CareQuality Commission

CARE IS WHERE THE HEART IS LTD

CARE IS WHERE THE HEART IS LTD

Inspection report

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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

About the service
Care Is Where the Heart Is LTD, is a domiciliary care agency providing personal care to people in their own homes. The service was supporting 17 people with personal care at the time of our inspection.

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
The provider's recruitment practices were not safe or robust, which meant people were at risk of being supported by unsuitable staff. Risk assessments had not always been completed in relation to known risks to people or plans developed for managing these risks. People's medicines were not always managed and administered safely. The provider was not following current government guidance regarding COVID-19 testing. The provider had not consistently recorded, analysed or acted on incident and accidents

People's needs and choices had not always been appropriately assessed to ensure effective outcomes of their care. People were not always supported by staff who had the skills and knowledge to meet their needs. People's individual dietary needs were not always addressed. People did not always have timely access to healthcare services and support. The provider was not working in line with the principles of the Mental Capacity Act 2005.

We were not assured the provider or manager adequately understood regulatory requirements. The provider did not have effective quality assurance systems and processes in place. We were not assured the provider or manager understood their responsibilities under the duty of candour. Relatives gave us mixed views on the provider's communication regarding people's care. Staff working for the provider told us they felt supported.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was requires improvement (published 10th December 2021) and there was a breach of regulation 17. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. The rating for the service has deteriorated from requires improvement to inadequate. For the last three inspection the service has been rated requires improvement or inadequate.

Why we inspected
The inspection was prompted in part, due to concerns received about the safe care and treatment and governance of the service. We received concerns about the provider's ability to support people safely and effectively. These concerns included infection control practices, poor recruitment practices, lack of staff

induction and training, and poor medicines management. Conversations with the provider prior to our inspection, did not give us assurances in relation to these concerns. A decision was made for us to inspect and examine these risks.
The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.
We have identified breaches in relation to the provision of person-centred care, safe care and treatment, governance of the service, staffing training and supervision, and unsafe recruitment practices.
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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

CARE IS WHERE THE HEART IS LTD

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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. At the time of the inspection there were 17 people using the service.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Healthwatch and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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.

We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and seven relatives about their experience of the care provided. We spoke with seven members of staff including the provider, assistant manager, care coordinator and care workers. We also spoke to one health professional. We reviewed a range of records. This included six people's care records and seven people's medication records. We looked at 12 staff files in relation to recruitment and staff competencies. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested and reviewed a range of documentation including policies, call records, care plans and additional staff files.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- The provider had not adhered to safe recruitment practices. This placed people at risk of being supported by unsuitable staff.
- We reviewed 12 staff members' recruitment records and found the provider had not completed consistent pre-employment checks to check their suitability to work with people. We could not be assured that the risk assessments in place for some staff members awaiting their up to date Disclosure and Barring Service (DBS) check, were robust and were always being followed. The DBS helps employers make safe recruitment decisions by checking the criminal records of potential employees.
- Where DBS checks had been obtained for staff, and the provider had completed risk assessments in light of matters disclosed, we found the provider was not always following the mitigations stated in the risk assessment. This meant we could not be assured people were always safe.
- The provider had not always obtained two suitable references prior to staff commencing employment, in accordance with their recruitment policy. The provider told us they had attempted to obtain the missing references but was unable to provide evidence of this.
- The provider had not followed up concerns raised by staff members' previous employers when responding to reference requests. The provider had received an employment reference for one member of staff six weeks after the commencement of their employment. On this the referee had identified concerns around the staff member's prior conduct, however the provider had not followed this up with the staff member in question.
- The provider had not always obtained satisfactory information about staff's physical or mental health conditions, relevant to the performance of their duties, and any associated adjustments made. They had not completed risk assessments, where required, to enable care staff who had known health conditions to safely perform their role, including those at increased risk of harm from COVID-19.

