Angel Heart Home Care Ltd

Angel Heart Home Care Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We inspected Angel Heart Home Care on the 29 September and 2 October 2015 and it was an announced inspection.

At our last inspection on 2 April 2015, breaches of legal requirements were found and we took enforcement action against the provider. We issued warning notices in relation to person centred care and good governance. Requirement actions were served in relation to staffing and safe care and treatment. The provider wrote to us to say what they would do to meet legal requirements in relation to safe care and treatment, person centred care, good governance and staffing.

We undertook this comprehensive inspection to check that they had followed their plan and to confirm that they now met legal requirements. We found the provider had made pockets of improvements however, sufficient improvements had not been made to meet the

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requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. Some of these breaches were repeated because the provider had failed to take proper action after the last inspection.

The overall rating for Angel Heart Home Care is 'Inadequate' and the service therefore remains in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Angel Heart Home Care is a domiciliary care agency providing personal care for a range of people living in their own homes. These included people living with dementia, older people and people with a physical disability. The support hours varied from one to four calls per day, with some people requiring two members of care workers at each care call. The agency's office was based in Camberley and the agency offered support and care to people in Camberley, Frimley, Blackwater and the surrounding area. At the time of our inspection, the agency was supporting up to 17 people and employed six care workers.

People and their relatives felt there had been improvements with the running of the agency in the past two weeks. One person told us, "My care has been better these past two weeks after the office staff have been out doing the work." One relative told us, "They seem to have some new care workers and trying to improve over past two weeks but am exhausted chasing things up." Although people felt some improvements had been made, the provider had not fully addressed the issues we found at our last inspection.

Risks to people's safety continued to be poorly managed. Risk assessments lacked sufficient guidance and information to enable care workers to provide safe care. Moving and handling risk assessments failed to document specific information required to safely move and transfer people. Where restrictive practice was used, robust risk assessments were not in place and did not provide detailed information about reducing the risks or what was in people's best interest.

Care plans lacked detailed information on how to effectively meet people's nutritional needs. For people who required a soft or puree diet, guidance was not in place on how to minimise any potential risks of choking. Where people required support to maintain a healthy diet or support with dietary requirements, such as diabetes, guidance and information was not in place.

The provider had not followed best practice guidance when they had recruited new care workers. New care workers had not been fully vetted before they worked with people.

The provider had not been able to respond fully to the inadequacies we raised with them at our last inspection. They had a lack of understanding about prioritising people's safety which was demonstrated by the continued lack of proper risks management, medicines management and safe staff recruitment practices. Audits were being carried out by the management team but they had failed to understand how they needed to follow relevant legislation and best practice. The provider was

Summary of findings

unaware of their legal requirement to display their Care Quality Commission (CQC) rating. Incidents and accidents were not monitored for any emerging trends, themes or patterns.

People and their relatives raised concerns over the timekeeping of care workers, not being informed if the care worker was running late and calls times being inflexible and not personalised to them. One person told us, “We never know who is coming sometimes no one comes and sometimes have duplicated calls.” Relatives also raised concerns regarding poor management of complaints. One relative told us, “They are not diplomatic when we raise concerns.”

A database management system was now in place which provided a centralised system of recording everyone’s details and frequency of care calls. The provider had also implemented a telephone monitoring system whereby care workers logged in and out care calls. This provided a clear audit trial of when care workers were late to a care call and provided a system for monitoring for any missed calls.

The provider had taken action to ensure care workers received the training and support required to effectively undertake their job role. Care workers now received regular supervision, team meetings were taking place. Face to face training was implemented and spot checks were being undertaken. Mechanisms were now in place to assess care worker’s competency with the training provided and ensure it is embedded into practice.

Care workers spoke with compassion for the people they supported. Individual reviews had been taking place which considered what was working for people and what was not working. However, further work was required to ensure care plans and risk assessments were updated following any review. Work was still being undertaken to ensure care plans were personalised.

Overall, we found shortfalls in the care provided to people. We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. We will publish what action we have taken at a later date.

Summary of findings

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 

Angel Heart Home Care was not safe. The risks to people's health and safety whilst receiving care had not been properly assessed, and in some instances, action had not been taken to mitigate any such risks. The provider did not follow safe recruitment practices. People were not always protected against the risks associated with the unsafe management and use of medicines.

The implementation of a telephone monitoring system enabled the management team to monitor for any missed calls and people and their relatives identified a significant improvement to the timings of care calls in the past two weeks.

The provider had experienced a high turnover of care workers and on-going recruitment was required to enable a consistent team of workers to deliver safe, effective and responsive care.

Is the service effective?

Requires improvement 

Angel Heart Home Care was not consistently effective. Guidance was not in place on how to effectively meet and manage people's nutritional needs.

Improvements had been made to staff training and support. Care workers now received regular supervision and moving and handling training was now provided face to face. Training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had also been implemented. However, people and their relatives continued to have mixed views about the competency and skills of the care workers

Is the service caring?

Requires improvement 

Angel Heart Home Care was not consistently caring. The changes required so that people and their relatives were fully involved in planning their care had not been fully implemented.

People and their relatives continued to express concerns with the delivery of care and how the care did not always respect and uphold people's rights.

Care workers spoke with compassion about the people they supported. Consideration was given to male care workers providing support to female's and care workers understood the importance of enabling people to have choice.

