Heritage Homecare Services Ltd

Lancaster

Inspection report

Riverway House
Morecambe Road
Lancaster
Lancashire
LA1 2RX

Date of inspection visit:
03 March 2016
09 March 2016
15 March 2016

Date of publication:
12 January 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service on 09 and 14 December 2015. This was because we received information of concern about the service. The concerns related to missed and late visits, administration of medication and delivery of the care provided.

After the inspection in December 2015, we received further concerns about missed and late visits. We also received information of concern regarding the disposal of important records. As a result, we undertook a further focused inspection on 03, 09 and 15 March 2016.

We undertook this focused inspection to assess if people were safe. The visit on the 03 and 09 March was unannounced. The provider was notified prior to our visit on the 15 March 2016. This report covers our findings in relation to this inspection only. You can read the report from our last inspection by selecting the 'all reports' link for Lancaster on our website at www.cqc.org.uk.

At this inspection we judged the provider continued to be in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment and Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Good Governance. The service was also in breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care and Regulation 18 Care Quality Commission (Registration) Regulations 2009 Notification of other incidents.

Lancaster is registered to provide personal care to people living in their own homes. At the time of our inspection, 31 people were receiving a personal care service. The office is based at Riverway House, which is situated between Lancaster and Morecambe. The service provides care and support for older persons, dementia care, end of life care, long-term conditions, respite care and night care.

There is a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

During this inspection, we looked at electronic systems and documentation that showed not all people who required support receive their scheduled visits. This left them at risk, because the provider did not provide the care and treatment identified to meet people's needs.

Records we looked at showed people who required a service did not always receive their allocated support time. We saw that the length of time carers were due to stay with people as part of a scheduled visit had been shortened to allow staff to complete additional visits elsewhere.

We saw examples of where people who were scheduled four visits a day, had received three visits because two of the visits had been merged. This placed vulnerable people at risk. They did not receive safe and

effective support with their physical and mental health requirements.

Risks were identified with the electronic monitoring system. The system was not effective as it did not always show when visits had not occurred. When the system did show missed visits, the staff member operating the system was unable to explain why they had occurred.

People were not given the support they needed with medicines as directed within the care plans. Ongoing medical conditions were not managed safely.

Care plans identified risks, although information was brief and lacked detail to guide staff on how to manage the risk. This placed people at risk of harm.

There were safeguarding policies and procedures in place. We saw the provider had raised a safeguarding concern with the local authority in relation to theft. They had not notified the Care Quality Commission as required.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Risks to people's safety and wellbeing were identified. However, documentation did not contain information to minimise and manage risk factors. This placed people at risk of harm.

Identified medical conditions were not managed in a safe manner and placed people at risk of harm.

The provider shortened or moved scheduled visits without consultation with people who received support.

Missed visits were not always identified or dealt with. This placed vulnerable people at risk.

Lancaster

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.

We undertook an unannounced focused inspection of Lancaster on 03 and 09 March 2016. An announced visit was undertaken on 15 March 2016. This was so that we could ensure personnel we wished to speak with would be available.

We carried out this inspection as we had received concerns regarding risk management and the safety of people receiving a service. The team inspected the service against one of the five questions we ask about services: 'Is the service safe?'

The inspection was undertaken by three adult social care inspectors and an inspection manager.

Prior to our unannounced inspection, we reviewed the information we held about Lancaster. This included notifications we had received from the provider about incidents that affected people who used the service. We checked safeguarding alerts, comments and concerns received about the service. We also spoke with the safeguarding team and commissioning department at the local authority. They told us they had significant ongoing concerns about Lancaster and Heritage Homecare Services Ltd. We did this to gain an overview of what people experienced who received support from the service.

We spoke with a range of people about this service. They included the registered manager, two staff members, four people who received a service and one relative. We looked at staff rotas for the time and duration of visits. We compared these against information held on the electronic call monitoring system for the actual time and duration of the visit. We focused on how staff provided care within a geographical area and if they had enough time to travel between clients. We looked at how many visits a staff member had completed per day. We looked at fourteen peoples' care records who received support from Lancaster.

Inadequate

Is the service safe?

