Heritage Homecare Services Ltd

Heritage Homecare Heywood

Inspection report

Independence House
Adelaide Street
Heywood
Lancashire
OL10 4HF

Tel: 01706629774
Website: www.heritagehomecarenw.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was a follow up inspection where breaches had been identified and in response to concerns received. At this inspection the service was providing care and support for 52 people living in their own homes. The provider had two other locations also providing care in people's own homes at Lancaster and Nelson. The service provided care and support for older persons , dementia care, end of life care, long term conditions, respite care and night care.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

People and staff gave a mixed view about the service. Overall relatives appreciated individual staff but told us that the service was not well managed and their relatives were not always safely cared for. Some staff thought they were well supported I their role whilst others told is they had not received sufficient training, instructions as to care for people or support in their role .

There were safeguarding policies and procedures in place. However these were not being implemented and safeguarding concerns were not recognised or addressed. The service was requested to make five safeguarding concerns with the Local Authority that were identified at the inspection but had previously not be recognised by the service. Safeguarding concerns were not always notified to CQC as required.

We checked medicines management. We found that clear and accurate records were not being kept of medicines administered by care workers. Care plans and risk assessments did not support the safe handling of some people's medicines. The service had failed to recognise and address risks to people they were supporting placing them at risk of harm. Were incidents had occurred no action had been taken to prevent these from reoccurring.
We checked how the service followed the principles of the Mental Capacity Act 2005 (MCA)

The MCA governs decision-making on behalf of adults who may not be able to make particular decisions. The requirements of the MCA were not being followed.
There were no systems in place to monitor any aspects of the quality of the service or to improve failing areas. Issue identified at previous inspections had not been addressed. As a result people were at risk of not having their health and welfare needs met.

Overall we found significant concerns as how the service was meeting the regulations. We are considering what further actions may be required and we will report on any actions once completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were placed at risk of harm as the service had failed to recognise or plan to reduce risks.

Medications were not correctly or safely given and in at least two instances this had resulted in the people requiring medical assistance.

Safeguarding concerns were not recognised, reported, investigated or addressed in a manner that prevent potential abuse and placed people at risk of harm.

Is the service effective?

Inadequate

The service was not effective

The service was not following the necessary requirements of the Mental Capacity Act.

Peoples rights not recognised and maintained.

Staff did not receive appropriate guidance and support to make sure that they understood how to appropriately support people with their rights.

Is the service well-led?

Inadequate

There were no audits and checks to monitor the quality of all aspects of the service. As such the service was not checking on areas for improvement and making sure that they dealt with any issues or risks in a prompt manner.

People's feedback was not sought or acted on.

Complaints and concerns were not appropriately addressed with no action taken to protect people from further harm.

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Detailed findings

Background to this inspection

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

This inspection was undertaken on the 14 of December 2014 and was unannounced.

The inspection team consisted of two adult social care inspectors. We received information from Social Services, people using the service, their families, staff and the Police regarding concerning information in relation to medicines management, staff not attending visits to people in their own homes, lack of training for staff and not managing risks for people.

The inspectors visited the main office of the agency on the 14 December 2014 and reviewed six peoples care records and records in relation to the management of the service. We requested contact details of relatives, staff and people using the service. Following the inspection the inspectors contacted fourteen relatives and six staff for their views.

Inadequate

Is the service safe?

Our findings

Relatives spoken with gave mixed opinions about the safety of their relatives. Some stated that in general they were very happy with the staff that attended but thought that the main office at Heywood lead by the registered manager was not well managed. Others also complimented the care staff who attended their relative but expressed concerns regarding staff not arriving on time, turning up at all and managing the medication of people. Two relatives gave examples when as a result of staff not giving the correct medication their relative had required medical assistance. One told us that, "they made mistake with tablets twice. On both occasions this meant that the doctor had to be called. In the end they were told not to give those tablets at all. I had to go and do them as they didn't get it right".

Overall relatives thought that care staff members were genuine, doing the best that they could but were not well supported and their relatives were not always safe. Comments from relatives included "my mum likes the staff and they are genuinely caring towards her. That's why we haven't changed who she gets the care from. In general we are not happy with Heritage. Care staff don't always turn up on time and we are not always told that they will be late. On other occasions care staff haven't turned up at all and I've had to go and see to my mum".

We saw there were safeguarding policies and procedures in place. The policies in place did not describe to senior staff how to manage any safeguarding concerns. A review of six randomly selected care records for people receiving a service showed five safeguarding concerns that had not been recognised or addressed by the service. This included, staff not attending to people's homes as they should and not managing medicines correctly. As a result of this inspection the service was requested to make the appropriate safeguarding referrals to social services, which they did subsequently.