Is the service responsive?

Inadequate 

Angel Heart Home Care was not responsive. The delivery of care remained often unreliable with care workers arriving at various times and people not being informed when care workers would be arriving or if they were running late.

Summary of findings

The management of complaints remained poor. Documentation failed to record when people had raised concerns and the action taken. The provider was unable to demonstrate how complaints were monitored for any trends, themes or patterns and how learning from complaints took place.

Is the service well-led?

Inadequate

Angel Heart Home Care was not well-led. On-going work to the quality assurance framework was required. Incidents and accidents were not audited for any emerging, trends, themes or patterns.

Where the delivery of care had compromised people's safety, there was no managerial oversight or investigation or root cause analysis to ascertain why this occurred and to ensure future incidences were minimised. The provider was unaware of their legal requirements to display their Care Quality Commission (CQC). The provider had not acted upon the Duty of Candour regulation and was unaware of their own responsibilities under this regulation.

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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. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection began with a visit to the services office which took place on 29 September and 2 October 2015 and was announced. Forty eight hours' notice of the inspection was given to ensure that the people we needed to speak to were available. We contacted people and their relatives on the 28, 29 and 30 September 2015 to obtain their views and feedback. On the 29 September 2015, we visited two people in their own homes to gain their views.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience helped us with the telephone calls to get feedback from people and their relatives.

We spoke with five people and 15 relatives by telephone. On the days of the office inspection, we spoke with the registered manager (provider), branch manager, deputy manager and five care workers. Over the course of the two days we spent time reviewing the records of the service. We looked at five staff files, complaints recording and accident/incident files. We also reviewed eight care plans and other relevant documentation to support our findings.

Before our inspection we reviewed the information we held about the service. We considered information which had been shared from the local authority, and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

Inadequate

Is the service safe?

Our findings

At our last inspection in April 2015, the provider was in breach of Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because risk assessments were not consistently in place or lacked sufficient guidance for care workers to follow. Staffing levels were inadequate and people were experiencing missed care calls. Care plans failed to record guidance on the level of support people required to safely manage their medicine regime. Recruitment practice was not safe and did not follow best practice guidelines.

Due to the concerns found at the last inspection, people were at significant risk of not receiving safe care and the delivery of care was inadequate. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by September 2015. At this inspection, improvements in some areas had been made; however, people's safety was still compromised in various areas.

People commented they had noticed improvements with the delivery of care recently. One person told us, "My care has been better these past two weeks." However, people and their relatives felt that the agency had been short staffed and noticed a high turnover of care workers. One relative commented on how the office staff had been carrying out the care calls. One relative told us, "They seem to have some new care workers and trying to improve over the past two weeks but I am exhausted chasing things up."

Assessment of risk is a significant component of safe care. Guidance produced by the Health and Safety Executive identified that the 'risk to both the person being cared for and those providing care, will vary greatly according to the individual's needs, the environment where care is provided, the type of care being provided and the competence of the care worker'. The last inspection in April 2015, found risk assessments were not consistently in place or lacked guidance and robust information. We found continued shortfalls assessing and recording of risk assessments.

Risk assessments were in place which covered a wide range of risks. These included moving and handling, nutrition and medicine management. Risks associated with moving and handling requires a clear handling plan to be in place which considers all of the potential risks and how to minimise those risks. Moving and handling risk assessments were in place but did not address all of the associated risks. They considered the equipment needed, the benefit from the support provided. They then considered the risks associated with specific tasks such as 'holding loads away from the body'. However, sufficient information was not recorded, such as the size of the sling required, how many care workers were required and what loops the sling should be placed onto the hoist.

Information was also not recorded on what equipment was required for each transfer, such as bed to chair or commode to bed. There was also no consideration to the views and preferences of the individual being hoisted. Where input from an Occupational Therapist (OT) or Physiotherapist was provided, guidance was then not incorporated into the person's moving and handling risk assessment. One relative told us how their loved one had suffered severe pressure damage due to incorrect sling size and the sling not being positioned under the person properly. An OT provided input and guidance which included for the sling to smoothly be positioned under the person (using a slide sheet) to reduce the risk of the sling rubbing and causing skin breakdown. The OT report also recommended for the bed to be moved away from the wall when being supported to move in the hoist. This guidance was not recorded in the person's risk assessment and therefore not readily available for care staff to follow. Another person had received input from a Physiotherapist who provided guidance on how to safely transfer the person. Guidance from the Physiotherapy had not been transferred into the person's risk assessments, therefore this information and guidance was not readily available for care workers.

Where people's level of need had changed, the risk assessments had not consistently been updated to reflect those changes and provide the guidance for staff to provide consistent care. For example, one person's risk assessment recorded they could move and transfer with the support of a hoist. However, their individual review form identified they were now remaining in bed all day. Risk assessments were also contradictory to the information recorded in people's care plans. For example, one person's care plan documented they were unable to walk unassisted, whereas their moving and handling risk assessment identified they could walk independently. Consistent guidance was not in place for care workers to follow, therefore increasing the risk of potentially placing people at risk of harm.

Inadequate

Is the service safe?

Where specific risks had been identified, risk assessments were not consistently in place. For example, one person's care plan review identified the need for a risk assessment to cover behaviours that challenged. We were unable to locate the specific risk assessment. The management team also were unable to locate the risk assessment and acknowledged it had not been implemented. Therefore guidance was not in place for care workers to follow and ensure they all responded to the risk in a consistent manner.