Our findings

As part of this inspection process, we telephoned people to gather their views on the service delivered. On the day we telephoned one person, no staff member had arrived that morning to support them with their personal care. The staff member scheduled for the previous evening had also not attended. The person who required support and their relative did not know why anybody had not attended. There had been no contact from the Lancaster office about the missed visits. Regarding the provider, the person told us, "It isn't working out, I want a change. The good ones [staff] have left." The person's relative told us, "We have nothing to say who is coming. Some days they are coming then they are not coming." They further commented, "They don't seem to have enough staff to cover sickness."

On these two occasions, we were told the care for the person who used the service was left to the relative. We visited the office base and looked at the care plan. The care plan for this person specified two people were required for moving and handling. The care plan recorded that the family were not involved in hoisting the person who used the service. We asked the care co-ordinator for clarification. They told us, "Their [relative] helps out if we are unable to get two staff. They are down as the main carer." We mentioned the care plan to the care co-ordinator who repeated, the relative would help. We looked at records held at the office relating to the care being delivered to this person. During the previous week, there had been two more missed visits and one visit lasted 30 minutes, not the scheduled one hour. We spoke with the care co-ordinator about the concerns we had identified. They could not explain the missed visits to us.

We spoke with one person about missed visits, they told us, "Staff had missed the odd visit." We asked what support they required from staff. They told us, "They make a drink and make sure I have taken my medication." They further commented, "I don't think I have missed any." However, they said they were unsure. They also commented, "Staff put cream on my legs for me. I'm not asking a bloke to do it, I prefer women. I have told the company I don't want men." We asked if male staff visited, and were told, "Not very often." We looked at rotas that showed male care staff had completed visits to the person. The type of visits were identified as personal care and meal preparation visits. This showed the provider failed to make suitable adjustments to the service delivered that ensured the safe, dignified administration of medicines followed people's preferences.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. This was because the provider did not provide care and treatment to meet peoples' needs.

At the last inspection, support plans did not say how to manage identified risks. We referred in our last report to one care plan in particular. The plan stated 'assist using a hoist' for staff to transfer a person from one chair to another. There was no information contained within the support plan on how to support the person safely. We also noted, 'support with personal care if required' but there was no information about what this would involve. We had told the registered manager the documentation did not provide staff with the guidelines to keep people safe. They had told us they would amend plans to include how to complete tasks around identified risks. During this inspection we found they had not done this. The registered

manager told us they had not had the time to implement any changes.

Records we looked at indicated two more people had inconsistent visit times and merged visits. For example, one person had three visits merged into one. The care plan indicated this person required, 'Diabetes support with balanced meals. Support with medication if required and record accordingly.' The person required support at regularly spaced intervals to manage their food intake and medication. We looked at diary sheets, which did not indicate the changes in visit times were at the request of the person. We spoke with the care co-ordinator about the merged visits who told us they counted as separate visits. The provider had not delivered the required support identified for people to meet their nutrition and medicinal needs.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The provider had failed to assess the risks to the health and safety of people who used the service and do all that is reasonably practicable to mitigate any risks.

Staff told us the electronic call monitoring system would show if visits to people were critical or if the visit had a tolerance level. They told us critical visits were time specific and could not be moved without management agreement and tolerance visits could be moved forward or backward from the initial time within an agreed period of time. Staff told us local authority funded clients had up to 10 minutes travelling time built into their allocated visit time. For example if someone was scheduled a 30 minute visit, 10 minutes could be used to travel between clients. This would leave the person 20 minutes support. If someone was identified as having a one hour visit, they would receive 50 minutes due to travelling time.

We looked at how the service was being staffed to meet peoples' needs. We reviewed past and present staff rotas focussing on how staff provided care within a geographical area. We looked at times of visits, alongside what support people required during their visit. We saw one staff member had back-to-back visits. The first visit to one person who used the service was from 8am until 9am and was a critical visit to assist with personal care. The next visit to another person who used the service was from 9am until 9:30am and was to assist with personal care and meal preparation. There was a distance of 11.9 miles between the two people. It was not possible for staff to support people as scheduled due to the distance they had to travel. Records we looked at indicated neither person got their allocated level of support at the times identified. We spoke with the registered manager about this who did not offer an explanation. We spoke with both people about the service being delivered. One person was unhappy with the care and support they received. The second person stated they had to wait for the staff member to arrive to support them with their personal care. The provider failed to support people to maintain their dignity and keep them safe.