The provider's failure to operate robust recruitment practices was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- The provider had not always fully assessed the risks to people's health, safety and welfare or put clear plans in place for managing these. This lack of robust risk assessments and care plans meant people were at increased risk of harm. No risk assessments or care plans had been completed for one person using the service, which meant staff had no written guidance on how to safely meet their needs. Two people had bed rails in place, but no risk assessment had been completed to alert staff to the associated risks. This put people at risk of injury and entrapment. Another person required support from staff with catheter care. The provider had not developed an accompanying care plan to guide staff how to safely support this person

with this aspect of their care, or to alert them to potential signs of infection.
● We were not assured people at risk of pressure damage were receiving consistent support from staff to minimise the risk of skin breakdown. For example, no risk assessment or care plan had been developed in relation to the treatment of one person's known pressure sore. This meant people were at increased risk of skin breakdown from pressure. In addition, there were no records to evidence advice on skin integrity had been sought from a district nurse for one person, when their skin condition began to deteriorate, and staff members continued to record the person's skin condition was poor.
● Not all staff had not been provided with training to provide safe care. This included a lack of training in relation to people's individual health needs and their role in monitoring and helping people to manage these.
● Some staff we spoke with were not aware how to access people's care plans and lacked understanding of what these contained. This increased the risk of people receiving inconsistent and unsafe care.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This 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.

Using medicines safely
● People's medicines were not always managed and administered safely to ensure they were not placed at risk.
● Medicines patches for one person were not always applied safely or as prescribed. We found this person's patch had not been changed as scheduled on one occasion and no guidance was available to staff to ensure the application site was rotated. Site rotation of patches reduces the risk of skin irritation.
● The provider had not always provided staff with written guidance on when to offer people medicines which were to be administered on an 'as and when required' basis (PRN medicine). This meant there was an increased risk PRN medication might be used inappropriately.
● The provider had poor oversight of the management of people's prescribed medicines. The care coordinator told us there was only one person prescribed a controlled medicine, but we later identified a further three people. No additional guidance was in place for staff to follow when supporting people with controlled medicines, beyond the information recorded on people's medication administration records (MAR charts). A controlled medicine has potential for harm or misuse so extra safety measures are needed to make sure they are prescribed, supplied, used and stored safely and legally.
● People's prescribed creams and ointments were not always recorded on their MAR charts. Where this medication had been recorded on a MAR chart, staff had not always been provided with clear instructions on when, where and how to apply these. This meant people were at increased risk of not receiving the consistent support they needed with creams and ointments.
● We were provided with a training matrix, this indicated not all staff involved in handling and administering people's medicines had received training inline with the provider's own medicines procedures. Since the inspection we have received a new training matrix which indicates all staff members have received medication training. However, the matrix does not include all staff members who were employed at the time of the inspection.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety in the management and administration of medication. This 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.

Preventing and controlling infection

● The provider had failed to follow current government advice regarding COVID testing of staff. This placed people and staff at increased risk of increased transmission of COVID-19. Following the inspection, the provider informed us they had increased the testing of staff in line with government guidance.

● COVID-19 risk assessments were not always in place for staff or people. The COVID-19 risk assessments completed did not accurately reflect risks to people, despite people at the service having known health vulnerabilities increasing the risk to them should they contract COVID-19.

● The provider had failed to identify an infection prevention and control (IPC) lead as per their IPC policy and had not carried out any IPC assurance checks.

● During the inspection, we observed a member of staff entering the office without completing the COVID-19 checks outlined in the provider's own policy.

● Records showed care staff had not always received training in the correct use of personal protective equipment (PPE) or COVID-19 specific infection control training.

● People we spoke with told us care staff wore the correct PPE during their care calls.

Systems and processes to safeguard people from the risk of abuse

● The provider had not fully protected people from the risk of abuse and improper treatment.

● Not all staff had received safeguarding training to ensure they knew how to identify and report potential abuse concerns. Some staff we spoke with lacked understanding of the different forms of abuse and their associated responsibilities.

● Following the inspection, we raised a safeguarding concern to the local authority for a person regarding the care they received. The provider had failed to identify or report these concerns, meaning their safeguarding processes were not sufficiently robust.

● People and their relatives told us they felt safe. One person's relative told us "They [staff] are very good; they take good care of [person's name]." Another person told us they felt safe and knew who to contact if they had any concerns.

Learning lessons when things go wrong

● We were not assured the provider had consistently recorded, analysed or acted on incident and accidents to reduce harm to people. Staff were recording incidents and accidents in people's daily notes, which were not consistently checked by the provider. This meant lessons were not learned following incidents and accidents or consistent steps taken to reduce the risk of reoccurrence.

