Healthcare at Home Ltd

Healthcare at Home - Head Office

Inspection report

107 Station Street
Burton-on-trent
DE14 1SZ
Tel: 07972211670
hah.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Healthcare at Home supplies medicines to patients in their own home throughout the UK and also provides nursing staff to administer essential medicines where needed.

We carried out an unannounced, focused inspection of Healthcare at Home between 26 November and 14 December 2020. The inspection took place at the headquarters of Healthcare at Home in Burton on Trent. This inspection was carried out in response to concerns raised in relation to patients not receiving their prescribed medicines on time and being unable to contact the provider. We did not look at all the key lines of enquiry during this inspection. However, the information we gathered and the seriousness of the concerns and clear impact on patients provided enough information to make a judgement about the quality of care and to re-rate the provider.

During this inspection, due to the seriousness of the concerns, we suspended Healthcare at Home's rating. We served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider that we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within four days that described how it was addressing the concerns. On receipt of the action plan we undertook a review and were not assured by the actions the provider described and therefore served a Notice of Decision to urgently impose conditions on the provider registration.

These required the provider to:

- Ensure all service users who have had a failed delivery of any kind from 1 October 2020 to be reviewed by a suitably qualified professional to ensure that service users have not come to any level of harm.
- Devise and implement a system to ensure that backlogs of medicine deliveries were effectively mitigated against.
- Provide an action plan to Care Quality Commission outlining how the registered person intends to make improvements to the areas identified in the Notice of Decision.
- Provide a report to the Care Quality Commission fortnightly which includes an analysis of audits undertaken to monitor completion and/or implementation of the systems set out in the above conditions.

Following the inspection, information received from the provider in order to comply with the conditions indicated performance had improved.

At the previous inspection in December 2019, the service was rated as good overall. Following this inspection we have rated the provider as inadequate.

This inspection was completed during the COVID-19 pandemic and therefore a considerable amount of activity was conducted remotely. For example, reviews of clinical systems, documentation and talking to staff and patients.

At this focused inspection, the key questions inspected were: Safe, Effective, Responsive and Well-Led. Caring was not reviewed because no concerns had been raised in relation to this key question. The good rating for Caring from the last inspection has been carried forward.

At this inspection, we found:

Summary of findings

- The provider had introduced new information systems into the service in October 2020; these had not been thoroughly risk assessed and tested and resulted in avoidable harm to some patients. This meant that delivery dates for medicines were missed and patients didn't get their essential medication required to treat their health condition or maintain their health, on time. Some patients' conditions deteriorated and they had to be admitted to hospital, whilst others experienced psychological trauma because of the uncertainty of not knowing when they would receive their essential medicines.
- The provider had not acted in a timely manner to address the issues caused by the introduction of the new information systems. In October 2020 we were told by the provider there were 2,397 patients whose medicines were missed or delayed, by December 2020 this had risen significantly to 9,885.
- As a result of the issues with the introduction of the new information system there was not enough staff to manage the volume of work resulting in a backlog of unfulfilled medicines orders. This included a lack of staff to take calls, pharmacists to make up prescriptions and drivers to deliver the orders to patients waiting for essential medicines.
- The provider did not always manage safety incidents well, did not always fully investigate and did not always learn lessons when things went wrong. Staff reported incidents but did not always get feedback on what had happened as a result. There were a number of incidents where harm had occurred to patients due to failed medicine deliveries. We found the provider had not adequately followed up the failed deliveries and there were multiple missed opportunities to ensure patients received their medicines on time.
- The provider did not always adequately assess risks to patients, or act on them. The provider's systems and processes did not always provide staff with the information they needed to adequately understand when patients were at risk of deterioration or when they were at risk of running out of essential medicines. Patients were not always followed up in time to prevent any avoidable deterioration or harm to patients or ensure patients didn't run out of medicines.
- The provider did not always have enough nursing staff to administer essential medicines; in patients' homes, for those who could either not do this for themselves or who needed clinical support to administer medicines due to the nature of the medicine.
- The provider did not have adequate systems and processes in place to ensure medicines were always administered safely. The patient record system did not easily enable nursing staff to identify patients who may have a known allergy. In addition, the documentation used by nursing staff did not include a section to record that the patients known allergies had been verbally checked with the patient, prior to administering medicines.
- Patients could not easily contact the provider when they had missed medicine doses due to a lack of nursing staff to administer medicines or because their medicines had not been delivered. In October 2020, only 55% of all calls into the service were answered, against the providers target of 85%. It was difficult for people to give feedback and raise concerns about care received. The service was overwhelmed with patients trying to contact them. The provider received a high number of formal complaints about their service and was unable to respond to them all in a timely manner.
- There was a lack of robust governances, oversight and assurance systems in place which led to significant risks to patient safety. The provider could not demonstrate how risks, issues and performance were managed to ensure that services were safe or that the quality of those services was effectively managed.
- Statutory notifications were not always sent to CQC in line with the legal, statutory requirements responsibility or the provider's own guidance.
- The provider did not always have an open culture where patients, their families and staff could raise concerns without fear. Some patients told us that they feared their medicines deliveries would be cancelled if they complained and some staff said they feared losing their job if they raised concerns or contacted CQC.

