Nestor Primecare Services Limited

# Allied Healthcare London Central

## Inspection report

66 Prescot Street
London
E1 8HG

Date of inspection visit:
21 February 2017
22 February 2017
24 February 2017

Date of publication:
27 April 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

We carried out an announced comprehensive inspection of this service in September 2016. Breaches of legal requirements were found regarding safe care and treatment, medicines, consent to treatment, good governance and notifying the Care Quality Commission (CQC) of significant events. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection between 21 and 24 February 2017 to check they had followed their action plan and to confirm that they now met legal requirements. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Allied Healthcare London on our website at www.cqc.org.uk.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of this inspection, there were 533 people using the service, including 306 people who used the domiciliary service and a further 227 people who either lived in one of five extra care services or used the Night Owl Service, which provides care and support to people in their own homes at night.

We found that the provider was still not meeting the requirements for safe care and treatment. We found that although the provider had audited checks of equipment in some services, this was not taking place across the whole service, which meant we couldn't be certain that equipment used was safe. There was insufficient recording and checking of financial transactions to protect people from loss or abuse.

The provider had carried out assessments of risks to people who used the service, however these did not always contain details on the risks to people from health conditions and did not always provide information for staff on possible warning signs that people were becoming unwell or how to respond to behaviour which may challenge. Medicines were not always safely managed, with gaps in medicines recording charts which were not always detected by audits. The provider had improved monitoring of calls through an electronic call monitoring system, and now had alerts in place for everyone who used the service. There had been a reduction in the number of missed calls, but use of the system was still not widespread enough to protect people from missed calls.

The provider had updated fire safety protocols at Lew Evans House to provide clear instructions on who would be responsible for contacting emergency services.

We found the provider was now meeting its requirements to obtain consent for care. However, we found that protocols and staff use of these did not always demonstrate an understanding of the Mental Capacity

Act (2005). We have made a recommendation about this.

At our last inspection we found the provider was not meeting regulations with regards to good governance, as care logs were not audited in a timely manner in a way which would detect possible errors. We found that this was still not taking place, and in some cases audits had overlooked potential problems.

At our last inspection we found that the provider was not always meeting regulations with regards to informing the Care Quality Commission of significant events and allegations of abuse. At this inspection we found the provider was meeting this requirement, but did not notify us of incidents of missed visits when these were raised as safeguarding alerts by the local authority. We have made a recommendation about agreeing a protocol for missed visits in line with the Pan-London Safeguarding Policy and Procedures.

At this inspection we found continuing breaches of regulations with regards to safe care and treatment, management of medicines and good governance. We served a warning notice against the provider with regards to these breaches.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not safe in all aspects.

There was insufficient checking of equipment and financial transactions to protect people from abuse or harm. Risk assessments did not always contain information on the risks to people from health conditions or from behaviour which may challenge.

There was not always accurate information about the support people required with medicines, and records of medicines records were sometimes incomplete and not always audited to detect issues.

### Is the service effective?

**Requires Improvement**

The service was effective. There was evidence that people had consented to their care and, where people lacked the capacity to do so, the provider could demonstrate that they were working in line with people's best interests.

The provider did not have systems which worked in line with the Mental Capacity Act, and sometimes staff completing these forms did not demonstrate an understanding of the Act.

We were unable to change the rating for this question as the provider was unable to demonstrate that these improvements were sustainable. We will look at this again during our next comprehensive inspection.

### Is the service well-led?

**Requires Improvement**

The service was still not well-led in all respects.

There was not adequate auditing of care logs to detect issues with the delivery of people's care.

Although the provider notified the Care Quality Commission of significant events, there was inconsistency between the local authority and the provider as to what constituted possible neglect due to missed visits.

# Allied Healthcare London Central

**Detailed findings**

## Background to this inspection

We undertook an announced focused inspection of Allied Healthcare London Central on 21, 22 and 24 February 2017. This was done to check that improvements to meet legal requirements planned by the provider after our inspection in September 2016 had been made. We inspected the service against three of the five questions we ask about services: Is the service safe, is the service effective and is the service well-led. This is because the service was not meeting some legal requirements.

Prior to the inspection we reviewed records we held about the service, including information we held on significant events the service had informed us about and other information we had received from the local authority. The inspection was carried out by two inspectors on the first two days, a pharmacy inspector and a single inspector on the final day. During our inspection we looked at records relating to 39 people's care and support and medicines records relating to nine people. We also looked at the provider's electronic systems for managing records of incidents, accidents and complaints, and records relating to electronic call monitoring.