● Some staff we spoke to were not aware of their responsibilities to record and report incidents and accidents involving people. One member of staff told us "I do not know how to report an incident; I've not read the policy." Another member of staff had not completed training regarding the recording and reporting of incidents and did not know how to report incidents.

Systems were not in place to ensure people consistently received safe care and treatment. This placed people at harm. 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

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last comprehensive inspection this key question was rated requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs and choices had not always been fully assessed to ensure effective outcomes of their care. Initial assessments were not always completed and did not consider people's physical, mental and social needs.
- Assessments completed for people were very basic and did not incorporate key information, such as their life history, wishes, preferences or protected characteristics under the Equality Act (2010).
- One service user had a known health condition. The provider had failed to holistically assess this condition and had not provided care staff with personalised care plans enabling them to best support the person.
- Where people's care was commissioned by the local authority, they had provided an assessment of the person's needs. Identified health needs within these assessments had not always been included in people's care plans to help staff know how to support them safely. For example, one person's assessment by the local authority recommended a specific diet. There was no plan in place to detail what staff should do to support the person.
- Where people lacked capacity to make particular decisions, the provider had failed to assess their mental capacity or record best-interests decision-making. This meant we could not be assured the provider was protecting people's rights under the Mental Capacity Act 2005 when assessing care needs and making decisions about people's care.

The failure to assess people's needs and choices is a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- The provider had failed to ensure staff received appropriate support and training to carry out their duties. However, we were provided with a supervision matrix and although it did not include all staff members employed by the service, it did demonstrate some supervisions had taken place.
- Training records indicated staff training was not up to date. We found multiple staff had gaps in their training record, including safeguarding, first aid, mental health awareness and medicines training. Staff we spoke with lacked understanding of people's current needs, and the content of their care plans and risk assessments.
- In addition, not all staff had received training to support people's complex health needs. This included health conditions such as; dementia, Parkinson's disease, catheter care, stoma care and meeting individual nutritional needs. This meant some staff may not have the training needed to fulfil their roles and people

were at increased risk of being supported by staff who were not suitably skilled or competent.
● The provider made no allowances for the completion of training and development activities in work time and expected staff to complete training outside of working hours.
● The provider's staff induction did not incorporate the requirements of the Care Certificate. The Care Certificate is aimed at ensuring health and social care staff have the knowledge and skills they need to provide people with safe and compassionate care.
● Staff did not always receive regular supervision to monitor and reflect on their practice, provide guidance and support, and identify areas for development. There were no records of supervision in staff files. One member of staff told us "I've not had any supervisions, and none are planned."

The provider had not ensured all staff received appropriate support to carry out their duties. Whilst some staff had received supervisions, new staff members had not received supervisions to discuss if they felt confident to undertake their duties following induction. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they felt supported by the provider and management team. One member of staff told us, "I can go to anyone [in management team] and ask for support." Another member of staff stated, "I feel supported by [provider and care coordinator]."

Supporting people to eat and drink enough to maintain a balanced diet
● Risks to people with swallowing difficulties were not always identified and managed safely. The provider and care coordinator told us they did not have anyone using the service who required a special diet. We later identified two people with special dietary requirements. No steps had been taken by the provider to ensure staff had the guidance and information to support these people safely and recognise the risks associated with their dietary needs.
● Staff supported people with meal preparations and to eat and drink People expressed mixed views on the support they received in this area. One person said, "Sometimes they [staff] are late so I'm hungry." Another person stated, "[Provider] found it difficult to prepare a meal during the 30-minute call so they bought me an air fryer. [Provider] really cares."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We were not assured the provider always liaised effectively with other agencies, teams and professionals to ensure people's health needs were monitored and met. For example, one person's known skin conditions had been deteriorating over the last two weeks. Daily records demonstrated a delay in the provider seeking advice from other health care professionals. This meant people were at risk of harm from worsening health conditions.
● Some people's relatives told us they were not kept up to date about their loved one's care. This meant people had less support to understand and be involved in decision-making about their health. For example, one person's relative told us "I know there are no care plans in place, and we haven't heard from [the provider] since the initial assessment."
● Some people's relatives told us the provider had made timely referrals to health services. One person's relative said, "[Person's] skin was worsening. [Provider] called the nurse about it."
● One healthcare professionals told us the provider was responsive and had acted on guidance they gave.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA

● The provider was not working in line with the principles of the MCA. They were unable to evidence that people's rights under the MCA were being protected. Assessment and care planning processes did not always consider people's capacity to consent to care and treatment.
● During the last inspection we found systems for confirming who had legal rights to make some decisions on people's behalves required further development, to ensure people's rights were fully promoted. During this inspection we found improvements had not been made. For example, there was no system in place for record people who lacked capacity and who had the power of attorney.
● Mental capacity assessments had not been completed to determine people's ability to make particular decisions. Where decisions had been made on behalf of people, there was no record to demonstrate these were in their best interests. For example, we found two people with bed rails in place. There was no record in their care files to demonstrate people's involvement in the decision-making process or that the introduction of bed rails was in their best interests. We also saw records in a person's care file indicating they lacked capacity. No further information had been recorded regarding the assessments of their ability to make particular decisions or associated best-interest decision-making.
● Most staff had not received training in people's rights under the MCA and when to act in their best interests to ensure people's safety and welfare was maintained. Some staff we spoke to had little understanding of the MCA. One member of staff said they had no knowledge in this area.
● The provider did not have a robust process for seeking consent from people. For example, one person's file we looked at did not have any signed consent forms. This meant we could not always be assured that people were consenting to their care.
● People told us they were asked for their consent when staff carried out day-to-day care tasks.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to implement robust audits and monitoring systems. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider did not have effective systems and processes in place to assess and reduce risks to people's health and safety. We identified concerns about people's safety during the inspection. This included the provider's failure to adhere to government guidelines on COVID-19 testing for staff, the lack of regular supervision for staff and the lack of a robust recruitment and selection processes.
- The provider had failed to implement effective systems to assess, monitor and improve the service. As a result, the provider had not identified the concerns found at this inspection, including those relating to unsafe management of medicines, staff training provision and lack of robust risk assessment and care planning processes. This was the provider's fourth consecutive rating of requires improvement or inadequate for this service.
- The provider had not established robust systems and processes to enable staff to record and report accidents or incidents, and to ensure these were thoroughly investigated to minimise the risk of reoccurrence and drive improvement in the service.
- The provider had failed to identify they were not consistently following their own policies. This included a failure to adhere to their recruitment policy.

The provider had failed to implement robust audits and monitoring systems. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider is required to have a registered manager for the service. There was no registered manager in post at the time of the inspection and no registered manager had been in place since February 2021.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Staff members we spoke with told us that they felt supported by the management team and said if they made suggestions they would be listened to. One care staff member told us "I haven't had to raise any issues. If I did, I feel [the provider] is approachable and would listen." Another member of staff stated, "I feel [the provider] is approachable and I would be able to go to [the provider] with any issues."

● Not all staff understood whistleblowing or were aware of the provider's related policy. Whistleblowing is the term used when staff report certain types of wrongdoing within an organisation

● Based on our conversation with the provider and manager about the duty of candour, we were not assured they understood their associated responsibilities, including the need to be open and honest with people when care had not gone according to plan.

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

● We received mixed views from relatives about the effectiveness of their communication with staff and management. One relative said, "I think the provider is lovely; she makes me feel confident and really cares. I feel listened to." Another person's relative told us, "Trying to arrange an appointment was hard; I had to keep chasing them." Another relative stated, "There's no folder for staff to write in or way of us seeing what's been done when [care staff] visit. I don't know what's been happening."

● One person's relative expressed concerns in relation to how the provider had responded to their concerns around their loved one's care. They told us, "I told [the provider] that I was not happy [with the care their relative was receiving]. [The provider] just said. 'If you want to complain then complain.'"

● People we spoke with told us they had not been asked for their feedback or views on the service.

● The provider told us they held monthly team meetings with care staff. We asked the provider to view the minutes from the meetings, however these were not made available. The care coordinator showed us the agenda for two recent meetings. Most staff we spoke to told us that they had been to a single team meeting which had been held the day following our visit to the location's office.

Working in partnership with others

● People's care records indicated staff and management had engaged with other health professionals to ensure people's care needs were monitored and met. However, communication with external professionals had sometimes been delayed.