We looked at the training in place for staff regarding safeguarding. Staff spoken with demonstrated a limited understanding about the actions they would take if abuse was suspected or how to recognise potential abuse. Safeguarding concerns had not been recognised or addressed by the registered manager as a result people were not protected from the risks of harm.

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

There had been a total of 12 safeguarding concerns since the service commenced since the service was registered in March 2015. The safeguarding concerns were in relation to the care and support provided. None had been report to us. At our last inspection we identified that an instance involving safeguarding and a police investigation had not been reported to us. The registered manager apologised and stated that in future all safeguarding concerns would be notified to CQC within 48 hours.

Since the last inspection of July 2015 there has been six safeguarding alerts made by social services with regard to the safe care and support of people. At this inspection the registered manager was not available and we with the person in charge who explained that they were aware of two of the six safeguarding

concerns but these not been notified CQC.

This is a breach of regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection we saw that risk assessments were in place that covered areas such as environmental risks and security. These risk assessments had not been updated since they were first put into place Additionally at the last inspection we saw that where instances that changed a person's risk such as falls had been recorded neither the persons care records or their risk assessments had been updated to reflect these risk.

At this inspection we saw that the service had continued not to update environmental risk assessments. Of the six care records we reviewed we saw that four people had records that showed they had a risk that had not been recognised or addressed by the service. We saw that care records contained no assessments regarding the risks around medication. Daily records reflected that two people had fallen but there were no risk assessments to inform the staff of this. Another person had an assessment that identified a number of food allergies. Staff prepared food for the person but there were no risk assessments or care plans in place that informed staff how to address the risks in relation to the person's food allergies.

The provider had not put into place risk assessments identified as need at the last inspection. As such action to recognise and reduce the risks to people they provided care and support for, had not been taken.

At our last inspection we looked at how the service managed medicines. At that time we found that there was limited information to inform staff as to how to give medicines safely. Additionally we found that staff competency to administer medicines had not been assessed. At this inspection we found the service had not made improvements needed to safely manage people's medicines and remained in breach of the regulation.

The person in charge of the inspection informed us that most people received medicines in blister packs supplied by the local pharmacy. We viewed the daily care records, medication administration sheets (MARS) these records did not accurately show the medicines that people received. The records showed that staff were recording, 'medication observed' but did not detail the medicines they had administered. In daily records returned to the office from peoples own homes, we saw that on two occasions staff had recorded that they had not given the correct medication or had failed to give the medication at all. Both these failures were reported at our request by the provider to the Local Authority as a safeguarding concern.

Additionally a complaint had been made by a family member that due to the services mishandling of the persons medication a doctor had had to attend the person. When we spoke to a relative they explained that as the service had not correctly given their relative their medication the person had required a hospital admission and the staff were no longer allowed to manage that particular medication. On reviewing the person's records we saw records that showed despite this arrangement staff had continued to give the person this medication placing them at risk of harm. We also requested that the service refer the matter to the Local Authority as a safeguarding concern.

Care records still did not contain up to date details of medicines that people were taking, that the services staff were responsible to give. Where care staff were managing the medicines for an individual this was unclear in the care plans viewed. There was no information as to the ordering, managing or giving of prescribed medicines. Another person was prescribed medicines known as "per required need" (PRN) or "as needed". PRN medicines are medicines prescribed that are to be given when the person needs them such as

painkillers or inhalers. As such instructions as to when to give and in what circumstances need to be available to care staff to support them to give PRN medicines safely. We examined care records and saw that there was no information available that told staff how to support people appropriately or how to record when PRN medicines had been given. As a result there was a risk that the person could receive their medicines too close together. One person who contacted us following the inspection informed us that they had raised concerns with the service that they were not receiving their pain relief correctly and this situation had continued.

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

Inadequate

Is the service effective?

Our findings

We were spoke directly with relatives and staff who gave a mixed view as to the effectiveness of the service. Whilst we received positive comments regarding the staff themselves, such as "my mum really loves the girls" and "the staff that visit are lovely". Relatives reported that people were not always appropriately supported to eat and drink. One relative told us that " I went on holiday and asked that they made meals. When I returned I found that the bread was mouldy and no way of knowing what food had been given".

We were informed by the person in charge of the service at the inspection that they did not check that care staff were competent to undertake their job role.

People and staff told us that staff contacted health and social care professionals to ensure that people's health care needs were met. We saw care plan entries which documented that care workers had sought advice from GP's, district nurses, podiatrists and speech and language therapists.

We checked how the service followed the principles of the Mental Capacity Act and its associated guidelines (MCA) which governs decision-making on behalf of adults who may not be able to make particular decisions at certain times.

At our last inspection we saw that the service was not meeting the MCA and that arrangements were not in place to ensure that people's rights were maintained. At this inspection we saw that there were no improvements in this area.

