Connected Health Limited

Connected Health Plus

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Connected Health Plus is a domiciliary care agency providing personal care to people living in their own homes. At the time of this inspection the service was supporting 163 people with personal care. 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
People did not receive their medicines safely and as prescribed. Examples included, medication to manage diabetes, epilepsy, blood thinners and antibiotics. The provider did not have clear information or understanding of people's individual medication needs. Medicines administration records (MARs) were poorly maintained and not in line with best practice.

Staffing levels and rota systems were unsafe. People's calls were significantly late, early, short or missed. People and their relatives told us staff were often late or missed calls completely. One relative commented, "The morning visit is scheduled for 10am, [staff] come at 1:30pm in the afternoon, so missed breakfast, lunch and medication."

People were not safeguarded from the risk of abuse, particularly neglect, due to late, early, short and missed calls. People and their relatives were unable to rely on the service to provide the essential care and support they needed when they needed it. One relative commented, "[Provider] is so unfit for purpose. [The staff] are meant to give [Relative] sandwich on plate, quite frequently goes without. We've observed staff pop head in then leave without giving [Relative] medication or lunch, no pad changed or bedding changed."

The provider's systems to assess, monitor and improve the quality and safety of service being provided were inadequate. Senior staff and governance systems had not recognised or responded to the significant and widespread issues we identified during this inspection. A poor culture had developed at the service. Shortcomings in care, poor practice and a failure to meet people's needs were not always challenged but accepted. CQC had not been notified of all significant events which had occurred, in line with the registered provider's legal obligations.

People and their relatives told us staff rarely responded or returned their calls when raising concerns about their care and call times. Staff told us they did not feel supported by the provider and had to work excessive hours to complete all their calls.

There was extensive call-cramming meaning staff were scheduled to be at multiple calls at the same time and/or back-to-back calls without any time for travel. The provider's approach to call cramming meant it was inevitable and obvious people's care needs would not be safely and effectively met or not met at all. The provider's electronic call data demonstrated clear and widespread evidence of significantly late, early,

short and missed calls. However, no action was taken to recognise the seriousness of the situation or seek support from other stakeholders.

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 21 April 2021).

Why we inspected
We received concerns in relation to late and missed calls, the management of medicines and a lack of leadership and governance processes. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safe management of medicines, safeguarding people from abuse, good governance, staffing.

Please see the action we have told the provider to take at the end of this report.

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
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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Connected Health Plus

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 Care Act 2014.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Connected Health Plus is a domiciliary care agency. It provides personal care to people living in their own homes.

The service did not have a manager registered with the Care Quality Commission (CQC). This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 24 June 2021 and ended on 28 June 2021. We visited the office location on 24 and 28 June 2021.

What we did before the inspection
We checked the information that we held about the service. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also gathered feedback about the service from the relevant local authorities. We used all of this information to plan our inspection.

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.

During the inspection
We gathered feedback from three people supported by the service and seven relatives about their experience of the care provided. We spoke with 15 members of staff including the operations director, senior managers, area managers and carers.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including electronic call data and staff rotas were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We also met with the provider and relevant local authorities to discuss the issues we identified.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
• People did not receive their medicines safely and as prescribed. People's calls were late, shorter than scheduled or missed which resulted in people not receiving their medicines. Examples included, medication to manage diabetes, epilepsy, blood thinners and antibiotics.
• The provider's unreliable call times also meant people received their medicines with unsafe gaps. For example, one person frequently received pain relief medication with significantly shorter and longer gaps than required. This meant the person was either being given too much too soon or being left in pain.
• The provider did not have clear information or understanding of people's individual medication needs.
• Medicines administration records (MARs) were poorly maintained and not in line with best practice. MARs lacked critical information such as medication dosages, quantities, frequency, dates were incomplete and no information about allergies was recorded.
• The provider's systems and checks to ensure the safety and quality of medicines administration were inadequate and had failed to identify and respond to the serious issues identified during our inspection.

Medicines were not safely managed by the provider which placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People and their relatives told us staff were often late or missed calls completely. One relative commented, "The morning visit is scheduled for 10am, [staff] come at 1:30pm in the afternoon, so missed breakfast, lunch and medication."
• Staffing levels and rota systems were unsafe. There was extensive evidence of significantly late, early, short and missed calls. For example, one 30-minute morning call was scheduled for 7:30am but carers did not arrive until 11:54am, almost three and a half hours late. The call then only lasted for nine minutes.
• There was systemic and widespread evidence of call-cramming meaning staff were scheduled to be at multiple calls at the same time and/or back-to-back calls without any time for travel. This meant it was inevitable people's calls would be late or missed and staff often stayed for less time than scheduled. For example, one person's morning calls to support them to get out of bed, wash and dress and have breakfast lasted 10, 8, 8, 5 and 1 minute respectively.
• Multiple staff rotas showed staff were working up to 90 hours per week and calls were being significantly shortened or missed as a result.
• Staff rotas for the following week were not shared with staff at the service until Thursdays or later leaving minimal time for staff to ensure all calls were covered. Staff also told us their rotas could change rapidly to absorb additional calls creating a risk calls would be missed in error.

