Blossoming Hearts Care Agency Ltd

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Inspection report

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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
Blossoming Hearts is a domiciliary care agency. It provides personal care to people aged 18 and over living in their own homes and flats.

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. The service was providing support to 20 people with personal care needs at the time of our inspection.

People's experience of using this service and what we found
We found a lack of oversight of systems and processes, particularly with regard to updating care plans and risk assessments. Risk assessments and care plans were not updated, and some staff were not aware of how to mitigate risks, which placed people at risk of harm. We did not find there was direct impact to people because of this, but the provider fully accepted the potential risks and had already started to work on improving these.

Staff had good insight as to people's likes and dislikes and respected their wishes, despite the lack of information about people's preferences and choices. People and relatives supported this with both written and verbal reports about the level of care they received.

The system to monitor staff training was not effective. Staff had not had annual refresher training where it was required. Staff were unaware of the training they had completed although they did know what to do and who to go to for assistance, including safeguarding. However, further action was needed in relation to the moving and handling training, particularly with using equipment in confined spaces.

Staffing was not adequate as systems did not allow time for travelling from person to person. People and their relatives commented carers did not always stay their allotted time or were late arriving because of this. Transport for staff was raised as part of the problem.

There had been some difficulties covering shifts at short notice, partly due to staff being unfamiliar with a different system and partly due to difficulties with wifi and telephone signals in rural areas. Short notice sickness also caused a problem. The management team recognised this could be improved with better communication going forwards, and a review of rotas as well as additional recruitment.

The registered manager and director had learnt from a previous report and had put robust and safe methods in place for recruitment. All information was correct and appropriate to ensure safe recruitment was in place. When there had been a lack of understanding about regulations this was immediately addressed.

PPE supplies were good and there were positive comments about the appropriate use of PPE by Staff from people and relatives. People felt confident with their care delivery.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; There were policies and systems in the service to support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at the last inspection and update
The last rating for this service was Requires Improvement published 7 August 2019 with two breaches of regulations. The provider failed to complete an action plan after the last inspection to show what they would do and by when to improve.
At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated Requires Improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about infection control and safe staffing practices. A decision was made for us to inspect and examine those risks.
We looked at infection prevention and control measures under the Safe key question. We look at this in all inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 not changed from 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 Blossoming Hearts 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 found evidence that the provider needs to make improvements. We have identified breaches in relation to Regulation 12 (Safe Care and Treatment), and Regulation 17 (Governance)

Follow-up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor

progress. We will 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.

Blossoming Hearts Care Agency 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

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 had a manager registered with the Care Quality Commission. This means that they and the provider are 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 visiting the office location. We gave notice of the office visit, because it is a small service and we needed to be sure that the registered manager would be available to support the inspection. We also checked whether anyone was diagnosed with COVID-19, to reduce the risk of transmission.

What we did before 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. We used the information the provider sent us in the Provider Information Return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two members of staff including the provider who in this case is also the registered manager, and the managing director.

We reviewed a range of records. This included three people's care records and electronic medication records. We looked at two staff files in relation to recruitment and staff supervision. 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 further documents to support our evidence. We looked at training data and quality assurance records. We spoke with two people who use the service, ten relatives, nine carers and a team leader, and two professionals who have people they support using the service.

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 Requires Improvement. At this inspection this key question has remained the same.

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.

Assessing risk, safety monitoring and management

● Although there were some risk assessments in place, these had not been reviewed for in excess of 18 months. The registered manager told us they had started to review these.

● People were supported by the same staff members, so they knew people's needs well. From speaking with staff, people and relatives, we were reassured people received appropriate support most of the time.

● The lack of updated and current risk assessments meant people could be at risk or harm if they were to be assisted by a staff member who was not familiar with the person's needs.

Staffing

● People and relatives told us they felt there were not enough staff and there were times when people did not have all their needs met. Staff were not given time to travel between calls meaning staff were unable to stay for the full time allocated for the call.

● Rotas did not allow for travel times between people, or in several cases staff were to visit two people's homes at the same time at different addresses. This was primarily due to a lack of familiarity with the new electronic system. We saw and heard that people were not receiving the care they needed due to this confusion.

● Relatives and people expressed concern about the staff 'being rushed'. They told us that on occasions people had not receive the care they required. This included people not receiving support with shaving and people not being fully dressed when staff left their home. "Rushing" also caused some minor damage in one person's home to furniture when hoists were used.

● The registered manager told us there had been some difficulties covering shifts at short notice, due to short notice absence, unfamiliarity with the system used and difficulties with telephone signals in rural areas. Staff, both in the office and those involved in care delivery had not received enough training in order to use the system correctly and maximise its effectiveness.

● Call logs and rotas showed that calls were sometimes early and sometimes late. In some cases, this meant someone had only just finished their lunch when their teatime call came.

●One person said "Carers are great, but they can be late" , another person said , " timings can be iffy"

●Staff were enthusiastic about their roles and felt that they made a positive impact to those they looked after. Several staff members said, "I love my job". Another staff member said "I really enjoy my regulars; I have a good client base"

Using medicines safely

● Oversight of medicines was currently primarily done by the team leader. The registered manager told us they intended to learn to better utilise the new electronic system to assist better oversight, as well as the checks in the home carried out by the team leader.

● There were concerns over pain-relieving patch medicines in use, which were not always properly recorded on body maps or checked that they were still on the person after they had been moved from bed to chair for instance. This meant the persons pain control was not always continuous.

● Where people were prescribed time specific medicines, call times did not always take account of this and the impact it had on the person when carers arrived to carry out care and they hadn't received medication that allowed them to be moved without pain.