As part of the inspection we visited people in their own homes. During one home visit, we raised significant concerns. We were unable to locate any risk assessments or care plan in the person's folder (located at their home). Due to the care needs of the individual, the absence of any guidance (such as risk assessments and care plans), meant care workers had no guidance to follow to ensure care was delivered in a safe, personalised and consistent manner. For example, guidance on moving and handling, skin integrity and choking risks. We brought this to the attention of the registered manager who confirmed the care plan and risk assessment would be placed back into the home immediately.

Where restrictive practices were taking place, with a view to keeping people safe. We were unable to locate any subsequent risk assessments which detailed whether the person had consented or if the restrictions were in place for their best interest and the least restrictive option. The registered manager told us, "Care workers should not be implementing restrictive practice, especially if we have not signed off on it." Whilst undertaking home visits, we identified that care workers were participating in implementing the restrictive practice and could not find any information in the person's care plans in relation to the restrictive practice. Therefore, the provider could not demonstrate if the arrangement were in line with legal requirements.

Angel Heart Home Care provided care and support to many people who required support to move and transfer and were dependent upon care workers to reposition. For people with reduced mobility, we were unable to locate any risk assessments in relation to skin integrity and the measures required to minimise the risk of skin breakdown. During one home visit, the relative informed us how their loved one had very fragile skin which broke down frequently. They told us how their loved one currently had a grade four pressure ulcer. The person received regular involvement from the community nursing team and required support from the care workers to apply barrier cream and reposition. A body map was in place which detailed areas of skin breakdown in August 2015. The purpose of a body map is to detail skin breakdown and monitor any current pressure damage. However, the body map had not been updated to reflect if those areas have healed or the currently assessment of the wound. The body map also failed to identify the new areas of skin breakdown. Therefore for new care workers providing support (or agency workers), information would not be clearly available on the person's level of skin breakdown and the support needed.

Whilst visiting people in their own homes, care workers understood how to safely move and transfer the person with the aid of a hoist and what equipment was required. Care workers told us that through regularly visiting people, they had gained an understanding of the associated risks and the mechanisms required to reduce those risks. One care worker told us how they would reposition people at every care call and apply barrier cream to reduce the risk of skin breakdown. However, the risks to people care continued to not be fully assessed. For new care workers or agency care workers, risk assessments would not provide the guidance to enable them to provide safe care. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection in April 2015, the management of medicines required improvement. The provider had taken steps in addressing the areas of concern. Where people were prescribed topical creams, these were now documented on people's individual MAR charts. The provider had started to bring MAR charts into the office for auditing, however, this had only started taking place recently and the management team identified that some people's MAR charts were still in the person's own home. Where MAR charts had been audited, we found that the MAR charts had numerous omissions in recording. For example, one person's MAR chart had omissions in recording for the months, May and June 2015. Another person's MAR chart had not been signed since the 6 August 2015 to show that prescribed medicines had been administered. Relatives also raised concerns regarding care workers not signing MAR charts. One relative told us, "I worry over proper medicines being administering without

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the MAR chart being completed, or signed." The provider also advised that a new format for the MAR chart had been implemented, however, was unable to demonstrate this as they had not brought any recent MAR charts into the office.

Most MAR charts had been created by the agency rather than being supplied by the dispensing pharmacy. These records had not been signed by the care workers creating them nor had they been checked and signed by a second person for accuracy against the prescribed instructions. Recording on the MAR chart did not consistently document the full information on the medicines prescription label and often only noted the name of the medicine. This meant that people may not have received their medicines as prescribed and there was no system to check for accuracy or errors.

People's individual medicines risk assessments were in the process of being reviewed and information was now in place which provided guidance on where people's medicines were stored and what to do in the event of refusal of medicine. Where care workers were required to record people's blood sugars, guidance was in place on what to do in the event of their blood sugar recording being high (over 20). Guidance included for 111 to be contacted or the district nurse. However, where care workers had recorded the individual's blood sugar level as over 20, documentation did not consistently record what action had been taken, whether 111 or the district nurse was contacted. For one person, in July 2015, their blood sugar level was recorded as extremely high on three occasions and extremely low on one occasion. Documentation failed to record what action had been taken. The management team were also unable to advice on what action had been taken. Therefore it could not ascertain if medical advice had been sought or not.

The provider was unable to demonstrate a clear oversight of the management of medicines and how they assured themselves that people received their medicines on time and their medical needs were attended to. Although they had started to audit MAR charts, concerns were raised as to why numerous omissions in recording had not been identified earlier by the provider and acted upon. This is therefore a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection in April 2015 safe recruitment procedures were not always being followed and the provider was asked to make improvements in this area. At this inspection people continued to be at risk of receiving care from unsuitable care workers. Care workers applications forms were not consistently completed and some lacked information about the person's past employment history and qualifications. On the day of the inspection, the provider was unable to demonstrate that all care workers had been subject to a DBS check. A DBS check allows employers to check whether the applicant has any convictions that may prevent them working with people. Subsequent to the inspection, the provider sent us evidence of care worker's DBS checks. The contact details for two references had not always been provided and the provider had not always sought feedback from two references before the care worker commenced employment. References are a mechanism of obtaining information from the person's previous employer regarding the skills, competency and calibre of the potential employee. The provider told us, "Sometimes we cannot always get hold of the person's references." At the last inspection, the same concerns were identified and documentation failed to record how often the references were contacted or in the absence of a reference, how the provider assured herself that the person had the right experience for the role of a care worker. Since April, the provider had recruited five more care workers and continued to recruit in an unsafe manner.

