Heritage Homecare Services Ltd

Nelson

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We undertook a focused inspection of the Nelson branch 24, 25, 30 November and 9 December 2015. The inspection visit on 24 November and 9 December 2015 was unannounced. This was as a result of the Commission receiving information and further concerns that related to the care and welfare of people using the service. The concerns related to missed and late visits, administration of medication, and delivery of the care provided. The inspection on the 9 December was undertaken with representatives from the Local Authority Safeguarding team along with representatives of the police.

Nelson provides care and support for people in the Burnley and Pendle area. The range of services provided includes, personal care, domestic help and shopping. The service provides support for older people, people living with a dementia, adults with physical disabilities and learning disabilities. The agency's office is located in the centre of Nelson. At the time of the first day of the inspection the service was providing support to seventy six people.

The Nelson branch was last inspected on 16, 17 and 21 September and 14 and 15 October 2015. This was as a result of the Commission receiving concerning information relating to the care received by people who used the service. As a result of the inspection a number of breaches of the Health and Social Care Act (RA) regulations 2014 were identified for Regulations 9 person centered care, Regulation 12 Safe care and Treatment, Regulation 14 Meeting nutritional and hydration needs, Regulation 16 Receiving and acting on complaints, Regulation 17 Good governance, Regulation 18 Staffing and Regulation 19 Fit and proper persons employed. The overall rating for this inspection was inadequate and the service was placed in 'Special measures'. Services in

Summary of findings

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.

During this inspection we identified ongoing breaches relating to Regulation 12 of the HSCA (RA) regulation 2014 Safe Care and Treatment and Regulation 17 Good Governance. We also found a breach of Regulation 18 HSCA 2008 (Registration) Regulations 2009 Notification of other incidents. As there are ongoing breaches we will report on our actions once our investigation has been completed.

We had been made aware of a number of safeguarding concerns raised about the service that had not been reported to the Commission by the service. As a result of our findings during this inspection we referred our concerns about the deficiencies in care for three people to the Local Authority Safeguarding team.

We looked at ten care files and noted deficiencies in their content. Records were brief and lacked detail to guide staff about people's individual needs. There was no evidence of specific risk assessment to manage people's individual need for example falls or medications. Evidence of missed visits was seen along with concerns around inappropriate responses to changes in people's health conditions.

We asked about how the service monitored that the visits were taking place. We were told that staff called into a call logging system that recorded when the visit had occurred. However we received conflicting information about this system. One person told us there were twenty five lines for this but another staff member said there were only two lines and up to forty five staff could be trying to log in at the same time. We were provided with records of visits for one person although the information provided by the service was different information to that provided to the Local Authority covering the same time frame. This meant that records of visits undertaken were unreliable as it was not possible to determine if visits to people had taken place or not.

We looked at how the service was managing complaints. Whilst there was evidence of a complaints file we could not see what actions had been taken as a result of one response to a complaint that had been filed in it. Team meeting were seen to be taking place but there were no records of who had attended the meetings or actions taken forward as a result of the meetings.

We saw that only three people had been invited to provide feedback about the care they received from staff. Whilst one of the records stated they had, 'been with the company nine years and were overall happy', two of these records identified some concerns relating to the care they received. One person's response to, 'How would you rate the overall service from the office was recorded as 'poor' with the comment, 'Not very happy at the moment' they also recorded that they were unhappy with carers attitude.

We identified that audits had been under taken relating to care files since our last inspection however we saw that all of these had taken place on the same day and had been completed by the same staff member. There was no evidence to confirm what actions had been taken to resolve the gaps or requirements in the records identified.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

We looked at the care files for 10 people in receipt of care from the provider and identified concerns in all of them.

We had been made aware of a number of safeguarding's raised about the service that had not been reported to the Commission by them.

As a result of or findings we referred our concerns about the deficiencies in care for three people to the Local Authority Safeguarding team.

Is the service well-led?

Inadequate 

The service was not well-led.

We saw that the call monitoring system used to ensure people who used the service provided inspectors with conflicting information. We were told by one person there were only two lines for staff to call in to however another said another figure. Records of visits undertaken to people were unreliable.

Monitoring of complaints was ineffective. A record of actions taken as a result of people's complaints had not been completed. Although there was evidence that team meetings had occurred we could not see which staff had attended them or what actions were taken forward as a result.

We saw that only three people had been invited to provide feedback about the care they received from staff. There was no evidence to confirm what action the provider had taken as a result of the feedback. Care file audits had taken place but evidence suggested all seventy six of these had been completed on the same day by the same staff member.

Nelson

Detailed findings

Background to this inspection

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

We undertook a focused inspection of the Nelson branch on 24, 25, 30 November and 9 December 2015. The inspection visit on 24 November and 9 December 2015 was unannounced. This was as a result of the Commission receiving information relating to further concerns about the care and welfare of people using the service. The concerns related to missed and late visits, concerns around administration of medication and delivery of care provided. The inspection on the 9 December was undertaken with a representative of the Local Authority safeguarding team along with representatives from the police. A total of five adult social care inspectors and one inspection manager undertook the inspections.

As part of the inspection we looked at a number of safeguarding concerns that had been identified to us from a number of sources including the Local Authority Safeguarding team, people using services, family members and staff. During the inspection we looked at a number of care files relating to some of the concerns that had been raised along with a sample of records relating to people who were in receipt of high levels of care. We spoke with both directors of the company along with a newly appointed manager and a care manager who was at the service on the first day of the inspection. We also spoke with two staff members as well as one person in receipt of care. We looked at 10 care files for people, policies and procedures, duty logging systems, and evidence of audit and monitoring.

Inadequate

Is the service safe?

Our findings

The Nelson branch was last inspected on 16, 17 & 21 September and 14 & 15 October 2015. This was as a result of the Commission receiving concerning information relating to the care received by people who used the service. As a result of the inspection a breach of Regulation 12 of the Hearth and Social Care Act (RA) regulations 2014 was identified. This was because the provider had failed to ensure people received care in a safe way. The service was rated as overall inadequate and placed into 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.

During this inspection we looked at all the records made available to us relating to ten people and identified a number of concerns relating to the content. All records we looked at had some shortfalls relating to their content. The care files were chosen because we had received concerning information about the person's care or they were selected as part of a random sample. As a result of our findings we referred our concerns about the deficiencies in care to the Local Authority Safeguarding team for further investigation

All of the care files reviewed identified gaps in the information that was contained in them. We saw medical conditions had not been documented. For example information relating to mobility and a medical condition and the impact this would have on the person's care delivery had not been documented fully to ensure delivery of care reflected the current need. Another record did not reflect a change in home circumstances that would impact on the support required from the staff. We also saw that essential information that would be required to safely manage meals as well as medication was incomplete in two records we looked at.

One person's record had no record to confirm an initial assessment had taken place to ensure effective and safe care was delivered. All care files we looked at contained a personal social care support plan however these records were brief and were incomplete. Care plans consisted of basic information and lacked details on what support was required and what actions staff were required to undertake to ensure people's needs were met. There was no record to guide staff on effective care delivery to reduce the risks associated with ineffective care planning.

One care file we looked at identified records that indicated restrictions were being placed on them such as limits were being applied to their consumption of cigarettes and the record stated, "[Name of person] to be given one packet of cigarettes per day". Records did not indicate who had been involved in this decision or if any capacity assessments had taken place. We noted a mental capacity assessment form had been completed on 3 November 2015 relating to "understanding the care plan" which had identified no concerns relating to capacity. In the visit record we saw staff had recorded, "Took fags from box while I was getting tablets. I told [Name of person] only one packet a day. I will replace them." We spoke with a senior member of staff about this documentation; they could not provide a valid reason why this had restriction had been implemented. People using services were at risk of unsafe ineffective delivery of care.

There was evidence of general risk assessments in place in people's records that we looked at however evidence of specific risk assessments to support people's individual needs were missing. For example one record identified that a person was having a specific medication to treat a medical condition. We saw that there was no reference to this in a risk assessment relating to their meals or medication and what actions staff were advised to take in the event of a concern or change in condition. Another record identified a risk of falls however again there was no specific risk assessment in place to advise staff of risks associated with this or how to manage this. There was no guidance for staff to follow to mitigate the risks associated with this.

Records we looked at identified conflicting information than what had been recorded in the Local Authority information that we checked. Reference to medical histories was noted to be different in both records, allergies listed in one care file was different to the records obtained by the Local Authority and there was reference to medication in them that did not provide consistent information relating to their medications. Systems to protect people from incomplete and inaccurate records were inadequate.

We looked at the records relating to medications which had documented to be used in the event of a hospital admission or medical review and noted these had not been completed in full. Records relating to the medications were seen to be incomplete and did not reflect what was being

administered by the staff. For example one file we looked at had records relating to a medication that was required at four hourly intervals however the medical details sheet did not give clear instructions for administration. A further two records identified that staff were administering antibiotic medications however there was no reference to this on the medical details sheet. Creams were seen as being applied in several of the care files we looked at however again we could see no reference to who had prescribed these, when they were prescribed and the site of administration required. This meant people using services were at risk of ineffective unsafe care delivery.

All of the medication records we looked at lacked detail about what was being given, the dosage to be given, why it was prescribed and without any clear instructions for when the medicine was to be administered. It was impossible to establish a clear audit trail of medication administration as records were seen with gaps in them, one record had question marks in the section where a signature would have been expected and there was little evidence of the times medication was being given. In one of the records we looked at we identified that staff were recording medication was being given with food. However it was not clear if this medication was being given covertly (without the person's knowledge) to this person and records did not have a clear care plan to guide staff on the medication administration for them. Medication sheets had been completed by staff and we saw that staff had used a code in the signing section. There was no evidence what this code was, however we asked a senior member of staff about this who told us this meant, "Not witnessed". We saw that this code had been used in a number of records where care records directed staff to prompt witness medicines being taken and to sign for medication. This meant people using services were at risk of ineffective, unsafe care delivery.

During our inspection we looked at the care files and identified some concerns relating to the care people received and the timeliness of staff responding to concerns or changes in people's conditions. For example one person's file we looked at identified that staff had raised some concerns relating to a change in their condition. We could not see evidence that staff had responded to these concerns in an appropriate manner. There was no evidence that staff had either contacted the office or a medical practitioner to ensure effective care delivery was maintained. Another record we looked at identified that staff failed to respond to one person who had an identified condition that required supervision which resulted in ineffective, unsafe care delivery. And another record identified a concern with the amount of medication that one person had taken. We could not see that these concerns had been referred to a medical practitioner to ensure this person received an appropriate and timely intervention. Systems to protect people using service from inadequate safe delivery of care were lacking

During the inspection we looked at some concerns that had been raised relating to missed and squeezed visits that had impacted on personal care, medication administration and food and fluid needs. We saw that one person records indicated that 15 missed visit had occurred between 15 October to 6 December 2015. We spoke with the provider about this who told us they were not aware that any missed visits had taken place since our last inspection. However the Local Authority Safeguarding team told us that the provider had been made fully aware of all the concerns relating to missed visits. Another record we looked at identified that one person had received two missed visits that had resulted in a number of hours before staff visited again. This person was found to have fallen at the follow up visit and required treatment from a medical practitioner. A third person was noted to have received only four of the eight expected visits over a two day period during our inspection. People using services were at risk of unsafe care because the provider failed to ensure the health and safety of them because the commissioned visits to meet their individual care needs were not met.

We looked at records relating to the monitoring and recording of food and fluids for people using service. Records were brief and lacked consistency in their recording. It was difficult to establish if people using services were being offered a balanced diet. For example one record we looked at had recorded that the person using service required support to maintain a balanced nutritional diet. We looked at the record relating to what meals were being provided for the person. We found there was little evidence that a nutritional meal was provided and we could not see that staff had recorded any discussion about meal choices or a nutritionally balanced diet with the person. People were at risk of ineffectively care delivery because staff did not follow guidance recorded in the care records for people using services.

Inadequate

Is the service safe?

Another record identified large gaps in their recording, for example there was 54 gaps seen were records of meals would have been expected. We noted staff were recording that out of date mouldy food was being identified; this was despite evidence that records indicated staff were responsible for undertaking shopping and meal preparation. One record stated, "Please check dates in fridge found milkshake dated 4 Nov this is 10 days out of date." Another entry recorded, "Out of date meat in fridge thrown away". People were at risk of unsafe care delivery because staff failed to act on the management of food and meal choices.

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

As part of the inspection process the Commission had been made aware of a number of safeguarding concerns that had been raised with the Local Authority safeguarding team. For example, missed and late visits, concerns around effective medication management, documentation and delivery of care given to people using services. A representative from the Local Authority safeguarding team confirmed that the provider had been made aware of all of the concerns that had been raised with them. We checked our systems to confirm if the provider had informed the Commission of the concerns that had been raised and could see that only one of the statutory notifications received by the Commission related to the safeguarding's that had been raised with the Local Authority. Systems to protect people using the service were inadequate as required notifications were not sent to the Commission as required as part of the regulations.

This was a breach of Regulation 18 HSCA 2008 (Registration) Regulations 2009: Notification of other incidents. The provider failed to notify the Commission without delay of safeguarding concerns made aware to them. As there are ongoing breaches with this provider we will publish our actions once this has been completed.

Inadequate

Is the service well-led?

Our findings

The Nelson branch was last inspected on 16, 17 & 21 September and 14 & 15 October 2015. This was as a result of the Commission receiving concerning information relating to the care received by people who used the service from the branch. As a result of the inspection a breach of Regulation 17 of the Hearth and Social Care Act (RA) regulations 2014 was identified. This was because the provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. The provider had failed to maintain accurate and complete records relating to people who used the service, people employed at the service and management of the service. The service was rated as overall inadequate and placed into special measures.

We undertook this unannounced follow up inspection as a result of further ongoing safeguarding concerns raised by Lancashire County council about the care people received. We were informed by the Lancashire County councils safeguarding team that the providers had been made aware of all the safeguarding's and they had requested information relating to these investigation to be provided to them. We were informed by the Lancashire County councils safeguarding team that this information is still outstanding. We attended a number of meetings relating to these concerns with representative from Lancashire County council and the police.

During our inspection we spoke frequently with one of the directors about the inspection process and our requirements for information. We found that they were unwilling to assist and on occasions they failed to provicde information requested in a timely manner. We found that the demeanour of the directors was unprofessional and we saw that they demonstrated a lack of understanding of their roles and responsibilities.

During this inspection we looked at how the service ensured visits to people using services were monitored and logged to ensure they were received the care required from staff. We were informed that the computer system (computer based call monitoring and recording system) was monitored during office hours as well as out of hours in the evening. We were told that staff were required to call into the system to log in the call. However inspectors were given conflicting information about the amount of staff able to log into the system. One person told us staff had access to 25 lines for them to call into however another staff member said there was only two lines for staff to log into during a visit at any one time and that there could be up to 45 staff trying to log in any one time. This would mean that they would have to call the office to manually log in. One member of staff we spoke with about how they ensured visits were being completed as required told us, "I will call the carer (Member of staff); I will know when they are lying".