We saw that one person's care plan stated they required four visits a day. These visits were for personal care support and meal preparation. Records we looked at showed no consistency on when the staff member completed the first visit of the day. Times ranged from 9am to 12.30pm. We spoke to the care co-ordinator about the variation in times. They told us, "I am not sure why the visit times changed, we will have to look in the files." On the day of our inspection, the care co-ordinator was responsible for completing rotas and overseeing call monitoring. There were visits that followed in quick succession. The length and times of visits were inconsistent and impractical for the support needs identified.

On the first day of our inspection, we sat with the care co-ordinator whilst they monitored visits on the computer system. Staff had to log in and out of each visit. If staff forgot, the person in charge of call monitoring had to contact them to confirm the visit had taken place. There was a code for late or missed visits. We looked at one person's visits over several days. We saw merged visits and visits shortened by up to 27 minutes. We asked the care co-ordinator about the shortened visits. They were unsure why the length of

visits varied. Within the same week, call monitoring showed one person had received a visit of three hours. We asked the care co-ordinator about this and were told, "It is a call monitoring error." They were unable to tell us how long the actual visit had lasted. This showed the call monitoring system was unsafe and ineffective in supporting people's safety.

In relation to one visit highlighted on screen, the code indicated the visit had been missed. We asked the care co-ordinator if the visit had been missed and why. They were unaware of the missed visit and why it had been missed. We shared our concerns with the registered manager who checked the system and stated there had not been a missed visit. The visit had been cancelled. We saw documentation that showed staff in charge of call monitoring had sought to confirm visits had taken place. However, the documentation indicated several missed visits in January and February 2016. We saw written records stated, 'Tried to call more than 20 times, no answer.' 'Staff not logged in and out.' 'When asked for arrival time or departure time, carers don't know. Outcome, '[Name of staff member], not answering the phone. There was no documentary evidence the provider had investigated the information related to the missed visits. This showed the systems in place to monitor missed visits did not manage the risks to people and was ineffective.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The provider had failed to ensure the electronic system was operated effectively to monitor and mitigate the risks to people who used the service. Accurate records were not maintained.

During this inspection we received concerns that important records relating to service users were being destroyed. On arrival at the office at Riverway House we spoke with the registered manager. The registered manager told us and showed us that service user records had been transferred from the provider's other offices in Heywood and Nelson when they had recently closed. Records were being condensed into archive files. There was no evidence that records were being destroyed.

The service had an up to date safeguarding policy and procedure in place. The policy guided staff about abuse and how to raise an alert. We noted safeguarding information and telephone numbers on display throughout the office base. The local authority told us the provider had raised a safeguarding concern related to an alleged theft by a member of staff. They had not notified CQC as required. We had spoken with the registered manager prior to the inspection regarding informing the commission of the alleged theft. We requested this on both days of our inspection and were told it would be completed However; we did not receive a notification from the provider related to the alleged theft of money from a person receiving support. This meant people were at risk because the provider had not enabled the Commission to fully carry out its regulatory duties.

This is a breach of regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009. The provider failed to notify the Commission without delay of safeguarding concerns made aware to them. They failed to provide evidence to show an investigation into concerns had taken place, and people were safe.

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 failed to notify the Commission without delay of safeguarding concerns made aware to them. They failed to provide evidence to show an investigation into concerns had taken place, and people were safe.

The enforcement action we took:

Notification of Decision to remove location

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not provide care and treatment to meet peoples' needs.

The enforcement action we took:

Notification of Decision to remove a location

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of people who used the service and do all that is reasonably practicable to mitigate any risks.

The enforcement action we took:

Notification of Decision to remove a location

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the electronic system was operated effectively to monitor and mitigate the risks to people who used the service.

Accurate records were not maintained.

The enforcement action we took:

Notification of Decision to remove location