The service did have a policy on consent but we found that some of the information in this conflicted with other sections and was confusing in its guidance to staff. There was no policy regarding how to implement and adhere to the MCA. We saw that care records made no reference to people's capacity and a number of people had been diagnosed with conditions that could potential impact on their capacity to make decision. There was no information regarding when to support people to make decisions and no information that informed staff if a person lacked capacity who had the legal standing to make decision on their behalf. We saw a number of people were receiving medicines from the staff, however there was no evidence that they had consent to this or that their best interests had been assessed if they were unable to manage their medicines safely. Assessments undertaken by the service prior to care commencing did not determine if the person consented to the care being provided in their homers by the service or if needed a best interest discussion had been undertaken for the service to deliver care.

This was a breach of Regulation 11, Consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At this inspection there was a registered manager in place. However we asked that she attend but were told by the person in charge that the registered manager was unable to attend as they were attending a meeting with social services that day. The assistant manager was the person in charge we spoke with during this inspection.

Relatives we spoke with gave a mixed opinion as to the management of the service. They expressed concerns in relation to staff not turning up to attend to their relative at times and not always being informed that the staff member would be late. Two relatives spoken with stated that when they raised concerns with the management team they did not believe that these were correctly acted on. We reviewed complaint records and saw that their complaints were not recorded and had not been investigated.

Staff spoke with said that on occasions they worked without breaks. Some staff felt that they were well supported others told us they had received little or no training and did not think the office/ management team gave them the information they needed to do their jobs correctly.

At the last inspection we saw that the service failed to check on missed calls, review the quality of the service they provided, monitored the quality of care or addressed concerns. At this inspection we saw no improvements in this area.

There was no quality monitoring of the service. "Spot checks" (a check on staff in people's own homes) were in place however there were no arrangements for these to be undertaken at planned or regular intervals. The spot checks reviewed the staff appearance, arrival time, duration of call and interactions but not the care planned and delivered met the persons assessed needs. Of the spot checks we reviewed there were three showed some areas of development but there were no actions in place to address these points.

We discussed with the person in charge if there was any quality checks or reviews of health and safety such as accidents, the quality of care planning, medications, policies and procedures, staff supervision or the views of staff and service users as examples. They confirmed that no quality arrangements were in place. There was a quality procedure but this did not detail how the service intended to check on the quality of the service of how any areas for development would be addressed.

We saw that records that were made in people's homes that recorded what actions staff had undertaken were not returned to the office for the manager to check that the care was being delivered correctly. One person had received care for over seven months and none of their daily records or medicine records had been returned to the office. We were informed by the person in charge that there were no formal arrangements to collect records from peoples own homes to be checked and this depended on whether care staff remembered to bring them into the office.

We found that the records were often unclear, poorly organised and failed to appropriately record the service delivered. Where records such as daily records and MAR charts had been returned to the office we

saw no evidence that these were reviewed to make sure that care was delivered correctly. When we reviewed the daily records and MAR charts available we saw that some people had not received their medicines correctly and others had, had falls that the service had not addressed. The information was readily available in the services records that would have enabled them to address the issues with the care delivered, but as these records were not checked the service had failed to recognise these issues and taken appropriate action.

Of the six peoples available records viewed we saw calls had been missed, medication had not been given correctly and complaints had not been addressed. There were no arrangements within the service to recognise and address these failings.

The service had failed to recognise concerns in relation to people's health and welfare needs such as risk or potential safeguarding and where they were aware of these no action had been taken to maintain the health, welfare or safety of people they supported.

The service provided support to fifty two people across two Local Authorities at our inspection. They had undertaken an exercise to review people's opinions. However a total nine people had been supported to respond since July 2015. All the nine responses received were in the same hand writing. We were informed by the person in charge that this was the handwriting of a staff member no longer working for the company. Of these records one person had expressed concerns that had not been addressed.

Of the six care plans we reviewed, four people's needs had changed and the care plans were no longer up to date and had not been audited. The person in charge of the service at the inspection stated that they had not had the opportunity to update the care plans. As a result staff did not have the instruction they needed to make sure they provided quality care to people.

This was a breach of Regulation 17, Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 18 Registration Regulations 2009 Notifications of other incidents The Provider did not notify CQC of incidents that affect the health, safety and welfare of people who use services in particularly in relation to safeguarding concerns.

The enforcement action we took:

NOP to cancel Provider

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not making sure that all people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment was provided.

The enforcement action we took:

NOP to cancel Provider

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not preventing people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. The risks to people's health and safety during any care or treatment had not been assessed and they did not made sure that staff have the qualifications, competence, skills and experience to keep people safe.

The enforcement action we took:

NOP to cancel Provider

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good

governance

The provider did not have effective governance, including assurance and auditing systems or processes in place that assess, monitor and drive improvement in the quality.

The enforcement action we took:

NOP to cancel Provider