Systems and processes to safeguard people from the risk of abuse

● The provider had systems and processes to protect people from the risk of abuse.

● Staff told us they had received training in safeguarding, when they had started and felt confident, they would recognise abuse. They told us they would report any concerns to the management team without delay.

● There was no evidence that any safeguarding risks had been identified, and we could not be assured that the registered manager fully understood local safeguarding procedures.

● The system to monitor staff training was not effective. Staff had not had any annual refresher training when required, e.g. for safeguarding.

● Some staff were unaware of the training they had completed, and the training matrix was not up to date although they did know what to do and who to go to for assistance.

● Further training and oversight was needed in relation to the moving and handling, particularly with using equipment which is carried out in confined spaces. One member of staff told us that moving and handling training was carried out as e-learning as there was no trainer on site.

These demonstrate a failure to provide safe care and treatment in relation to assessing the risks relating to the health safety and welfare of people. medicines, training and competency, risk assessments and staffing levels. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment

At the last inspection a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 Regulations 2014 had been found. This has now been addressed, and at this inspection we found improvements had been made and the provider was no longer in breach of this regulation.

The registered manager and director had learnt from the previous report and had put robust and safe methods in place for recruitment. All information was correct and appropriate to ensure safe recruitment was in place.

Preventing and controlling infection

● We were assured that the provider was preventing visitors to the premises from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● The registered manager and director had learnt some lessons from a previous report and had put robust and safe methods in place for recruitment.
● Where there had been a lack of understanding about regulations, in this case about the need to display the organisations previous inspection rating on their website this was immediately addressed.

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 Requires Improvement.

At this inspection this key question has remained the same. 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.

At the last inspection a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been found. This had not been addressed, and at this inspection we found the provider was still in breach of this regulation.

- We found a lack of oversight of systems and processes, particularly with regard to updating care plans and risk assessments.
- The provider was not following their own policy and procedure for auditing the administration of medicines. The team leader told us they spot checked medicines administration records when visiting people in their homes but did not have documented evidence to show this was being done.
- The system to monitor staff training was not effective as it had not been updated.
- The provider was not able to clarify how the practical side of manual handling training was carried out.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People and their relatives told us they couldn't remember when there was last a review of their (or their relatives) needs.
- As there were no up to date care plans and risk assessments, we could not be assured there had not been an impact on people's outcomes, as risks may still be present that could cause harm.
- The service had recently moved to a new electronic management and recording system, which would assist in auditing and oversight. However, all staff required further training in order to maximise the effectiveness of the system.
- Care plans were not person centred but people and relatives were able to assure us they felt staff knew people well enough to be able to respect their wishes and feelings.
- People's likes and dislikes were not recorded. However, carer's written reports did indicate person centred care was being carried out, and they did know what people liked or didn't like and respected their wishes.

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

- Because risk assessments and care plans have not been reviewed this has had an impact on the organisation being unable to successfully demonstrate it is able to deliver a quality performance, but we found no evidence of impact on people's care at this point.
- People's care records were not reviewed in a timely way and audits that had taken place were ineffective

at identifying areas for improvement.
● Other issues identified within the last report regarding care plans and risk assessments have not yet been addressed. Areas identified last time included risks not being always being formally assessed and the provider not providing staff with sufficient information about how to reduce risk.
● Another issue identified in the last report concerned insufficient oversight of service delivery because systems and processes were not operated effectively to ensure compliance with regulations.
● During this inspection visit we found that improvements had not been made to systems to assess, monitor and mitigate the risks relating to the health and safety of service users.
● The registered manager acknowledged that they were unskilled at auditing and more training would be helpful for the purpose of their oversight and audit

The above demonstrates a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had been acknowledged by the registered manager immediately prior to the inspection and additional office support had been recruited so this could be addressed.

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 did not notify CQC of significant events. For example, when people had died or if staff had a raised a safeguarding alert with the Local Authority. This meant we could not check appropriate action had been taken to maintain people's safety.
● Because of the poor governance at the service, the registered manager was unable to demonstrate how they complied with the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, staff and relatives had found communication with the provider and management team difficult over the past 18 months.
● There had not been any use of virtual meeting rooms to keep engaged with staff groups, although there had been 1:1 phone calls, some staff felt left out of communications.
● All relatives and people said there had been difficulties generally with communication.
● Carers written reports did indicate person centred care was being carried out, and they did know what people liked or didn't like and respected their wishes. People and relatives supported this with both written and verbal reports about the high level of care they received. One person commented "My relatives care was proficiently and sensitively carried out. The continuity of carers enabled a good relationship to develop between the carers and my relative."
● There had been surveys posted out and returned and again these indicated satisfaction with care delivery.

Continuous learning and improving care
●The registered manager acknowledged training generally had slipped and although care delivery itself remained good for people, there was a potential lack of progress and identification of risks to people due to training not being up to date.

Working in partnership with others
● External health agencies were complimentary about the service delivery, particularly for people with

complex packages. They had taken on a care package where the person didn't really want carers, but they had managed to build a relationship with the person, which had had a positive impact. Relatives also told us this and were grateful for the care provided.

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 risks were not managed, training was not regularly updated, and staffing allocations did not always allow peoples needs to be met in the time allowed. There were issues with unsafe medication practices and moving and handling which could cause harm to people.

The enforcement action we took:

we are issuing a Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was poor governance at the service. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was primarily due to the lack of oversight including audits, no reviews, inadequate care plans, poor communication and a failure to follow our Regulations.

The enforcement action we took:

We are issuing a Warning Notice.