Routes Healthcare (North) Limited

Routes Healthcare Manchester

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Routes Healthcare Manchester is a domiciliary care agency providing personal care to people in their own homes. The service also provides a reablement service and bespoke service to people with physical health needs. The service was supporting 218 people at the time of the inspection, including older people, those living with dementia, people with a physical disability and younger adults.

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.

People's experience of using this service and what we found
The risks associated with people's care were not always managed in a safe way. This included the provider not knowing whether staff had attended calls and poor management of medicines. This meant people were at risk of avoidable harm.

People, their families and other people that mattered were sometimes involved in the planning of their care. However, the care plans did not contain information specific to people's needs and how to manage any conditions they had.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Safeguarding incidents were documented, and records showed that some action had been taken to address concerns. However, following a recent substantiated safeguarding concern we found the previous manager had not followed up on their assurances provided to the safeguarding team. This meant poor staff practice had not been addressed.

Feedback and oversight of the reablement service and bespoke service provided to people with physical health needs was positive. They operated separate governance systems and had access to a workforce that's was not connected to the care at home service.

There was a lack of robust systems in place to monitor the delivery of care and this impacted on the care that people received. The provider had failed to ensure there were robust systems in place where staff either arrived late for a call or and there had been a small number of instances where staff failed to attend a call. Audits taking place were not identifying or preventing issues occurring or continuing at the service.

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

Rating at last inspection
The last rating for this service was good (published 13 September 2018).

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Why we inspected
The inspection was prompted in part due to concerns received about the management of people's care, missed and late visits, medicine management, quality of care and management of the service. A decision was made for us to inspect and examine those risks.

Enforcement and Recommendations
We will continue to monitor the service and will take further action if needed.
We have identified breaches in relation to person centred care not always being delivered, the management of medicines, need for consent and ineffective governance systems.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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 take action 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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Routes Healthcare Manchester

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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors, a medicines 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. The Expert by Experience made telephone calls to people and their relatives.

Service and service type
This service is a domiciliary care agency. It provides personal care to older people living in their own houses and flats.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post, however this manager had cancelled their registration in June 2022, but due to a technical error they were still registered for this service. Shortly after the inspection the registration error was resolved, which meant there was not a manager registered at this service.

Notice of inspection

We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 22 November 2022 and ended on 30 November 2022. We visited the location's office on 22 November 2022.

What we did before the inspection
We reviewed information we had received about the service since it had registered with us, including notifications the provider had sent to us. We also gathered feedback from the local authority.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
During our inspection we spoke with 3 people and 17 relatives. We also spoke with the provider, two managers, service manager, service improvement director and 17 care staff. We looked at the care records for 19 people and various medicines records. We checked that the care they received matched the information in their records. We looked at records relating to the management of the service, including audits carried out within service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not managed safely. Good practice guidance was not routinely followed, which meant people's medicines were not always given as prescribed.
- We found 5 people had missed doses of their medicines, this was due to their medicines not being available. We identified there was no information recorded to guide staff as to what action to take when medicines were low in supply or unavailable. We found 1 person ran out of a critical medicine for 3 weeks. There were no records to show whether staff had attempted to obtain a supply or inform the office they had not given the medicine.
- People's care plans lacked detail about the support people needed for each of their medicines.
- People were not given their time sensitive medicines (medicines which need to be given at a certain time) safely, because the system for managing these medicines was ineffective. This included time critical medicines for people with Parkinson's Disease, diabetes, gastrointestinal treatments and people who needed pain relief at the right time.
- Records about medicines administration were not accurate and could not always show what medicines or creams people had been given. Some records were not legible and sometimes staff failed to sign the records, so it was not always possible to tell if medicines had been administered as prescribed or if they had been omitted.
- No information was recorded for staff to follow when medicines were prescribed to be given 'when required' or with a choice of dose, so people may not be given their medicines prescribed in this way safely.

The provider had failed to ensure safe systems for the management and administration of medicines. We found no evidence people were harmed at the time of the inspection, however, unsafe management of medicines placed people at increased risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The call monitoring system was ineffective. There was no oversight or monitoring of the calls undertaken by management or provider, which meant when care workers were not staying the full length of the call, this was not always known.
- We reviewed records of people's daily notes and staff schedules, this showed a number of discrepancies between agreed hours and actual hours delivered. There was systemic and widespread evidence of unsafe practice. Staff were scheduled to be at multiple calls with minimal time for travel. Care workers tended to receive between 3 to 5 minutes for travel time, which meant care workers would have to leave calls earlier or be late for a visit.
- We received mixed feedback from staff about the calls they provided to people. Care workers told us,

"Timings between calls are very tight, you have to rush the job sometimes", "Impossible to stick to times, I do my best and very lucky to have a car so I can make the time up" and "Mornings are very busy, you do have to clip some calls where you can, but I always make sure the work is done before I leave."
● Staff retention was poor with a high turnover at the service. Although the provider informed us they were actively recruiting, we were informed the retention rate was just 48.95%. We found work had not yet commenced to establish why there was poor staff retention at the service.
● Feedback from people and their relatives regarding call times was also mixed. Comments from people included, "Yes, some of them [staff] rush. Odd one will leave early", "Not here very long. I assume they [staff] are rushing", "No, when they [staff] have finished, I let them go. They [staff] always ask if there is anything else, they can do for me" and "1 or 2 in the past, have rushed. Regular ones [staff] are very good. Occasionally some rush, if they have finished, they can go."