Three experts-by-experience made telephone calls to 34 people who used the service and six relatives of people who used the service. An expert-by-experience is a person with personal experience of using this type of service. We spoke with the registered manager, service delivery manager, two care delivery managers, and two administrators. We attempted contact with 15 care workers and spoke with 6. We also contacted two officers with the local authority.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection in September 2016 we found that medicines were not being safely managed. This was because some medicines administrations recording (MAR) charts were not correctly completed, and that several weeks passed before these records were audited, meaning that urgent problems could continue undetected.

At this inspection we found the provider was still not meeting this requirement. Medicines were not always managed safely.

We reviewed nine people's care plans and the MARs related to these. We found that most people had risk assessments in place for medicines administration. However, not all risk assessments contained consistent information for people. For example, one person's risk assessment stated the only support they needed was for a care worker to collect their medicines, but then later stated they needed help opening medicines packaging. Another person's care plan stated they required to be prompted to take their medicines, but there was no list of the current medicines in the care plan.

MARs contained additional information about medicines to support staff with administration. We found that some MARs were not always signed when medicines were administered. Some MAR audits had highlighted this as an issue but it was not clear if this meant the person had missed their medicines. We found an example where one person had three gaps on their MAR in a month, and there was no follow up from the MAR audit to find out if they had actually missed their medicines, or if staff had forgotten to record administration. Records also showed that some people did not regularly have their MARs audited. For example, one person had not had a MAR audit undertaken since October 2015. This meant it was not possible to tell if people were receiving their medicines as prescribed.

Another person was prescribed a cream; a body map had been filled out and application guidance from the prescribing team was held on file, but there was no record of this cream having been applied to the person.

The provider had an electronic system to keep records of medicines errors. We saw that some learning from these events was recorded and shared. However, we did not see that some of those errors that we identified from MAR charts or MAR audits were always recorded on this system.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Records demonstrated that staff had completed appropriate medicines training and had been assessed as competent to administer medicines. This also included competency assessments for medicines with more complex administration instructions, such as eye drops and patches.
Policies were in place to support staff to carry out medicines risk assessments for people and support the medicines administration process.

At our previous inspection in September 2016, we found that care and treatment was not always safe. This was because the provider did not ensure that equipment for providing care to people was safe, and that fire evacuation plans in one extra care service were inaccurate. Where people were supported with their money or where care workers shopped for people, there was insufficient record keeping to ensure that people were protected from errors or financial abuse. The provider had also not assessed the risks to people from diagnosed conditions such as diabetes or dementia. Electronic call monitoring was not effective at monitoring the punctuality of care workers and was not set up in a way which would protect people from the risk of missed calls.

At this inspection we found that the provider had made progress in some of these areas, however was still not meeting this requirement.

At our previous inspection, we saw that servicing of equipment used for moving and handling was not always documented and was in some cases overdue. At this inspection we saw that the provider had undertaken an audit of all equipment used in the extra services and night owl services. This showed that dates of servicing had been recorded and where necessary visits had been booked to carry out these checks.

However, for people who used the domiciliary care service, there were no such checks in place. Risk assessments contained a list of equipment which was in use and required staff to record when the last check had been carried out and when it was next due, but in many cases this was blank or incomplete. For example one person had a ceiling hoist in use, but there was no servicing date recorded. In another case, we saw that a person was using a standing hoist which was last tested in January 2015, but there was no evidence of further tests recorded. This meant we could not be certain that this equipment was safe.

At our previous inspection, we found that risk assessments did not contain sufficient information on the risks to people from health conditions. At this inspection, staff we spoke with told us that risk assessments contained these details. Comments from staff included "Most care plans will detail what the person is suffering from" and "They have enough information from the care plan and the doctor's report." However, we found that in many cases there was not sufficient information for staff on how to manage these risks.

For four people who had a diagnosis of dementia, there was a recent clinical risk assessment for managing diabetes and recognising the signs of hypo and hyperglycaemia. These were personalised to the individual, and contained details of possible warning signs such as increased thirst and urination, fatigue and agitation. However, for these assessments, there was no further guidance on what staff should do if any of these symptoms occurred.

For several other people with diabetes, there was not enough detailed information to ensure risks associated with people's health conditions were adequately mitigated. For example, one person's care plan stated they were supported by a district nurse to manage their blood sugar levels and insulin, but although the care plan stated that regular meals and drinks were required, it didn't state why this was important or inform staff about changes in their condition to be aware of that may mean they required medical attention. In some cases, plans stated staff needed to arrive early to ensure the person ate their meal to maintain their blood sugar levels, but provided no further information. For another person, there was a note on the front sheet of the file that the person's blood sugar and medicines were monitored by the district nurse, but there was no information about diabetes listed on the visit summary for carers, and the clinical summary did not list any medical conditions. The person's plan stated that they were to eat a "variety of diabetic [foods]."