• On the day of our inspection over 600 hours of care calls for the following week were not covered by the standard rota and somehow needed to be covered by existing staff.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff were not always safely recruited. Appropriate checks were carried out to ensure new staff were suitable to work with vulnerable adults. However, two of the four staff files we reviewed lacked full employment history information.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• People were not safeguarded from the risk of abuse, particularly neglect due to late, early, short and missed calls.
• People and their relatives were unable to rely on the service to provide the essential care and support they needed when they needed it. One relative commented, "[Provider] is so unfit for purpose. [The staff] are meant to give [Relative] sandwich on plate, quite frequently goes without. We've observed staff pop head in then leave without giving [Relative] medication or lunch, no pad changed, or bedding changed."
• One person who has Alzheimer's disease waited for over an hour for their morning call and when the carer failed to arrive, they left their home in search of food unaccompanied and without any money. The person was later found taking food from a local supermarket.
• Safeguarding concerns, accidents and incidents were not effectively recorded and responded to. We saw reports submitted by staff about missed medication, medication errors, unsafe gaps between medication, missed calls and incorrect moving and handling practice. There was no evidence action had been taken to investigate and address these concerns nor had they been reported to the relevant safeguarding authority or CQC.
• The provider did not have effective oversight of this information and there were inadequate systems in place to ensure staff had taken appropriate action and lessons were learned.

The provider had failed to protect people from abuse and improper treatment. This placed people at risk of harm. This was 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.

Assessing risk, safety monitoring and management
• Risks associated with people's care were not effectively assessed, monitored and managed.
• People's care plans lacked detailed and personalised risk assessments which meant staff did not always have all the information needed to manage the risks associated with their care. For example, the provider was unsure of the individual medication needs of all the people it supported.
• Staff were only able to access a very brief summary of people's care needs and some people did not have care plans in their homes. This summary information was often based on the information provided by the local authority rather than any assessment carried out by the provider.

Preventing and controlling infection
• People and their relatives said the staff wore the required PPE when they were providing support.
• Staff had received training on infection prevention and control practice, including specific training and guidance relating to COVID-19 and the use of PPE.
• Staff were provided with supplies of PPE from the office.
• Staff were supported to access COVID-19 testing and were encouraged to get vaccinated.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and how the provider understands and acts on their duty of candour responsibility

- The provider's systems to assess, monitor and improve the quality and safety of service being provided were inadequate. The provider's senior staff and governance systems had not recognised or responded to the significant and widespread issues we identified during this inspection.
- Quality assurance processes and audits had not been completed for several weeks prior to our inspection. Staff did not have capacity to maintain this work as they had to complete care calls.
- The provider had inadequate oversight and scrutiny of the service's performance.
- The provider's call-cramming approach towards staff rotas and call scheduling meant it was inevitable and obvious people's care needs would not be safely and effectively met or not met at all.
- The provider's electronic call data demonstrated clear and widespread evidence of significantly late, early, short and missed calls. However, no action was taken to recognise the seriousness of the situation or seek support from other stakeholders.
- A poor culture had developed at the service. Shortcomings in care, poor practice and a failure to meet people's needs were not always challenged but accepted.
- The provider did not meet their responsibilities regarding the duty of candour and were ineffective in promoting a culture of openness and transparency within the service.

The provider had failed to implement robust and effective systems to assess, monitor and improve the safety and quality of care being provided. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- CQC had not been notified of all significant events which had occurred, in line with the registered provider's legal obligations. We saw multiple examples of safeguarding concerns that had not been reported.
- The provider did not have a registered manager at the time of this inspection. Senior staff at the service were unable to carry out the leadership and governance aspects of their roles as they were regularly required to cover care calls.
- Ratings from the last CQC inspection were clearly displayed as required.
- There was a range of regularly reviewed policies and procedures in place to help guide staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• People and their relatives told us staff rarely responded or returned their calls when raising concerns about their care and call times.
• People, relatives and staff said the on-call support phoneline was ineffective as it was often not answered.
• Staff told us they did not feel supported by the provider and had to work excessive hours to complete all their calls. One member of staff said they had to complete 13 or more morning calls before continuing with lunch, tea and bed calls.

Working in partnership with others

• The provider had failed to work effectively with other organisations. For example, local authority quality teams, safeguarding authorities and CQC were not informed by the provider about significant events or safeguarding concerns.
• There was a lack of honesty and transparency in the provider's communication with local authorities and CQC. It was clear the provider had been unable to safely and effectively deliver its commissioned calls for several weeks by the time of our inspection. The provider did not disclose any information to or seek support from local authorities or CQC regarding the challenges it was facing. This was only identified when a local authority received independent information of concern in the days prior to our inspection.

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 Medicines were not safely managed by the provider which placed people at risk of harm.

The enforcement action we took:

We issued an urgent notice of decision imposing conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to protect people from abuse and improper treatment. This placed people at risk of harm.

The enforcement action we took:

We issued an urgent notice of decision imposing conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement robust and effective systems to assess, monitor and improve the safety and quality of care being provided.

The enforcement action we took:

We issued an urgent notice of decision imposing conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.

The enforcement action we took:

We issued an urgent notice of decision imposing conditions on the provider's registration.