CARE IS WHERE THE HEART IS LTD

# CARE IS WHERE THE HEART IS LTD

## Inspection report

117 Bodenham Road
Oldbury
B68 0SF

Tel: 07306055082

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## Ratings

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

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

# 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 10 people from the location, with personal care at the time of our inspection.

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's relatives told us their family members valued the care provided and were confident if they made suggestions for improving the service provided these would be listened to. However, the processes the provider had in place to check people's care had not identified areas for improvement we found at this inspection. Further development of checks and audits were required in order to ensure opportunities to improve the service provided to people were consistently driven through. This included in identifying any patterns or trends relating to accidents, incidents and safeguarding, so learning could be taken from these. In addition, there were some inconsistencies in risk assessments and care planning and staff recruitment practices. The provider gave us assurances these would be addressed.

Improvements had been made in the way people's risks were managed and the level of detail provided to staff to support people's care needs. This included details of people's individual health needs. We found some checks were working effectively, so the provider could be sure people received their medicines as prescribed, at the time people required these. In addition, the provider's checks to make sure staff had the skills they needed when assisting people to move around their homes safely had improved. The provider and senior staff also undertook spot checks on how staff cared for people. This helped to give the provider assurance risks to people were reduced. Where any actions had been identified, these were addressed. The provider had further developed their spot check processes, which in the future will provide opportunities for people and relatives to give their experiences of the care provided.

There had been further changes to the staff managing the service and providing care. People's relatives told us this had not affected their family member's safety. Staff were positive about working for CARE IS WHERE THE HEART IS LTD and said the provider and senior staff took prompt action to support people if there were any concerns for their well-being.

Staff gave us examples of support provided to people, so people could maintain their relationships with family members. Staff also gave us examples showing how they worked with external organisations and professionals, such as GPs, occupational therapists and housing providers, so people had improved outcomes.

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 inadequate (published 30 June 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection the service has improved to requires improvement. We found although some improvements had been made the provider continued to be in breach of a regulation. Please see the well-led section of this full report.

This service has been in Special Measures since 23 June 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
The inspection was prompted in part due to concerns about people's safety. For example, staffing arrangements, and the governance of the service, as the provider had not effectively demonstrated what they had done to improve since our last inspection. A decision was made for us to inspect and examine those risks. 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.

We found no evidence during this inspection that people had experienced harm from safety concerns. However, we have found evidence that the provider needs to make improvements. Please see the well-led section of this full report.

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 inadequate to requires improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for CARE IS WHERE THE HEART IS LT D on our website at www.cqc.org.uk.

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 a continuing breach in relation to how the service is managed at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

# 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors at the provider's offices, and an additional two inspectors contacted relatives to find out their views of the care provided.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service did not have a manager registered with the Care Quality Commission at the time of inspection. The provider was in the process of applying to become the registered manager for the service. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider 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 and professionals who work with the service. 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 of this information to plan our inspection.

During the inspection
We spoke with seven relatives about their experience of the care provided. We spoke with six members of staff including the provider, office manager and care workers.

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 competencies. A variety of records relating to the management of the service, including checks undertaken by the provider were reviewed. This included processes for checks made by the provider to ensure people received their care as assessed and planned.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, additional call monitoring checks and policies and procedures. The provider also submitted additional records to show us what action they had taken in response to the findings of the inspection.

Requires Improvement

# 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 inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
At our last inspection the provider had failed to follow safe recruitment practices. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

- Improvements had been made to the way staff were recruited. For example, references had been obtained before staff were permitted to work alone with people. In addition, staff were not allowed to provide care to people until the provider had confirmed their Disclosure and Barring Service, (DBS), checks. We found where staff had initially provided their individual DBS, the provider had followed this up by obtaining their own DBS checks. This helped to assure the provider new staff were suitable to work with people.
- We found not all the initial DBS checks undertaken by the provider with staff had been recorded. The provider gave us their assurances they would consistently record the individual DBS details provided by staff in the future.
- Newly recruited staff's employment history had been recorded. Further development was required, to ensure the provider consistently had the full information they needed to identify gaps in staff employment histories and to record follow up action taken. The provider gave us assurances after the inspection this had been followed up.
- Where staff had underlying health conditions, consideration had been given to the support staff may require to maintain their health and well-being.
- New staff worked alongside more experienced staff to develop their understanding of how people liked their care provided. New staff also completed an induction. We saw the provider used this time to check staff were competent to safely provide people's care. For example, in relation to assisting people to move safely and to check staff had developed the skills they needed to ensure people's medicines were safely administered.