This placed people at risk of receiving care from care workers who had not been subject to a robust recruitment process. This is now a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Improvements had been made to monitoring of missed care calls. Angel Heart Home Care now used a telephone monitoring system to enable care workers to report their arrival and departure time from each care visit. This was implemented in August 2015. This information was monitored by the management team to ensure all planned care visits were provided each day. When a care worker had not arrived to a care call on time, the system immediately turned red. If a care worker had not dialled in after twenty minutes of the care call starting, an alert would be sent to the office via email/phone. The management team told us, "When we receive an alert, we then phone the care worker to ascertain where they are." The implementation of the monitoring system meant no care calls had been missed in the past month. The management team recognised

Inadequate

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on-going work was required to ensure care workers consistently logged in and out of each care call and on a monthly basis they were going to be auditing the logging in/out and taking action where necessary.

At the last inspection in April 2015, staffing levels were stretched and the provider lacked formal systems to determine staffing levels. Improvements had been made and a system was now in place for assessing how many care workers were required to meet the needs of people. The management team told us, "We use staff planner (online data management system). We consider the number of hours of care we need to cover and the hours of care worker. We then plan care calls a week in advance." The provider reflected that the agency had experienced a high turnover of care workers recently, which therefore meant office staff were going out and covering the care calls. The provider told us, "We currently have six care workers employed which totals to 250 hours' worth of care, we have 300 hours of care to provide." The management team told us, "If we are unable to cover care calls ourselves, we have used an agency to assist, to ensure all people get a visit." When agency care workers had been used, relative's feedback that they were not informed of this. One relative commented on how their loved one living with dementia was sent an agency care worker. They commented that their relative recognised it wasn't a care worker from the agency due to them wearing a different uniform and was extremely distressed as they didn't know who this person was.

The provider had not considered the impact of sending an agency care worker to a person living with dementia. As a result, the person was left in a state of distress which did not promote their well-being. We have identified this as an area of practice that needs improvement.

Requires improvement

Is the service effective?

Our findings

At the last inspection in April 2015, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because care workers had not received supervision and the provider had no mechanisms to assess staff's competency with the training provided. The provider was also asked to make improvements in relation to the recording of people's nutritional needs and for care workers to receive training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Due to the concerns found at the last inspection, we found people were at risk of receiving care from care workers that were not adequately trained or supported. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by September 2015. Improvements in some areas had been made, however, people and their relatives continued to express concerns with the competency of some care workers. On-going work is required in meeting people's nutritional needs.

At the last inspection in April 2015, we raised concerns as people's care plans lacked detailed information on the level of support required to maintain their nutritional health and wellbeing. We found at this inspection care plans continued to lack sufficient information and guidance on how to effectively meet people's nutritional needs. One person was provided a soft diet and care workers supported the person to eat and drink. There was no guidance, including any from any health care professionals such as the Speech and Language Therapist (SALT) to advise whether a specialist diet was required and if the texture of the food and drink was of the right quantity. The provider commented that the person's family had made this decision and they had recommended a referral to a SALT (which had not yet been made). In the absence of a SALT assessment, the provider was unable to demonstrate an assessment of the possible risks, such as choking and what position the person should be in when supporting to eat and drink.

Where required, people had a nutritional care plan in place which recorded the level of support required with eating and drinking, such as their eating skills, using cutlery and planning food shopping. One person was who living with dementia and diabetes and also lived alone, feedback from their relative identified that it was crucial they were supported to eat and drink regularly. The care plan failed to reflect the importance of ensuring the person was offered regular food and drink and how to ensure diabetic diet was provided. Guidance was also not available on the signs and symptoms of high and low blood sugars. The provider told us, "Guidance about diabetes is available in the person's care plan in their home." However, the provider was unable to demonstrate this as this information was not recorded in the person's care plan held in the office. One person's needed support to maintain a healthy diet. No further guidance was available on how to support the person with this and a nutritional care plan was not in place. Therefore sufficient guidance was not available on how to effectively meet the person's nutritional needs.

Where concerns had arisen regarding people's nutritional intake, food and fluid intake charts were completed. We looked at a sample of food and fluid charts dated between August and September 2015. They were not completed correctly with numerous omissions and gaps in the recording. The provider had recently audited the food and fluid charts with the action recorded as 'send text message to all carers to complete form correctly.' There was no documentation to confirm if this action had been completed and if this had been effective.

Guidance produced by the Social Care Institute for Excellence identifies that 'mealtimes and nutrition are important to older people in relation to their quality of life and as a measure of the quality of service they receive'. Insufficient guidance and care planning could place people at risk of malnutrition and not receiving the support they require to meet their nutritional needs. Sufficient improvements had not been made to improve people's wellbeing and therefore this is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Care workers did however; demonstrate a firm understanding of some people's nutritional needs. Whilst visiting people in their own homes; care workers offered people choice about what they wished to eat and drink. Where care workers supported people to eat and drink, they sat down with the person, ensuring they were sitting in an upright position. They gained consent from the person and ascertained if they liked the option chosen. They supported the person to drink at their own pace, not rushing the individual, whilst engaging with the person.