Effective systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff available to meet people's needs at the complex care and reablement services. A contingency plan was in place for staff shortages. Staff told us they worked well as a team to ensure holiday and sickness was covered with regular staff. This ensured people using the complex care and reablement service experienced continuity of care.
● A framework was in place to support safe recruitment practices. However, the administration of pre-employment checks was not consistent. For example, professional references were not always obtained when a candidate had previously worked in care, and pre-employment medical screening was not always completed.
● Checks in relation to criminal records were completed. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● There were some evidence lessons were learnt when things had gone wrong, however this approach was not consistent.
●There were insufficient systems in place to ensure incidents were thoroughly investigated, reviewed and monitored to prevent further occurrences. The service did not ensure lessons were learned when things went wrong and did not have systems in place to ensure reported safety concerns were addressed.
● Opportunities for lessons learnt were missed. For example, one person's medicines had not been ordered in a timely manner, which meant they went without their prescribed medicines for 21 days. This person had also not received one of their medicines the previous month, however repeat issues continued.

The provider has failed to ensure there were effective systems in place to to assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● When people had individual risks such as diabetes or a health condition there was not always care plans or risk assessment in place identifying this. We found no evidence of harm as staff knew people well and supported them to stay safe.
● Risks at the complex service were well managed. People's malnutrition and dehydration were well monitored and managed, referrals were made for professional support promptly.

Systems and processes to safeguard people from the risk of abuse

● The provider's systems to recognise and take action, on poor practice were not always effective. Prior to our inspection the previous manager made a number of assurances to the safeguarding team regarding improvements following substantiated concerns around late and missed calls. However, we found these assurances had not been followed through until we reminded the provider.

●Staff were trained in safeguarding people and understood the signs of abuse and how to raise concerns if they needed to inside and outside of the organisation. Staff had access to a whistle-blower policy to support them with raising concerns.

Preventing and controlling infection

● People and relatives raised no concerns around staff practice in relation to infection control. They confirmed staff wore personal protective equipment (PPE). Office staff ensured staff had all the correct equipment they needed to support people.

● Staff had received training and there were infection control procedures in place.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
- The provider was not always working within the principles of the MCA.
- When mental capacity assessments were completed, we found these were not completed in great detail and failed to detail what questions were asked in respect of the decision that was being assessed. When people had been assessed as lacking capacity to make decisions about their care, there was not always evidence of a best interest decision as legally required.
- Where a person lacked a mental capacity, the provider had not taken steps to confirm whether their relative had the legal authority to make decisions for them. Without robust procedures, people were at risk of decisions being made for them unlawfully and outside of their best interests.

The provider had not consistently acted in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had received MCA training and had access to the provider's MCA policy for guidance. However, there was a lack of evidence to demonstrate how the manager had verified if the staff had understood the training provided or the policy.

Staff support: induction, training, skills and experience
- Newly recruited staff completed an induction. Previous care experience and related qualifications was

considered before a person was deployed to work with people who used the service.
● The complex care element of the service provided staff with bespoke training, tailored to the client's individual needs.
● Training was a blend of online e-learning and face-to-face. Competency and knowledge checks were completed in the classroom environment and out in the field.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People received food and drink that met their dietary needs and preferences.
● Care plans contained information about what support people needed with their meals. However, one person's risks associated with food and drink intake did not detail the guidelines noted from this person's Speech and Language Therapist (SALT) assessment. We brought this to the providers attention. They took immediate action in response to this concern. Some people's risks related to diabetes had not been assessed. So there was a risk that some people would not be supported appropriately with their diet.
● People's care plans contained information about healthcare professionals who should be contacted with any concerns. Records show that when needed healthcare professionals had been involved.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care and support was planned, however, support plans required further work to make them relevant and person centred.
● The provider gained consent from people and developed care plans in line with peoples' needs and choices. However, this needed to be reflected in the care planning and the documents were not always signed or dated.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People and their relatives told us they were treated well and their needs in general were met, but the lack of clear information and risk assessments in care files meant we could not be assured people received individualised care consistently. There was a risk staff may not support people's diverse needs.
- People did not always have their preference to receive personal care from the gender of staff they preferred. Prior to our inspection a person's relative contacted CQC to raise concerns about this. Once the provider became aware, they ensured the correct gender support was provided.
- People and their relatives spoke positively about the staff and staff approach. One relative told us; "They [care workers] are friendly and courteous enough." Another relative told us, "The carers themselves do a good job and are friendly and nice."

Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- Care records did not always detail tasks that people were able to carry out for themselves. Therefore, we were not assured that people were supported to be as independent as they could be.
- People were encouraged to make decisions about the care they received. However, it was not always clear in care plan evaluation reviews if people had been consulted about their care.
- People's records included basic information about their personal circumstances and some information on how they wished to be supported. However, the staff did not have enough information to learn about people so they could engage with them in decisions about their care and support.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans generally lacked person-centred detail and contained little information about people's specific needs and/or preferences as to how they would like their care to be delivered including what was important to them.
- Care plans contained contradictory and inaccurate information and lacked enough detail for staff to provide person-centred, safe and effective care. For example, 1 person's care plan stated 3 different dates of birth and recorded they didn't require support with their medicines, however we found this was not the case.
- Information to support staff to understand people's individual health conditions was not detailed within the care plan records.
- People's care and support plans did not always focus on positive outcomes to improve their quality of life. There was very little evidence that staff supported people to identify aspirations for their future.

The provider had not ensured the care of service users was appropriate, met their need and reflected their preferences This placed people at risk of harm. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Care plans at the complex care service were detailed and supported staff to provide the care people required to keep them safe and well. For example, plans were comprehensive and guided staff how to support people to live full and meaningful lives. Records contained clear information about people's likes and dislikes and any specific needs including in relation behaviours resulting from anxiety and distress.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their careers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Although the provider and staff were aware of the Accessible Information Standard. These were not always considered as care plans were not always in place for people.
- People's communication needs had been considered as part of the initial assessment. This was documented, however there were no individual plans in place for people stating how they may choose to communicate and the level of support they may need with this.

Improving care quality in response to complaints or concerns

● People and their relatives had access to a complaints policy should they wish to raise any concerns. The complaints policy detailed who to contact if people or their relatives were not happy with the service.

● Within the last 6 months we noted there had been a high volume of complaints. The management team said they took complaints and concerns seriously and identified some themes. However, there was no further analysis of complaints or satisfaction with responses about the service that could be used as a means of continuously reviewing performance, quality and safety.

End of life care and support

● The service was not supporting anyone with end-of-life care at the time of our inspection.

● People's care plans lacked information regarding their end-of-life wishes and preferences. We discussed the need for consideration of advance care planning with the management team. They told us end of life care was an area they were looking to redevelop at the service going forward, this had also been identified in their action plan.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- We were not assured that effective management arrangements in place. The previous manager left the service in September 2022 and a new manager joined the service, but was only in post for 4 weeks. While the provider was actively looking to recruit a new manager, two experienced managers from the providers other services were brought in to share the responsibility for overseeing the service.
- The provider could not demonstrate the effectiveness of their audits. Government processes did not identify shortfalls found throughout the inspection. For example, medicine audits were not routinely completed, and when they were, action to explore errors and improve staff practice was not always undertaken. Without regular quality assurance processes, shortfalls could not be shared, addressed and learned from.
- The lack of systems to monitor the quality of the service and provide effective managerial oversight did not allow for lessons to be learnt, or actions taken to drive improvements. The service continued to receive a high number of complaints, but no formal analysis took place to determine potential trends.
- The service tended to sample 10% of records every month for quality assurance purposes. However, this approach was haphazard and meant quality checks of people's care may not take place for a number of months. Record keeping was poor, and records were incomplete and inaccurate. Care plans and risk assessments did not include all current information or enough guidance for staff.
- There was some evidence demonstrating the provider was taking steps to ensure improvement in the quality of care. For example, the provider had worked with the local authority to develop an action plan to improve the quality of service provision. However, this was in response to concerns raised rather than a systematic reflective approach utilising a range of data and feedback sources to assess quality.

Effective systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Governance systems at the complex care service and reablement service was well managed. Staff understood their roles and responsibilities and there were clear lines of delegation.
- The management team explained the organisation was on a digital care management transformation and plans were due to roll out the implementation of a digital care management systems. They told us the Manchester service would be prioritised.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We received mixed views from people and relatives about the service they received. People told us, "The carers coming through are not up to standard. They try their best, but the more experienced carers are okay" and "Very good, excellent service. I have regular carers and new carers occasionally." A relative told us, "The majority of carers are great, but the lack of communication from the office is a major factor. The office staff don't seem to care."

● The provider told us they had taken on board the views of people and their relatives, and they would look into their concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood their legal responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others

● People and relatives said overall they were satisfied with the service provided although it was felt the timing and duration of visits needed to improve. One person relative said, "Get the times better and inform us. I have to phone them and sometimes they call me, sometimes they don't."

● We saw surveys had been completed by 23 people for 2022. Feedback generally indicated people were satisfied with the service.

● The management team-maintained contact with commissioners and staff as well as health care professionals such as GPs and district nurses to support people's needs.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured the care of service users was appropriate, met their need and reflected their preferences This placed people at risk of harm.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not consistently acted in accordance with the requirements of the Mental Capacity Act 2005.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure safe systems for the management and administration of medicines.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm.

The enforcement action we took:

Warning notice.