Assessing risk, safety monitoring and management

At our last inspection the provider failed to robustly assess risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● People and their relatives were involved in identifying people's risks and care needs. This helped to ensure people's safety needs were identified and responded to.
● Further improvement had been made to people's risk assessments and care plans. This included clear guidance for staff where people required specific support to move safely, use bedrails or needed catheter care. Care plans and risk assessments also guided staff on potential signs of infections. Some further development was required to ensure information to guide staff was consistent. For example, to ensure there were clear instructions for staff in care plans which were also fully reflected in people's risk assessments. This would help to reduce risks to people further by providing full instruction to staff who do not know people's safety needs well, should this be required.
● People's care plans and risk assessments now recorded people's underlying health conditions. Staff were supported to understand general aspects of these. However, further development was required to ensure staff were fully supported to understand how people's individual health conditions may affect them, to further promote people's safety and well-being.
● People's relatives told us staff knew how to support people to stay as safe as possible. Staff were positive about the training they received to promote people's safety. Some staff had undertaken specific training, such as diabetes, dementia, skin and catheter care, so the provider could be assured staff knew how to care for people safely.
● People's relatives told us they could rely on staff providing care calls at the times, or near to the times, agreed. One relative told us staff understood their family member became anxious if staff were late. The relative said if there were any minor delays in care being provided, for example, because of traffic conditions, staff got in touch with them, to reassure them. Another relative told us staff had been unable to provide a scheduled call, owing to an emergency; the relative had provided the care the person required. The relative told us this was not a regular occurrence.
●The provider checked people received their calls on time and confirmed if staff had stayed the length of time people needed. Where there had been any variation in the call times the provider had taken appropriate action to review this. Staff gave us examples showing how the provider and senior staff had covered care calls in emergency situations, to ensure people still received their care as assessed and planned. This ensured people did not experience missed calls.
● We saw where staff had any concerns for people's safety or well-being these were promptly escalated to the provider. The provider took immediate action to help people to remain as safe and well as possible.

Learning lessons when things go wrong
● Learning was taken when people's needs changed. As people's risks and needs changed this was communicated promptly to staff.
● In addition, staff were encouraged to reflect on people's care needs, and areas for improvement, during checks on their practice done by the provider and senior staff, and during staff meetings.
● We found no evidence of harm to people, but further development was required to ensure the provider had information available which would allow them to identify patterns and trends in relation to people's safety.

Using medicines safely
● Staff had been provided with additional guidance to promote the safe administration of 'as and when required' medicines, such as what frequency they should be administered. However, further action was required to ensure staff were consistently provided with the information needed to support individual people. For example, guidance to advise staff how they would know if people wanted 'as and when required'

medicines. This would help to reduce the risk people may experience unnecessary pain. The provider took immediate steps to address this during the inspection.
● People's relatives told us staff administered their family member's medicines as planned. This included medicines which had to be administered at specific times, to ensure people remained well.
● Staff had been provided with additional guidance to promote the safe administration of people's prescribed creams, where these were required to promote good skin health.
● Staff told us checks were undertaken by the provider and senior staff, to ensure people received their medicines safely.

Systems and processes to safeguard people from the risk of abuse
● Relatives gave us examples of times staff had contacted them if there were any concerns for their family member's safety or well-being.
● Staff knew what signs to look out for to support people who may be at risk of abuse.
● Staff we spoke with told us they were confident the provider and senior staff would take action to protect people, should this be required.

Preventing and controlling infection
● Relatives told us staff consistently used PPE when providing care to their family members.
● Staff practice in the use of PPE was checked by the provider and senior staff, so they could be assured the risk of infections was reduced. Staff gave us examples showing how they reduced risks to people through the correct storage and disposal of PPE and food items.
● We saw the provider took other steps to reduce the risk of the spread of infections. For example, by checking people's temperature before they entered the office, and by ensuring staff undertook COVID-19 testing.