Requires improvement

Is the service effective?

Regular and good supervision is associated with job satisfaction, commitment to the organisation and staff retention. Supervision is significantly linked to employees' perceptions of the support they receive from the organisation and is correlated with perceived worker effectiveness. At the last inspection in April 2015, care workers were not offered the opportunity for formal supervision. Improvements had been made. Documentation confirmed care workers were now receiving regular supervision. Care workers commented they found the forum of supervision useful and felt able to approach the provider or management team.

Upon commencing employment with Angel Heart Home Care, care workers underwent an induction period, whereby they shadowed alongside more experienced care workers and received training on various subjects such as moving and handling, infection control, dementia awareness, safeguarding and medication administration. Care workers were also supported to undertake the Care Certificate (induction into health and social care). The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with care workers in mind, the Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. The provider was unable to demonstrate a completed certificate as care workers were still working through their induction.

Training was also now provided on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and care workers recognised the importance of gaining consent from people alongside people's right to refuse consent. Concerns were raised at the last inspection, as care workers only received e-learning training and mechanisms were not in place to assess their understanding and competency. For example, face to face manual handling training was not taking place; therefore the provider had no mechanism to review care staff's ability in safely using a hoist. Improvements had been made. Care worker's competency was now assessed and face to face manual handling and medicine administration training was provided. The provider told us, "We now assess care worker's competency with moving and handling. We hire a room and using a hoist, do practice sessions where we assess care worker's level of understanding and ability to safely use the hoist."

Spot checks of care workers were now taking place. These considered how the care worker engaged with the person, if they read their care plan before delivering care and how they effectively communicated to the person. A recent spot check in August 2015 identified that one care worker did not read the person's care plan before delivering care and how they did not communicate appropriately with the person. The need for additional monitoring and supervision for this care worker was identified.

Feedback from relatives identified that people and relatives had mixed views about the competency and skills of the care workers. One relative told us, "They are fantastic, and efficient with hoisting. They are supportive, spot things straight away and have helped push OT for everything." One person told us, "They have brought in new carers recently and they are trained well." However, one relative told us, "I do wonder if they are trained, they never seem to clean (person) properly." Another relative told us how care workers often leave soiled pads on the floor. One person told us, "The manager is a good care worker but needs help with communicating with clients, care plans and training others."

Guidance produced by Skills for Care identifies the importance in a skilled, competent and well-trained work force. 'A good, strong, well-developed workforce that is fully equipped and motivated will make a significant contribution to delivering a quality service'. Feedback from people and relatives identified that although improvements were noticeable on-going work was required in ensuring people and relatives felt confident that care workers were appropriately trained to deliver safe and effective care. We have therefore identified this as an area of practice that needs improvement.

Requires improvement

Is the service caring?

Our findings

At our last inspection in April 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because there had been a failure to respect and involve people. Care plan reviews were not taking place and not all care tasks as identified in people's care plans were being undertaken.

Due to the concerns found at the last inspection, people were receiving care that was not consistently caring. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by September 2015. Improvements in some areas had been made; however, on-going work is still required to ensure people receive care that respects their rights.

The last inspection in April 2015 identified that the provider had not completed formal reviews of people's packages of care. The purpose of a care review is to assess whether the package of care continues to meet the person's needs, whether the timings of the carers are sufficient or whether the package needed to be increased or decreased. The provider had conducted a formal review of all packages of care since April 2015. Individual review forms were available in people's care plans. These considered the current support plan; if the support plan was meeting the person's needs, any changes/improvement, the action plan and the date for the action to be implemented. What the person wished to achieve, and their long term goal.

Where people had received their individual review, the care plan and risk assessment was not consistently updated following the review to reflect the changes made. One person's review from June 2015 identified that they could get scared on their own and would like the care workers to double lock the door and draw the curtains at the tea-time call. These requests had not been transcribed into the person's care plan. Subsequent to the inspection, the provider told us that they did not encourage care workers to double lock the door as in the event of a fire, the fire officers would not be able to get in. However, this information had not been recorded in the care plan. During one home visit, the care worker was aware of the importance of double locking the door as the person had told them; however, they advised if it wasn't for the person telling them they would be unaware as this information was not recorded. They were not aware they should not be locking the front door.

Another person's review dated June 2015, recorded that 'support plan could do with a few tweaks and information from daughter'. However, information was not recorded on what this information from the daughter included. The review form also identified that the daughter had requested more support with showering should be offered and for care workers to stay the correct length of time. This information was not transferred into the person's care plan. People's care plans were therefore not consistently updated following their individual review with key changes and information.

Feedback from some relatives included that they regularly provided information to be included in their loved one's care plan, however, they found this information was not consistently transferred into the care plan. One relative told us how they sent a revised care plan to the provider but this care plan was not implemented. Another relative told us how during their loved one's review they gave Angel Heart Home Care a copy of what they wanted from the new care which included what the timings of the care calls should be. They commented, "To date this has never been followed." They advised that if the care workers arrive too early, their loved one is unlikely to get up and therefore goes without a wash and doesn't have their basic needs met.