However, we also found:

Summary of findings

- The provider tried to fill gaps in the nursing rotas with bank and agency staff and were running regular recruitment campaigns to recruit new nurses. The provider shared information following the inspection which provided assurance that vacancy rates had reduced.
- Staff had training in key skills. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff we spoke with told us they had regular appraisals and were supported by their line manager.
- Staff delivered care and treatment which was based on national guidance and evidence-based practice. For example, nurses followed national protocols and guidance when administering chemotherapy.
- Patients who received homecare visits from nurses had regular health assessments and were given practical advice and support about how to lead healthier lives.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other and communicated effectively with other agencies.
- Staff controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. The provider had clear and effective systems for the management of COVID-19.
- Staff understood the service's vision and values. Staff were focused on the needs of patients receiving care and all staff were committed to continually improving services.
- The provider had an action plan to recover their services back to pre-incident level. As part of conditions placed on the provider, we received a fortnightly report which showed an improving picture of recovery to pre-incident level. The provider hoped to achieve this by the end of January 2021.
- The provider participated in national networks and associations seeking to find innovative ways to improve access to and the quality of healthcare.

The Chief Inspector of Hospitals is placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Inadequate 	We carried out an unannounced, focused inspection of Healthcare at Home between 26 November and 14 December 2020. The inspection took place at the headquarters of Healthcare at Home in Burton on Trent. This inspection was carried out in response to concerns raised in relation to patients not receiving their prescribed medicines on time and being unable to contact the provider. We did not look at all the key lines of enquiry during this inspection. However, the information we gathered and the seriousness of the concerns and clear impact on patients provided enough information to make a judgement about the quality of care and to re-rate the provider.

Summary of findings

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Summary of this inspection

Background to Healthcare at Home - Head Office

Healthcare at Home is operated by Healthcare at Home Limited. Healthcare at Home was established in 1992 and provides clinical homecare and the supply of essential medicines to patients throughout the UK. Patients medicines and care is funded either through the NHS or privately, and are dependent on a referral from a GP, hospital consultant or private health insurer.

Clinical homecare is a term used to describe care and treatment that takes place in a person's own home, including nurses administering essential medicines. It minimises the need for patients to attend hospital either as an inpatient or on an outpatient basis and helps support early discharge from hospital for patients with complex care needs.

Healthcare at Home also provides a supply and delivery service to patients who administer their own medicines at home, delivering approximately 110,000 prescriptions each month. Medicines supplied are for patients with a variety of conditions including; chronic diseases, cancer care, HIV medicines, medicines for haemophilia patients and rheumatoid arthritis.