Requires Improvement

# 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 inadequate. At this inspection this key question has now improved to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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.

● People's relatives were confident if they raised any concerns about the quality and safety of the care provided this would be addressed. However, systems needed to be developed to ensure the provider was able to review safeguarding, accidents and incidents. This would enable the provider to identify any patterns and maximise opportunities for taking learning from these, to reduce risks to people further.
● The providers audits and checks had not always driven through improvements in care planning arrangements. For example, further improvements in the consistency of guidance across risk assessments and care planning was required, in order to further reduce risks to people. We also identified during the inspection some people required additional care plans to be put in place. This included in relation to an individual person's specific health concerns, and people's future wishes and preferences.
● 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.
● The provider had identified additional improvement was required to their call monitoring systems, so they could check people received their care as assessed and planned over time, so any trends could be identified, and the service developed further.
● The provider had further developed their staff induction programme, so they could be assured new staff were supported to care for people. Staff told us they were confident if they requested additional on-going training this would be provided. However, we found some staff still had not had the opportunity to access some specific training, such as Parkinson's disease. The provider gave us assurances staff currently providing care to people had received the specific training they required to care and support people as safely as possible. The provider also confirmed they had planned for all staff to access specialist training.
● The provider had begun to develop links with other local care providers and external specialists, such as training providers. Further development of support mechanisms for the provider and senior team was

required in order to ensure they consistently understood what is expected of their roles. This includes how to establish further improvements in the care provided and to ensure these are consistently communicated to other agencies.
● There was no registered manager in post at the time of the inspection. Following changes to senior staff the provider had applied to become registered manager for the location.

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.

● Some checks were now further embedded and gave the provider assurances people were receiving the care they needed. This included unannounced spot checks on staff practice, and improvements in medication checks and daily care log audits. We saw where actions had been identified these were followed through. For example, in relation to ensuring people's allergies were consistently recorded, so staff would have the guidance they needed to promote people's safety.
● The provider also undertook some care calls and used this as an opportunity to check on the care provided and staff practice.
● We discussed our findings with the provider during our inspection. They gave their assurances they would continue to drive through improvements in their quality assurances processes. The provider also took action to address some areas during and after the inspection. For example, in relation to consistency of guidance within care plans and risk assessments, the introduction of planning for people's future wishes and confirming staff training arrangements. More time is required to ensure these improvements are fully embedded.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People's relatives told us they were encouraged to make suggestions for their family member's care and their views were listened to. One relative said, "We know the [provider] well, they go above and beyond to help. Any issues or concerns [they] are on the case and sort it." The relative told us because of this, "[We] wouldn't swap them for the world."
● Another relative gave us an example of how clear communication between the staff, provider and themselves had led to improved health outcomes for their family member. The relative explained staff had carefully monitored their family member's health needs, and staff had advocated with other health professionals on their family member's behalf. The relative said because of the actions taken by staff their family member had been able to promptly access the health care they needed, and to regain their health quickly.
● Most people's relatives told us care was provided by regular staff, and this encouraged them to make suggestions for developing their family members care. One relative told us they were concerned a number of care staff had recently left the organisation and they would welcome more continuity of staffing.
● Staff said CARE IS WHERE THE HEART IS LTD was a good place to work because the way the service was run focused on the needs of the people care was provided to. Staff gave us examples of actions taken by the provider so they would feel supported and appreciated. This included the provider and senior staff supporting staff to work flexibly when this was required and acknowledging when staff had 'gone the extra mile' to support people.
● Staff told us they were encouraged to make suggestions to ensure people's changing care needs were met and gave us examples showing they were listened to. This helped to ensure people continued to receive appropriate support.

● The provider confirmed they intended to further develop reviews of people's care so that people and their relatives had additional ways to provide feedback on the service provided.

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

● The provider understood the need to be open and honest if anything went wrong with the care people received.

Working in partnership with others

● We saw where staff had concerns for people's well-being these were escalated to the provider and addressed for individual people. This included liaising with other health and social care professionals, such as occupational therapists and people's GPs, so people would be supported to receive the support they required.

● Staff gave us examples of work they had taken with housing providers, so they could be assured people would enjoy the best well-being outcomes possible.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider's governance systems were not sufficiently embedded or broad enough to consistently drive through improvements in the quality of the service. |