Individual reviews had taken place which considered how improvements could be made, however, documentation and feedback from people and their relatives identified that these improvements were not consistently embedded into practice or care plans were not updated to reflect the changes. Therefore the delivery of care was not in line with people's preferences and needs. This is therefore a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection in April 2015, we raised concerns that due to staff shortages, people's identified care needs were not being met. Since April 2015, some people felt improvements had been made whereas others felt their dignity and autonomy was not consistently respected by care workers. One person told us, "I'm pleased with my individual carer as they know what they are doing." One relative told us, "The carers are caring and attentive but always rushing." Another relative commented how they felt one of the care workers clashed with their loved one and felt they talked down to the person. They subsequently asked for this care worker not to be sent again but find the

Requires improvement

Is the service caring?

care worker is regularly sent. Another relative told us how their loved had disclosed they didn't like a certain care worker. They were informed this person would only be sent in an emergency but they continue to be sent on a regular basis. Another relative told us, "I have been very patient with Angel Heart but they have not shown them the same respect in caring for (person)."

The Social Care Institute of Excellence, guidance 'Dignity in Care Practice Guide' identified that dignity covers a wide range of topics which include independence, choice, autonomy and being listened to. We found people's views and preferences were not always being acted upon or adhered to. Consequently people received care within their own homes from care workers they may clash or feel uncomfortable with. People's right to autonomy was therefore sometimes undermined. We have therefore identified this as an on-going area of practice that needs to be improved upon.

Care workers did demonstrate compassion when talking about the people they supported. One care worker told us in a caring manner how they supported people to choose their own clothes and told us about one person who they made smile by remembering their favourite colour was blue. Male care workers were conscious of people's privacy and dignity and how they had been introduced to female's to ensure they were happy to receive care from a male care worker. It was clear care workers had spent time getting to know people. One care worker told us in detail how they supported one person. They described how they would start the care visit with making breakfast and a hot drink. They commented how this approach usually cheered the person up.

Inadequate

Is the service responsive?

Our findings

At our last inspection in April 2015, the provider was in breach of Regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the delivery of care was not responsive or flexible. Communication was poor and people were not informed if care workers were running late.

Due to the concerns found at the last inspection, we found people were at significant risk of not receiving responsive care and the delivery of care was inadequate. Warning notices were served and the provider was given until the 13 July 2015 to make improvements. Improvements in some areas had been made. However, the delivery of care was still not responsive or personalised for some people.

In April 2015, we found significant concerns whereby timings of care calls would change on a day to day basis, people were not consulted or informed when care workers would be arriving and people were unaware if care workers were running late. At this inspection, we spent time looking at the delivery of care between the period May to September 2015.

We received unanimous feedback from people and their relatives that timings of care calls remained an issue alongside not being informed if care workers were running late and poor time keeping. One relative told us, "The carers are supposed to come 07.15 to 8.00am but care plan keeps changing. They seem to change without any consultations. Changed to anytime between 09.00 to -10.00am and today they came at 09.15am. Further daily calls are supposed to be midday, 17.00pm and 21.00pm. But can be up to 45 minute late at night even though requested not after 21.00pm. As care workers give medicine, it's important the care calls are four hours apart."

Angel Heart Home Care provided support to many people who required assistance with repositioning, toileting needs and medicine administration. The impact of an unreliable service can place people at risk of harm and it is therefore imperative people receive care calls at set times that are evenly apart, so medicines can be administered at the correct time and people can be repositioned regularly. The rota for one person who required four care calls daily for the week beginning 7 September 2015 identified that they could receive their morning call at 08.30 to 09.15am with their lunch call taking place at 12.00 to 12.30pm. The timing between the morning and lunch call was only three hours and not four, therefore the person would be administered their medicines again without sufficient time between the morning medicine and lunch medicine.

People's call times varied on a daily basis, one person's morning call for the week of the 7 September 2015 identified that there morning call varied between 06.45am and 09.15am. Another person's lunchtime calls could vary between 10.25am and 13.10pm. Another person's morning call could vary between 07.00am and 10.45am. One person told us, "My time should be 08.00am but they can come in at any time, even 11.00am, today they came at 10.00am." One relative told us, "They come anything between 07.00am to 09.30am." Another relative told us, "The bed time night time call is supposed to be 21.00pm but can be 10.15pm."

The management team commented they tried to be as personalised as possible with the call times but were limited due to the restrictions placed upon them by only having six care workers. The management team told us, "Many people want a call at 09.00am; we try and implement a call at that time or close to 09.00am but this is not always feasible. When more care workers are recruited, we will be able to make the care calls much more personalised."

Timekeeping remained an on-going issue. People and their relatives continued to feel they were not adequately informed if care workers were running late. The implementation of the monitoring system meant the management team were notified if a care worker was twenty minutes late dialling into a care call. The management team told us that when they received an alert, they would contact the care worker and ascertain where they were and how long they would be. We were subsequently informed the person would then be notified and this would be logged. We audited a sample of the logging in and out times. During the month of September 2015, we found examples whereby care workers were 20, 30, 35 and 50 minutes late. We requested evidence to demonstrate that people and their relatives had been contacted to let them know the care workers were running late. The management team was unable to demonstrate this and acknowledged further work was required to ensure people were consistently informed when care workers were running late. One relative told us, "Timekeeping is a big issue."

Inadequate

Is the service responsive?