The service is registered to provide the following regulated activities:

- Treatment disease disorder and injury.
- Transport services, triage and medical advice provided remotely.
- Management of supply of blood and blood derived products.
- Diagnostic and screening procedures.
- Nursing care.

The provider has a nominated individual and eight registered managers.

The main service provided by this provider was community healthcare services for adults. Our findings also apply to the core service community healthcare services for children, young people and families, as such we do not repeat the information but cross-refer.

This was a focused inspection reviewing specific areas of Healthcare at Home's services. Healthcare at Home's services at the time of the inspection comprised of:

Pharmacy dispense and delivery - 36%

Chemotherapy and compounding - 31%

Chemotherapy and complex nursing - 24%

Early supported discharge - 9%

This focused inspection focused on concerns raised with the pharmacy dispense and delivery and complex nursing services.

Summary of this inspection

How we carried out this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with four legal requirements (Regulations 12, 16, 17, 18). This action related to one service.

- The provider must ensure all patients who have had a failed delivery and did not receive the care they should have done are reviewed by a suitably qualified clinical professional to ensure patients have not come to any level of harm. This review must be completed with the patient or patient's representative or prescribing clinician. (*Regulation 12 (2) (a) (b)).*
- The registered provider must devise and implement a system to ensure backlogs of medicine deliveries are effectively mitigated against. (*Regulation 12 (2) (a) (b)).*
- The provider must ensure a patient's allergy status is always recorded and checked with each patient immediately prior to every medicine administration. (*Regulation 12 (2) (a) (b)).*
- The provider must investigate and respond to all complaints in a timely manner. (*Regulation 16 (1) (2)*).
- The provider must investigate all reported incidents and establish what, if any, level of harm has occurred. Learning from these investigations must be shared with relevant staff and the wider organisation to ensure lessons are learnt. (*Regulation 17 (2) (a) (b)).*
- The provider must ensure its information systems meet the needs of the service and any issues are identified in a timely manner with a clear plan and time framework for recovery. (*Regulation 17 (2)).*
- The provider must develop and embed robust governance, oversight and assurance systems to identify, reduce and/or mitigate risks to the service. (*Regulation 17 (2) (a) (b) (c) (d) (e) (f)).*
- The provider must ensure there are enough staff deployed across all it's services to ensure patients' needs are met. (*Regulation 18 (1)).*
- The provider must ensure it submits all statutory notifications to the Care Quality Commission in a timely manner. *(Regulation 18 (Registration regulations)).*
- The provider must ensure that the leadership and culture of the organisation encourages all staff and patients to raise concerns without fear of retribution. (*Regulation 17).*

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Inadequate	Good	Not inspected	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Good	Not inspected	Requires Improvement	Inadequate	Inadequate

Inadequate

Community health services for adults

Safe	Inadequate
Effective	Good
Responsive	Requires Improvement
Well-led	Inadequate

Are Community health services for adults safe?

Inadequate

This was a focused inspection responding to specific areas of concern. Our rating of safe went down. In our previous inspection report, December 2019 we rated it as good. In this inspection we rated it as inadequate because:

- The provider did not always remove or minimise risks to patients. Following the installation of a new information technology system in October 2020, systematic issues with the provider's electronic patient records system 9,885 patients did not always receive their medicine on time. This included time critical medicines, which when missed, could result in the patient's condition deteriorating. Some patients required hospital treatment due to missing doses of their prescribed medicines as a result of failed or missing deliveries. Following the inspection, the provider told us six patients suffered moderate harm.
- The provider had not acted in a timely manner to address the issues caused by the introduction of the new information systems. The provider recognised the implementation had caused considerable service disruption and although steps had been taken to address the issues, a significant number of patients failed to receive essential medicine or had their medicines deliveries delayed. In October 2020, the provider told us 2,397 patients had a missed or delayed dose of their medicine. But from 1 October to 9 December 2020, the provider identified significantly more patients (9,885) may have missed a dose of their medicine due to a failed or delayed medicine delivery. The provider was working through a plan to contact all 9,885 patients and establish exactly how many patients had missed a dose of medicine. As of 14 December 2020, the provider had contacted 3,942 patients (40%).
- The provider did not always manage safety incidents well or learn lessons from when things went wrong. However, policies and procedures to manage safety incidents were in place. In October 2020 there were 587 incidents reported which had been classified as 'medication'. This compared to 191 in September 2020, and 228 in August 2020. Data supplied by the provider showed throughout the previous 12 months, staff consistently reported many incidents due to medicine issues. We reviewed four patient incidents where harm had occurred to patients due to failed medicine deliveries. We found the provider had not adequately followed up the failed deliveries and missed opportunities to ensure the patients received their medicines on time.
- In October 2020, reasons for missed medicines included: 91 failed deliveries because the patient had not been called by the provider at the appropriate time to arrange a delivery; 72 had orders which were not raised correctly by the provider; 80 packages went missing and 167 prescriptions were not dispensed by the provider, despite a current order being in place. Following the inspection, the provider told us this equated to 0.6% of deliveries in October 2020 and information supplied by the provider following the inspection showed improvement.
- The provider recorded incidents relating to medicines. From April to October 2020, there had been 13,126 incidents where patients had missed a dose of medicine. Not all of these indicants resulted in patient harm or were attributed to the provider. Reasons for these incidents were broken down into factors of; 'external, internal, patient not in to accept

delivery and faulty device/medicine'. However, there was no evidence supplied by the provider that all these patients had been appropriately reviewed to ensure that no harm had occurred due to their missed dose(s). However, following the inspection the provider informed us of the process in place to review patients who may have missed a dose of their prescribed medicine. Following the inspection, the provider told us that missed doses equated to an average of 1.62% of interactions from April to October 2010.

- The provider's systems and processes did not always identify when patients were at risk and therefore staff did not act quickly enough to prevent deterioration in their condition. Patients who were at risk of missing a dose of their medicines were often not contacted early enough to prevent them from experiencing unnecessary harm. From October to November 2020, CQC received 32 complaints from patients who had missed their medicine or who were at risk of missing their medicine due to failed deliveries. Patients told us of the physical harm and of the psychological trauma they felt had been caused by the worry of not receiving their medicines on time. In addition, NHS professionals informed us that some of their patients had required extra outpatient treatments due to missed medicines. The provider's social media accounts included many comments from patients who indicated they were at risk of harm due to missed medicines.
- The provider had some systems and processes in place to help ensure patients had sufficient medication stock, including buffer stock where relevant, however these were not always effective. The margin of error built into this system did not allow for the fact not all patients always had a buffer stock of spare medicines, in case of delays. Therefore, some patients ran out of their medicines before the provider had expected them to do so. These patients were not picked up by the provider's system and relied on the patient contacting the provider to arrange an urgent delivery. We saw examples of this during our onsite inspection.
- The provider's dispensing sites were unable to meet all demands for medicines. During our inspection, we saw emails which were sent to Care Coordinator staff (call handlers) regarding the dispensary services' capacity that day. This evidence indicated for several days the dispensary services were operating above capacity. For example, on 28 November 2020, one dispensing location was 576 deliveries over capacity. Care Coordinator staff informed us they were still able to book urgent deliveries for these days, despite already being above capacity, providing they received approval from a supervisor. We saw this was happening during our onsite inspection. Staff told us that these urgent deliveries would be fulfilled, however, some complaints received by CQC showed not all patients who had been promised an urgent delivery received one. Following our inspection, we were told the dispensary had increased its staffing by the equivalent of 38 full time employees and that a change to the booking system would prevent backlogs of medicines waiting to be dispensed.
- The provider did not always have enough nursing staff to administer essential medicines in patient's homes despite trying to fill vacant shifts with agency and bank staff. From July to October 2020, 807 medicine incidents were identified by the provider due to a lack of nursing resources. This was 0.3% of all visits in October 2020 and 0.2% of all visits in November 2020. However, we did not see any evidence of direct patient harm as a result of nurse vacancies.
- The service did not always effectively use systems and processes to safely administer all medicines. We found the patient record system did not easily identify patients who may have a known allergy. Nurses had access to the prescriber's notes which included a section on allergies. However, there was no checking requirement for nurses administering the medicines to always verbally confirm with a patient their known allergies prior to administration. During our inspection we looked at one incident of patient harm where the checking of a patient's allergy status had not been recorded.
- The service did not always manage patient safety incidents well. Some patient safety incidents were not investigated and completed in a timely way or had no evidence learning from the incident had been implemented. We looked at an incident involving an adverse medicine reaction in September 2020 which had not been finalised by the time of the inspection. We found the provider had not taken any actions to prevent a reoccurrence of this incident for the patient or any other patient using the service.
- We also found that systems to share learning from incidents were not embedded across the service. Although incidents were reported by staff, not all staff received feedback about the incident they had raised.