We asked to look at the system that identified what visits had taken place for people who used the service. We were told by one of the directors that they had not been made aware of any missed visits taking place since our last inspection. However we identified some concerns relating to this. One record we looked at identified that a number of calls had been entered into the system manually therefore we could not be confident that these visits had actually taken place. We crossed referenced this information with a record that covered the same time period that had been provided to the Local Authority Safeguarding team by the service and noted that records were different and some visits that had been missed on the local authority documentation was showing as completed on the information that had been provided to us during our inspection. The computer based call monitoring and recording systems could not be relied on as effective system to monitor delivery of visits as the record was being manually overridden by staff employed by Heritage who were managing the system

During the inspection we were shown how the systems worked to record and monitor call logs. We were shown how the system identified when calls were overdue their allocated time and what actions the staff member would take in response to this. However we identified some concerns in relation to this system. This was because evidence was seen that the system had recorded that a visit had been completed as taking one hour and the system indicated the staff member had been logged as left the visit fifty four minutes prior to the log as them arriving at the visit. The system was an ineffective means of monitoring staff attending visits to people using services.

During the inspection we looked at how the service was managing complaints and examined the evidence in the complaints file. We saw there was only one entry logged in the file however this information only related to a response

Inadequate

Is the service well-led?

letter to a complainant. There was no evidence of what the complaint was or what action the provider had taken as a response to the complaint to ensure learning and moving forward with the service.

During the inspection we examined how staff were kept up to date. We were shown a team meetings file. There was evidence to suggest four team meetings had taken place, the last one being 4 September 2015. However we saw that records did not include any staff list, agenda, minutes from the meetings or any actions going forward as a result of the meetings. People who used the service were at risk of ineffective systems and processes to ensure the quality and experience for them.

During the inspection we looked at how the service managed the quality of the service being delivered by the provider. We saw that only three people had been invited to provide feedback about the care they received from staff. Whilst one of the feedback forms stated they had, 'been with the company nine years and were overall happy', two of these records identified some concerns relating to the care they received. In response to the question, 'How would you rate the overall service from the office' they recorded 'poor' with the comment, 'Not very happy at the moment'. They also recorded they were unhappy with carers attitude. We saw evidence that an action sheet had been completed however we could not see what concerns they had raised or the actions to be taken by the provider other than, 'Certain carers to be barred as [name of person using the service] does not want them in her home.' Another feedback form identified that the, 'last few weeks have gone to pot'. Again there was no reference to actions taken as a result of comments that had been made or evidence further investigations in to the comments made.

As part of the inspection we looked at how the service monitored the care files for people using the service and identified some concerns relating to this. We identified that audits had been under taken relating to care files since our last inspection, there were concerns relating to the content and accuracy of the details contained in the audit. We noted that the same member of staff had completed the audit of all of the 76 care files on the same day. We spoke with the director about the audits who confirmed that the audit had taken place on the same day. There was no evidence to confirm what actions had been taken as a result of the findings to address the gaps in the care files or what the review of the care files consisted of. The systems to ensure effective quality monitoring of care files was inadequate and ineffective.

We checked what systems were in place to ensure staff had access to policies and procedures to ensure effective monitoring of safe care delivery was taking place. We looked the, 'Standards for quality assurance' policy dated 3 April 2014 and saw that whilst there was a list for staff to follow in respect of quality assurance there were no details or clear guidance for staff to follow to ensure effective delivery of care to people who used the service.

This is a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance. The provider failed to ensure systems and processes were established and operating effectively. As this is an ongoing breach we will publish our actions once this has been completed.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe Care and treatment. The provider failed to ensure people received care in a safe way. 12. – (1) (2) (a)(b)(f)(g)

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 HSCA 2008 (Registration) Regulations 2009: Notification of other incidents The provider failed to notify the Commission without delay of safeguarding concerns made aware to them. 18.- (1) (2) (e)

The enforcement action we took:

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance The provider failed to ensure systems and processes were established and operating effectively. 17. – (1) (2) (a)(b)(e)(f)