The provider showed us records on how they were working with the local authority to implement nationally

recognised protocols for addressing the risk of people with dementia going missing. We saw a plan for one person which gave information on their medical history, any equipment such as a GPS tag and how to use this, and the likely places the person would go to. This had not yet been implemented across the extra care services.

Where the provider worked with children with complex conditions, there were detailed risk assessments in place. For example, we saw examples of epilepsy plans including triggers, types of seizure, instructions on when to call an ambulance and clear protocols for the use of rescue medicines and post-seizure plans. There was a clear action plan for one child with severe allergies, and information on another child's medical condition with detailed information on their mobility plan, including safe moving and positioning.

However, in some cases where children and young people had behaviour which may challenge the service, there were sometimes insufficient measures to mitigate the risk from these. For example, one young person's risk assessment stated that staff should hold their hand at all times, including highlighting some of the possible dangers from crossing the road or getting lost in a crowd. However, for another young person the assessment stated there was a high risk of challenging behaviour, including pushing and hitting, and that they could run away from their care worker. However, the plan stated that staff needed to "communicate, reassure, retreat and call [their] parents." There was no action plan in place should the young person run away, or if the care worker retreated. There was also no information about what to do if they were unable to contact the young person's parents, and no further information about ways to communicate or specific key phrases which may reassure them. There was also no information for staff on how to safely handle the situation should the person fall to the floor, which was highlighted as a possible risk. In some risk assessments it was mentioned that the person may be at risk of self-harm, but this was not explained in further detail, with no information about what kind of self-harm they could be at risk of. The provider acknowledged that staff required further information and guidance.

In one instance there was a falls management plan in place for a person whereby the care plan stated staff needed to ensure they transferred from their wheelchair to their shower seat safely, but there was no moving and handling plan in place. One person who used the service told us that they had several health conditions which may put them at risk, and although this was recorded on the risk assessment there was no further information about how they may be at risk from these conditions. The person told us that the provider had arranged to visit them and complete a new risk assessment.

The provider told us that they had scheduled further training for staff on assessment and how risks were to be managed.

At our last inspection we found that there was insufficient recording of financial transactions to protect people from loss or financial abuse. At this inspection we found that this was still the case. For example, one person's care plan stated that they were to be supported every Monday with shopping; transactions were recorded by the care worker but not countersigned by the person. Another person had countersigned by signing across all transactions at once, which suggested that these had not been individually checked, and in other cases there was no evidence at all of recording transactions, even though some risk assessments stated that this was to take place. There was no evidence that these transactions were checked by managers. This meant that people were still not protected from loss or financial abuse.

At our last inspection, we found that people were not protected against the risk of late or missed calls as the electronic call monitoring system was not being used correctly. At this inspection we found that the provider had made substantial progress in improving this, but use of the system was not yet adequately deployed to protect people. The electronic call monitoring system was provided by the local authority, and was designed

so that staff could call when they visited people's homes to confirm their arrival and departure.

At our last inspection we found that only 23 people were set up to receive alerts, which meant that the provider would receive a notification in the event that staff did not arrive. Planned visits on the system did not accurately reflect when staff were due to arrive, meaning that the system would not notify the office of late or missed calls or provide accurate information on staff punctuality.

The provider told us that they now had alerts in place for everybody who used call logging, and that 13% of people who used the service did not currently use it. We saw that there were alerts in place for records we checked. There were now two staff allocated to monitor these alerts, and the provider told us that they had a dedicated care quality supervisor whose role was to visit people and support them to use the call logging system. We observed staff responding to alerts from the system in real time and following up with care workers to see where they were. Staff told us "Now we've got more people on alerts it's easier to see, it's so much better now."

The local authority gave us information on how the use of this system had changed with time. We saw that compliance, that is to say the proportion of visits logged onsite by the care worker had improved since October 2016 from 65.2% to 69.2%. This was below the local authority's requirement of 80%. During the month of October, there had been 50 missed visits, and this had decreased to 24 for February. However, there had been an increase the previous month to 57 missed calls, and so it was too early to say that these measures would be effective in reducing the risk of missed visits.

The provider told us they were still working to improve scheduled visits on the system to accurately reflect people's actual planned visits, as the system could not be used effectively without the system being in place. We saw examples of incorrect information being noted by the officers and passed to care co-ordinators for further investigation. The provider told us they were liaising with the local authority to improve this information.

The above demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At Lew Evans House, which was a supported living scheme we found that the fire evacuation plan had a serious inaccuracy. It stated that it was not the responsibility of staff to call 999, even though this was no longer the case. We saw that this plan had been revised immediately after our last visit, and was now clear about the responsibility of staff to call the emergency services.