Inadequate

Community health services for adults

- Although staff protected patients from abuse, and received appropriate safeguarding training there was no immediately recognisable way of identifying vulnerable patients. Staff could write specific information in a free text box on the patient's electronic record, however, there was no flag for vulnerable patients. Vulnerable patients were not searchable or immediately identifiable to all staff providing care for the patient. This meant staff supporting patients were not always immediately aware of any vulnerabilities and the provider was unable to search for, and find, vulnerable patients who may need additional support.

However, we also found:

- During our inspection, managers told us they were regularly recruiting new nurses to fill vacancies and that managers made every effort to fill gaps in nursing rotas with regular bank and agency staff. The service provided mandatory training in key skills to all staff and supported staff to complete it. At the time of the inspection 95% of staff had completed mandatory training. This was at a similar and consistent level during our previous inspection.
- Staff recognised and reported incidents and near misses. Call centre staff completed incident reports when patients contacted them with a complaint and nurses completed incident reports for clinical concerns.
- Where the provider was aware things had gone wrong, letters were sent to patients following a patient safety incident. The provider had a service level agreement to also contact the patient's referral centre. The provider was aware of duty of candour requirements and followed guidance where levels of harm were identified. Where complaints had been upheld and where duty of candour was not applicable, the provider wrote to patients and apologised.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Clinical staff involved with the care of children had the appropriate level of safeguarding training.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff had training in infection control and had access to personal protective equipment. From July to August 2020 the service reported one Healthcare at Home attributable COVID-19 infection.

Are Community health services for adults effective?

Good

This was a focused inspection responding to specific areas of concern. In our previous inspection report, December 2019 we rated it as good. During this inspection our rating of effective stayed the same. We rated it as good because:

- The provider delivered care and treatment that was based on national guidance and evidence-based practice. For example, nurses followed national protocols and guidance when administering chemotherapy.
- Staff protected the rights of patients in their care.
- Staff monitored the effectiveness of care and treatment. Nurses contacted the patient's doctor or healthcare provider if they had any concerns about a patient or about the effects of the treatment they were having. This enabled the patient's doctor to improve care and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other and communicated effectively with other agencies.
- Key services were available seven days a week to support timely patient care. Nursing appointments were available during the weekend. There were dedicated patient support lines for patients receiving some medicines and these were available 24 hours a day, seven days per week. The dedicated patient support lines were separate to the usual customer service telephone lines and were treated as a priority.

Inadequate

Community health services for adults

- Staff gave patients practical support and advice to lead healthier lives. Patients who received homecare visits from nurses had regular health assessments and were provided with health advice. For example, on how to avoid pressure ulcers and guidance on food and diet, while receiving chemotherapy medicines.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. All patients receiving care from this provider were referred by either a hospital doctor or a GP. The referrer was responsible for ensuring the patient was happy to have their medicines supplied by the provider. All patients had a telephone consultation with Healthcare at Home staff prior to commencing their treatment. Agreements were sent out to patients to ensure consent was recorded.

Are Community health services for adults responsive?