Guidance produced by the Equality Human Rights Commission identified that for older people receiving care the lack of control and choice many older people have over the timing of their home care visits or not being aware when care workers would be arriving can undermine their personal autonomy. The impact of an unreliable service can also affect people both physically and psychological. Being dependent and having to wait for a visit from their care worker leaves people feeling vulnerable and undervalued. People did not receive the care and treatment to meet their assessed needs or which reflected their individual preferences or wishes. This is therefore a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Improvements had been noticed by people and their relatives in the past two weeks. People confirmed they had been sent a rota telling them who would be coming the following week and at what times. One relative told us how it was nice to receive the rota but they would have to question the timings on two days as they were too late. Another relative told us, "They seem to have some new care workers and are trying to improve over the past two weeks but I am exhausted chasing things up." Another relative told us, "They are much better now."

At the last inspection in April 2015, improvements were required on the management of complaints. For example, where people had raised concerns such as the timings of missed calls, documentation failed to reflect what action had been taken and the outcome of the investigation. Sufficient improvements had not been made.

A complaints policy was in place and also available in people's care plans within their own homes. The provider did not have a complaints log detailing all of the complaints received, the action taken and the learning derived from the complaint. The provider told us, "If we receive any concerns, we would log these on the person's journal and record any action taken." This meant there was no accessible system for responding to complaints in order to identify themes or areas of risk in order to drive improvements.

Feedback from four relatives we spoke with identified that they had raised concerns/complaints about time keeping and the quality of care delivered. However, we were unable to locate any documentation in relation to these concerns/complaints raised. One relative told us, "I have raised several concerns about changes to times and reliability of medication." We looked at this person's care plan and journal, there was no documentation confirming any concerns had been raised. Where concerns were documented they were not consistently recognised as a complaint. One relative made contact with the management team in September 2015 advising they were unhappy with the call times as care workers were always late. The person was contacted advising the call times had been re-arranged. There was no investigation, root cause analysis or mechanisms put in place to ensure future incidences such as this did not happen again. Another relative commented on how they raised a complaint following receipt of an invoice when they had been charged for two care workers but only one had arrived. They told us, "We were not happy with the response from the management team; they were not diplomatic when we raised our concerns."

The management of complaints required on-going work. There was no quality oversight of complaints and the provider was unable to demonstrate how the service learnt and developed from complaints and also acted upon complaints in order to improve the service. This is therefore a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities).

Personalisation means thinking about care and support services in an entirely different way. This means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives. At the last inspection in April 2015, we raised concerns as care plans were not person centred and contained little information on the person's life history and what was important to them. Since the inspection, the provider had sourced a 'This is about me' and had given it to all people and their relatives to complete. However, this had not yet been completed by anyone and care plans continued to contained little information on the person's likes, dislikes and personal history. The provider told us, "The 'this is about me' will enable us to learn more about people, their life history and then this can be incorporated into the care plan."

Inadequate

Is the service well-led?

Our findings

At our last inspection in April 2015, the provider was in breach of Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider had no quality assurance framework in place which governed the running of the agency. Feedback from people, relatives and care staff on the quality of the service had not been obtained or collected in order to help drive improvements.

Due to the concerns found at the last inspection, Angel Heart Home Care was not well-led. Warning notices were served and the provider was given until the 13 July 2015 to make improvements. Improvements in some areas had been made. However, on-going work was required to improve the quality assurance framework governing the running of the agency.

Care workers felt sufficient improvements to the running of the agency had been made since the last the inspection. One care worker told us, "Things have improved a lot since we got the phone (logging in and out system) and having our duties on there. We've got time to sit and talk to people and spend time with them." The registered manager commented that the logging in and out system had been in place for the past two weeks. People and relatives felt improvements had been made since the implementation of the logging in and out system. One relative told us, "We have definitely noticed a difference in the past two weeks." Relatives commented that since the provider had started to send out rotas in the past two weeks, there had been a marked improvement. One person told us, "I actually received a rota this week, which does not usually happen."

A robust quality assurance requires systems in place to monitor and improve the quality of care provided. Providers must also have systems and processes in place which enable them to identify and assess risks and where the quality or safety of care is being compromised, respond appropriately and without delay. At the last inspection in April 2015, the provider had no systems in place to review the quality of care provided. Since September 2015, the provider had begun to audit daily logs, logging in and out times and MAR charts. The audit process helped the provider to identify any omissions in recording or where care workers were not logging in and out. However, the provider acknowledged further work was required to ensure robust quality assurance systems and processes were in place in relation to the overall running of the service and how they were meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us, "We aim to start auditing care plans and incidents and accidents and we have recruited a quality manager for this who will start in November 2015."

Work was required to improve the quality of the audits completed. For example, where MAR charts had been audited and identified omissions. There was no action plan implemented identifying what needed to be done and when. The MAR chart contained two sentences which read', MAR chart audited, training and supervision to be organised'. There was no evidence to confirm this had taken place.

Where people had received poor quality of care, there was a lack of managerial oversight alongside no robust investigations or root cause analysis into what happened. We were informed that between the periods June to July 2015, there were 13 incidences of only one carer arriving to a double up care call. Incident and accident documentation was in place which identified the care worker completed the double up care call alone. The relative told us, "We have had numerous issues with only one carer arriving. This means (person) isn't always turned and doesn't receive proper care." The incident and accident documentation confirmed the care workers were spoken with; however, the lack of managerial oversight of incidents meant the situation was left to continue resulting in 13 different occasions when this person received care that was not adequate.