Requires Improvement

# Is the service effective?

## Our findings

At our previous inspection in September 2016 we found that the provider was not always ensuring that people's rights were protected. This was because people had not always consented to their care, and the provider was not always assessing people's capacity to make decisions in line with the Mental Capacity Act (2005). The Act provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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.

At this inspection we found that the provider had made improvements, but we have made a recommendation about this.

Where people were able to consent to their care they had signed their care plans to indicate their agreement. In one case, where a person was unable to sign, it was clearly documented why they were unable to sign, and that a relative could sign on their behalf. Where people were under 18 years old consent for care had been signed by a parent or guardian. There was evidence that people's capacity had been considered, and where people may lacked capacity, the provider could demonstrate that they were working in people's best interests.

However, the provider did not have procedures in place for ensuring this improvement was sustainable. For example, the provider did not have a framework in place for assessing people's capacity. Instead, there was a best interests plan which asked staff to identify if the person had a diagnosis of dementia, whether they had memory issues and whether they required others to make best interests decisions on their behalf. This did not demonstrate that the provider understood the need to assess people's capacity in relation to an individual decision.

In some cases, best interests plans did not demonstrate an understanding of the MCA. For example, one person's plan stated "[person] is able to make decisions in their own best interests." In another case, the plan stated that the person had capacity, and that their relative was able to act as their advocate, "If for any reason I am unable to make a best interests decision."

We recommend the provider take advice from a reputable source on ensuring forms and staff training demonstrate an understanding of the Mental Capacity Act (2005).

We were unable to change the rating for this question as the provider was unable to demonstrate that these improvements were sustainable. We will look at this again during our next comprehensive inspection.

Requires Improvement

# Is the service well-led?

## Our findings

At our previous inspection we found that the provider was not meeting the regulation in regards to good governance. This was because there was insufficient or untimely audit of care logs, which meant they did not maintain an accurate and contemporaneous record of care they had provided. At this inspection we found that the provider was still not meeting this requirement.

People who used the service told us that staff visited them regularly to check on the quality of the service, and staff told us that managers carried out spot checks. However, managers did not check daily logs as part of the spot check.

The provider's action plan stated that they were to check all logs monthly, however this was not taking place and the scale of this task was unrealistic. In some cases, we found that logs had not been checked for over six months. We saw some logs had been checked recently, where audits had noted that there were discrepancies for example with regards to timing. However, we saw one audit which had failed to note that there were significant gaps related to a hospital admission and a subsequent period of missed calls, although the auditor stated they had looked at this page and noted a discrepancy of timing only. For four people, there were no logs available of their care. For another person, we saw that the auditor had recorded "some timings out but not drastically." The logs showed that some visits were taking place either an hour early or late, but although this person had diabetes there was no follow up to ensure that this was not detrimental to their health.

In one case, a person's care logs for three weeks until early November had not been audited until January, whereby the auditor noted that staff had recorded concerns about a person's wellbeing and had reported these to the office, but the auditor could not find a record of this. Since this time, the person's condition had deteriorated significantly.

The above issues relate to a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

At our previous inspection in September 2016, we found that the provider was not always notifying the Care Quality Commission (CQC) of significant events, including allegations of abuse. At this inspection we found that the provider was meeting this requirement, but we have made a recommendation about this.

We reviewed records of incidents, accidents and allegations, which were held on a computer database. We found that where allegations of physical and financial abuse had been made, the provider had submitted a notification to CQC about this. Where people using the service had died, this had also been notified in accordance with the regulations.

However, in many cases, the local authority had raised safeguarding alerts in respect of missed calls, which were not notified to CQC. In one instance an administrative error had caused a person to miss several calls, which was referred by a social worker as a safeguarding matter, although the provider noted that the person

had a family member present and had not been at risk as a result and had not submitted a notification. In another case a missed call had been raised as a safeguarding matter, but the provider had demonstrated that the call had taken place, however they had not notified CQC of the safeguarding alert. The provider's protocol stated that if there was either harm as a result of a missed call, multiple missed calls or a safeguarding referral this would be notified to CQC, but this was not taking place. The provider told us that there was not always consistency between social workers on what was referred to the safeguarding team.

We recommend the provider agree a protocol with the local authority for reporting missed visits in line with the Pan-London Safeguarding Adults Policy and Procedures.

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 | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not assess the risks to the health and safety of service users or do all that was reasonably practicable to mitigate such risks, ensure that the equipment used by the service provider for providing care to a service user was safe for such risks or demonstrate the proper and safe management of medicines 12(2)(a)(b)(e)(g) |

**The enforcement action we took:**

A warning notice was served

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not maintain an accurate, complete and contemporaneous record of care and treatment in respect of each service user or evaluate and improve their practice in regards to the processing of this information 17(2)(c)(f) |

**The enforcement action we took:**

A warning notice was served