Requires Improvement

This was a focused inspection responding to specific areas of concern. Our rating of responsive went down. In our previous inspection report, December 2019 we rated it as good. We rated it as requires improvement because:

- Patients told us they were unable to access the service to raise a concern in relation to their failed deliveries and missed doses. When patients tried to contact Healthcare at Home to arrange a delivery, they were not always able to get an answer on the telephone or live chat function on the provider's website. In October 2020, 55% of all calls into the service were answered, against the providers target of 85% of all calls answered. On 25 October 2020, only 9% of calls to the provider were answered. This led to a risk that patients without medicine were unable to contact the provider to arrange for an urgent delivery. The provider told us the volume of calls had increased due to their system issues, and this would be a temporary performance decrease, and calls answered prior to the system upgrade in October 2020 largely met their target. However, from January to March 2020, the call answered time also fell below the target and ranged from 62% to 73%. Following the inspection, the provider told us the performance levels improved to meet their agreed performance standards.
- Following the service issues in October 2020 it was difficult for people to give feedback and raise concerns about care received. The service was overwhelmed with patients trying to contact them, which meant patients could not always tell the provider about their concerns. Following the inspection, the provider shared data with us which showed there had been an improvement.
- The provider received a high number of formal complaints about their service. The provider had policies and procedures in place for complaints handling. From October to 9 December 2020, the provider received 1,703 formal complaints. The provider had a service level agreement (SLA) to investigate and close formal complaints within 20 days. In October 2020, 575 complaints (51%) were outside of this SLA. However, the provider told us they were working through their backlog of complaints, and that the average closure time was 23 days.
- Although we found Healthcare at Home generally treated concerns and complaints seriously, they did not always include patients in the investigation of their complaint. We found some patients were given standard responses from the provider. We reviewed the root cause analysis of six patient safety incidents and found the patient had not been contacted throughout the process.

However, we also found:

- Staff coordinated care with other services and providers. Nurses worked alongside NHS doctors and clinical teams to follow up concerns about a patient care and to share information.

Inadequate

Community health services for adults

- Patients on specific medicines had access to dedicated hotlines to clinical nurse specialists 24 hours a day, seven days per week. Clinical nurse specialists provided advice and support to patients and could arrange extra nurse visits if required.

Are Community health services for adults well-led?

Inadequate

This was a focused inspection responding to specific areas of concern. Our rating of well-led went down. In our previous inspection report, December 2019 we rated it as good. We rated it as inadequate because:

- There was a lack of effective governance and assurance structures and systems which led to significant patient safety concerns which we identified during the inspection. The provider could not provide evidence that risks, issues and performance were managed to ensure that services were safe or that the quality of those services was effectively managed. We found examples where patient care was of poor quality and the provider had failed to act.
- Leaders did not always operate effective governance processes throughout the service and with partner organisations. Notifications, for example, those relating to service interruption were not always sent to CQC in line with the providers regulatory responsibility, nor in line with the provider's own policies. Following our inspection, the provider updated their serious incident policy.
- Notifications were not always consistently submitted, accurately completed, or policies followed. The provider's serious incident requiring investigation (SIRI) policy flow chart, stated that CQC must be informed of all patient harms rated moderate or above. From November 2019 to November 2020, the provider recorded 26 incidents of moderate harm, none of which had been notified to CQC. The provider did not inform CQC of any issues disrupting the service, despite significant service disruption occurring in October 2020. A statutory notification from the provider advising CQC of the events was received only following a request by CQC, and it contained inaccurate information regarding patient medicine stock levels, and levels of harm. Following our inspection, the provider updated their serious incident policy.
- The provider did not always evidence that learning was shared effectively or used to make improvements. Learning from previous events were managed with the individuals involved in the event, but not always shared across the wider staff team. This led to similar errors being repeated.
- Although the service collected data and analysed it, staff could not easily find the data they needed, in easily accessible formats, to make decisions and improvements. We saw this during our inspection, when staff had difficulties in demonstrating actions taken during investigations into adverse events. The provider also collected some of the same data in different formats which meant it was difficult for us to gather a true picture of their current performance. We saw this in information presented to us prior to our inspection. Following our inspection, the provider told us it had improved its data collection and analysis and we saw this in some of the data they submitted to us as part of their conditions.
- Leaders did not always use systems to manage performance effectively. Although there had been testing of the new information system before it went live, performance issues significantly affected patient care. Leaders had not identified the relevant risks and issues prior to release or identified actions to reduce their impact. Although the provider had plans in place for major incidents and business continuity, by the time the issues had been identified, there was a large backlog of patients who did not receive their deliveries. Issues continued to affect patients throughout October, November and December 2020. There was no evidence that the providers major incident policies had reduced the impact of this incident.
- The service did not always have an open culture where patients, their families and staff could raise concerns without fear. Some patients and some staff contacted us anonymously. Patients told us they did not want to give their names in case their medicine deliveries were cancelled. Some staff who raised concerns did not leave their contact details and

we were unable to ask for more information about their concerns. One member of staff told us they feared losing their job if it became known that they had contacted us. The provider had a whistleblowing policy in place. We gave all staff the opportunity to provide feedback on working for Healthcare at Home, (either anonymously or not). However, from November to 8 December 2020, we only received one response, which was a positive response from a member of staff.

However, we also found:

- The provider had an action plan to recover their services back to pre-incident level. Plans were submitted fortnightly to CQC and showed improving levels of service.
- Staff we spoke to were clear about their roles and accountabilities and had regular opportunities to meet and discuss issues. Meetings were held remotely to allow staff working across different regions to attend.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were aligned to local plans within the wider health economy.
- The provider participated in national networks and associations seeking to find innovative ways to improve access to and the quality of healthcare.
- Leaders encouraged innovation and new ways of working, and the plan behind the new patient record system was to improve services using the most up to date systems available. During the pandemic, the service had embraced new ways of working to allow staff to work remotely and to continue running services for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:** • The provider did not always manage safety incidents well, did not always fully investigate and did not always learn lessons when things went wrong. **There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:** • The provider did not have effective governance, oversight and assurance systems to identify, reduce and/or mitigate risks to the service. **The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular:** • The leadership and culture of the organisation did not always encourage all staff and patients to raise concerns without fear of retribution. **There was additional evidence of poor governance. In particular:** • The provider failed to ensure its information systems met the needs of the service and issues were not identified in a timely manner and did not have a clear plan and time framework for recovery.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular:** • The provider did not always have enough staff deployed across all it's services to ensure patients' needs were met.

Regulated activity	Regulation
Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. In particular:** • We found the provider did not always include patients in the investigation of their complaint. We found some patients were given standard responses from the provider. We reviewed the root cause analysis of six patient safety incidents and found the patient had not been contacted throughout the process.

Regulated activity	Regulation
Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **There were no systems or processes that enabled the registered person to submit all statutory notifications. In particular:**

This section is primarily information for the provider

Requirement notices

- The provider failed to submit all statutory notifications to the Care Quality Commission in a timely manner.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Following the inspection, an urgent Notice of Decision to impose conditions on the provider's registration was issued under Section 31 of the Health and Social Care Act.** **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • We found that ineffective systems and processes led to service users being exposed to a serious risk to their life, health or wellbeing. • We found a lack of effective systems and processes to identify service users who may be at risk of being exposed to a serious risk to their life, health or wellbeing. • We found that ineffective systems led to issues preventing the ability to deliver all medicines as required on time. The delay in service users receiving their prescribed medicines increased the risk of service users missing doses and being exposed to a serious risk to their life, health or wellbeing. • We found ineffective systems prevented service users from accessing the service and restricted the provider's ability to respond to all service users as required in a timely way to ensure they received safe care and treatment. • We found systems and processes to learn from adverse/ significant incidents and events, in order to mitigate against potential reoccurrence, were ineffective.