complaints to the service and that no-one called them back to discuss their concerns.

We looked at care records for a person who had been assessed as Green on the vulnerability rating. However, on 7 March 2018 staff noted that the person was feeling depressed and had two more pressure ulcers and called the GP. On the 13 March 2018 pressure areas were noted as being further developed. The vulnerability index identifies pressure areas as a category for Amber vulnerability but this had not triggered a change in vulnerability. This person was being prioritized as low risk and visits could be cancelled despite their care needs having escalated. It is noted in the person's care records they did not receive any visits on 28 February 2018 and 1 March 2018. These were logged as cancelled calls because of no staff. We were seriously concerned that despite knowing that the person's health had deteriorated there was no reassessment or review of their vulnerability.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Staff were aware of what constitutes abuse and were also able to tell us about the local safeguarding processes and who they would contact if they suspected abuse or neglect. However staff also told us that they had raised several issues with managers in relation to the risk they were putting people in by cancelling calls to vulnerable people. Staff told us that nothing changed and they were still cancelling calls for people who needed them every day, whilst also still processing further packages. Staff told us that they felt very vulnerable and lacked support from the managers at the service. Staff told us that whilst they were openly told to call Green rated people and cancel calls when staff were unable to attend, they were also handed pieces of paper with lists of Red rated people who they knew were at risk to call and cancel. Staff told us that these cancelled calls were not being risk assessed and there was a risk that important medication would be missed and these were not being raised with the local authority as per the required safeguarding protocol.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

Inadequate

Is the service well-led?

Our findings

We found that the management of the service lacked a system of effective oversight of the logistical management of the service which left people at severe risk of harm. The impact to service users of continued missed calls and late visits is that they have been left at risk of malnutrition, dehydration, skin breakdown, falls and injury, missed medication and a negative impact on health and well-being. We were told by the Regional Director that alerts were received for late and missed calls via their reporting system. They were handed to the manager to investigate and carry out a root cause analysis and implement lessons learnt. There were far too many missed or late calls for the manager to analyse and report on therefore this was not happening and there was no assessment of the impact of the missed and late calls on the most vulnerable people who should be receiving care.

This meant that the managers were not aware of the risks and whilst they could see that there was an issue with capacity and staffing, we were told by the regional director that this would be resolved by a recruitment campaign and an increase in the use of agency staff. When we asked about staffing levels and shift requirements to meet people's needs, the interim manager was unable to tell us the number of hours required on each shift in each area and there was no record or report run which could identify where the staffing gaps were. We were given a brief report for the mid area which suggested a need for 17 staff on the morning shift and 9 staff on the evening shift but there was no comparison of the number of hours required with the staff available and any agency staff required were booked based on an estimate. We were not assured that any person within the service had an understanding of the number of hours required and the number of staff available to meet people's needs.

The lack of oversight, understanding and management of the service left a large number of vulnerable people at high risk of harm to their health and wellbeing. There were continuing missed and late calls and no indication that this situation would improve in the short term. On 15 March 2018 we asked for a plan of action to address the concerns. We discussed this with the management team at the service. The action plan included recruitment of staff, a lifting of the restriction on use of agency staff and a staff incentive scheme, alongside a series of assessments via physiotherapists and occupational therapists to move people onto social care or independent living. Whilst this action plan did address some of the cause of the problem in the longer term, there was a lack of understanding at a senior level within Allied Healthcare of the immediate risk and there was no action plan to address the missed and late visits happening currently which left 530 people at risk of harm.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

Staff morale was not good. Staff were leaving and others were visibly distressed and upset by the situation at the service. There had been some staff meetings but staff felt that they were not being listened to and that the managers did not understand the gravity of the situation they were in. Staff in the office told us that they had asked that there was a halt on new care packages whilst they focus on the support of the people already receiving care, but they were told that this was not an option. Staff in the field told us that they were

exhausted. One staff member told us that they were expected to complete a care call at 3 am then to be out again the next morning. One of the scheduling staff told us that as staff had so many care calls to deliver in a day these were getting later and later and staff were becoming increasingly tired. All staff we spoke to felt that they were not appropriately supported by the Provider

Some staff we spoke told us that they felt that they would be blamed if something went very wrong. One staff member told us that whenever they were asked to make a call to cancel a care visit, their name was put next to the persons. They felt that this was to ensure they would be held to account if this person came to harm, even though they were told by managers to make the call to cancel. Some staff we spoke to told us that they felt that if they told us the real situation that they would risk their jobs. When we spoke to senior managers about this they acknowledged that they had not provided support to the office staff and said that this was in part due to the registered manager who was no longer at the service.

At the time of writing this report and following urgent enforcement action taken by the Commission, the management team acknowledged that they did need a break from the contract to review and resolve the capacity issues. In the two weeks following the imposition of a condition to restrict new care packages to the reablement contract, there had been a reduction in capacity from 530 people to less than 200 people. Capacity within the staff team was now there to provide a safer service and since the first week in April there has been a significant reduction in missed and late calls.