On the 1 April 2015, the Care Quality Commission (CQC) implemented the Duty of Candour regulation. The intention of the regulation is to ensure that providers are open and transparent and sets out specific guidelines providers must follow if things go wrong with care and treatment. We looked at the incident and accident records dating back to June 2015. We found incidences whereby people had not been administered their medicines or administered the medicines at the wrong time. One incident in June 2015 reflected that a person experienced a missed call. Documentation failed to reflect what consideration had been given to the Duty of Candour and if the threshold for Duty of Candour had been met. From reading the incidents and accidents, we could see that no harm had occurred to the person; however, the provider was unable to demonstrate how they had been transparent

Is the service well-led?

and honest with people regarding the incidents in relation to missed medicines. We asked to see the provider's policies and procedures in relation to the Duty of Candour. The provider acknowledged they were unaware of this new regulation.

Following each incident and accident, documentation recorded what had happened and the conclusion. In relation to the missed call in June 2015, documentation confirmed the person was phoned and apologised. The care worker involved had supervision and was informed of the importance of not missing care calls. Although incidents and incidents were responded to individually, they were not reviewed and monitored collectively to monitor for any emerging trends, themes patterns. Under the Care Act 2014, Providers and registered managers are required to have systems and mechanisms in place to enable them to identify patterns or cumulative incidents.

The provider continued to lack a robust quality assurance framework. Lack of effective quality assurance and monitoring systems increases the risk that the service will not be run effectively and that areas of poor practice will not be identified and addressed. This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From the 1 April 2015, it became a legal requirement of providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. Angel Heart Home Care had not displayed their rating either in their office or on their website. The provider advised they were unaware of the requirement to display their rating. Failure to display CQC rating is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection in April 2015, the provider had no data management systems in place, whereby all records were stored centrally, along with people's details, contact number, level of need and the frequency of care calls.

Improvements had been made and the provider now had a central database which recorded people's and staff's details, along with the frequency of care calls. Feedback from people who received care had also been sought. The provider told us, "We have sent out satisfaction surveys. They have just been returned and we are yet to go through them and analyse the results." Seven responses had been received from people. People made positive comments about the kind nature of care workers however; people also raised concerns with timekeeping, care workers arriving late and the service not being flexible.

Communication was seen as a significant issue at the last inspection. People raised concerns that getting hold of the provider was difficult and often the answerphone machine for the agency was full so they were unable to leave a message. People felt improvements had been made. One person told us, "I now have the out of hour's number and there are more people in the office to answer the telephone." Another person told us, "They've given me more numbers to get hold of them now."

The provider recognised on-going work was required and was committed to making on-going improvements. They told us, "Since April when it was just me running the agency, a firm management team is now in place, we are looking at sourcing a bigger office and we want to continually drive improvement. We've been holding staff meetings and work collectively to make the improvement that we need to make."

The provider promoted an inclusive working environment for care workers. During the inspection, care workers were seen popping in and out of the office. The registered manager told us, "I feel it's important we work together and communication is important." Care workers spoke highly of the inclusive nature of the service and valued the open communication. One care worker told us, "I regularly pop into the office; it's a good opportunity to talk about any concerns I have or learn about someone I may not have supported before."

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person Centred-Care Regulation 9 (1) – The provider had not ensured the care and treatment of service users was – (a) appropriate, (b) meet their needs and (c) reflect their preferences.

The enforcement action we took:

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment 12(2)(a) - The provider was not assessing the risks to the health and safety of service users of receiving the care or treatment. 12(2)(b) doing all that is reasonably practicable to mitigate any such risks; 12(2)(g) the proper and safe management of medicines; 12(2)(i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

The enforcement action we took:

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 17(2)(a) – The provider was not assessing, monitoring and improving the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services. 17(2)(b) - The provider was not assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. 17(2)(c) – The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; 17(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; 17(2) (f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

The enforcement action we took:

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 HSCA 2008 (Regulated Activities) Fit and proper persons employed

This section is primarily information for the provider

Enforcement actions

19 (2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in-

19(2)(a) paragraph (1), or

19(2)(b) in a case to which regulation 5 applies, paragraph (3) of the regulation,

19(3) The following information must be available in relation to each such person employed –

19(3)(a) the information specified in Schedule 3, and

19(3)(b) such other information as is required under any enactment to be kept by the registered person in relation to such persons employed.

The enforcement action we took:

Regulated activity	Regulation
Personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments 20A (1) This regulation applies where, and to the extent that, a service provider has received a rating of its performance by the Commission following an assessment of its performance under section 46(1) of the Act (reviews and performance assessments) 20A (2) There must be shown on every website maintained by or on behalf of any service provider— 20A (b) the place on the Commission's website where the most recent assessment of the service provider's overall performance and of its performance in relation to particular premises or activities may be accessed, and 20A (c) the most recent rating by the Commission of the service provider's overall performance and of its performance in relation to particular premises or activities, in a way which makes it clear to which activities or premises a particular rating relates.

This section is primarily information for the provider

Enforcement actions

20A(3) There must be displayed at each premises from which the service provider provides regulated activities at least one sign showing the most recent rating by the Commission that relates to the service provider's performance at those premises.

The enforcement action we took: