JN Community Care Limited

Blessed Hearts Home Care

Inspection report

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06 April 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Blessed Hearts Home Care is a care at home service providing personal care to 23 people aged 65 and over at the time of the inspection. The service supports people living in their own homes.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People were not consistently supported by safely recruited staff as the provider had failed to implement safe recruitment processes. Staff did not always have the necessary skills and experience to meet people's individual needs.

People's experience of infection control and moving and handling put them at risk of harm. People found carers were often late or care calls were missed. Systems in place did not always identify these issues to ensure appropriate action was taken to learn lessons and minimise the risk of further incidents.

We found people did not always feel well treated or respected by staff when entering their homes. Communication with people was inconsistent and people and relatives were not consulted or involved in reviewing their care.

The registered provider had not ensured there were robust systems in place to keep people safe and meet their needs in a person-centred way. Following our last inspection, the provider had not implemented the improvements in systems and processes required. There continued to be a lack of oversight regarding recruitment practices, accidents and incidents and feedback from people.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 16 November 2019) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection improvement had not been made or sustained and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to staffing levels, care calls being missed, the safety of the equipment used for training and the governance of the service. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, caring and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Blessed Hearts Home Care on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, the safe recruitment of staff and the governance of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect to check for significant improvements.

If the provider has not made enough improvement and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Blessed Hearts Home Care

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector and an assistant 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 did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours notice of the inspection. This was because it is a small service and we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 31 March 2021 and ended on 06 April 2021. We visited the office location on 31 March 2021. Calls were made to people and staff on 01 and 06 April 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We sought feedback from the Local Authority and Healthwatch. Healthwatch is an independent consumer

champion that gathers and represents the views of the public about health and social care services in England. This information helps and supports our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and two relatives about their experience of the care provided. We spoke with eight members of staff including the provider, care manager, recruitment manager, one senior care worker and four care workers.

We reviewed a range of records. This included three people's care records. We looked at five 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 looked at training data and quality assurance records. The provider took immediate steps to address the concerns found during the inspection.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment
At the last inspection the provider failed to ensure systems were robust enough to demonstrate staff were safely recruited. This placed people at risk of harm. This was a breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that:

- Staff had not been recruited safely in line with requirements. This placed people at risk of harm as the provider had failed to ensure the staff they employed were suitable to work with potentially vulnerable people.
- We examined recruitment records for five staff members. We found staff members with criminal convictions had not received a risk assessment. The recruitment manager and Nominated Individual were not aware this was a requirement. This meant that steps had not been taken to minimise risks to people being supported in the community.
- Gaps in staff employment history had not always been explored. One staff member had not given specific dates of previous employment. Another staff member did not complete their employment history.
- Suitable references had not always been sought for new employees. We found two instances where references had been written and verified by a current staff member at the service. Another staff member's reference was submitted by a person not detailed in their application. Due to this, we were not assured evidence of staff conduct in previous roles had been satisfactorily explored.
- People told us they didn't always feel suitable staff were recruited. A relative said, "They'll take anyone off the streets."

Improvements had not been made in regard to ensuring the safe recruitment of staff. People continued to be at risk of harm and the provider is still in breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection
- Feedback from people and relatives consistently reported incidents of care calls being late, missed or a single carer attending when two staff were required to meet the person's needs. This meant that people were placed at risk due to not receiving the care they needed at the appropriate times.
- One relative informed us that carers were already over an hour late and were yet to arrive. This meant the relative would need to support the person with personal care without the carers present. They said, "I have to most days because they're late." The person was assessed as requiring support with these activities and this put them and their relative at risk of harm.

● A different relative reported that carers were regularly late which meant their loved one's needs weren't met at the appropriate times. For example, the morning call was 90 minutes late which meant the person had recently had breakfast when carers then arrived to support with lunchtime. The Nominated Individual acknowledged there had been some instability due to a high turnover of staff and a period of carers testing positive for COVID-19 and unable to be at work. However, they assured us a stable staff team was in place and the new manager had established rotas in place.
● Feedback from people and relatives raised serious concerns that moving and handling practices were not safe. For example, one relative described having to intervene to stop their loved one falling when being assisted by carers. Another relative told us carers had assisted a person to sit up by dragging their arms. This kind of support should not be used as it puts the person at risk of injury. We raised these concerns with the Nominated Individual as the service was not previously aware of this feedback. The provider said they would look into the concerns.
● People needed support with a variety of equipment to support their mobility. We found staff records did not detail the specific equipment that individual staff were trained to use. The manager informed that regular staff competencies in moving and handling techniques were not yet completed following initial training. This meant the provider lacked oversight about which carers could safely support different people.
● People's care plans and risk assessments detailed people's needs and how staff could support them safely. However, plans were not always reviewed in line with the provider's own policy. For example, the risk assessment for a person at high risk of pressure areas had not been reviewed regularly.
● People and relatives did not always find infection control practices were safe. For example, one relative told us that carers wore the same gloves for all tasks, including after carrying out personal care or applying creams. Another relative reported that staff wore the same apron for personal care and food preparation. They said, "They don't wash their hands for every task. I have to tell them every time to take their apron off."
● People didn't always feel COVID-19 was taken seriously. One person told us the previous manager had entered their home without wearing PPE. Another person said, "They're not hot on COVID. They'll tell you I've had COVID so you're alright."
● Spot checks carried out by the provider did not consider if staff were following safe infection control practices.
● Training records showed that only half of staff were up to date with Infection Prevention Control training. The provider advised these figures were due to the ongoing induction period of newly recruited staff.

The provider had failed to ensure care and treatment was provided in a safe way. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not always protected from abuse. Feedback from people and concerns received by CQC informed of occasions where the provider was made aware of accidents or incidents that were not recorded, investigated or escalated to external agencies.
● On one occasion, a person who required two carers to receive personal care safely had been supported by a single staff member. The manager had been aware of this incident, but no further action had been taken. This meant opportunities to learn lessons and improve the safety of the service were missed.
● There was no system to track when care calls were taking place. As a result, the provider did not analyse any trends relating to missed or late calls which could have driven improvements.

Using medicines safely
● One person's care plan recorded a number of time sensitive medications they needed carers to administer. However, the person's daily records did not detail whether support with medication was taking

place and Medicine Administration Records (MAR) were unavailable. This meant whilst we did not identify any concerns regarding the use of medications, records were not robust.

● One person's records showed that prescribed creams were administered in line with their care plan. Body maps informed carers of the correct areas to administer the treatments.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People didn't always feel well treated by staff or the care agency. One person explained, "I think some of the carers don't fully appreciate how reliant the clients are. They were laid back if they didn't turn up."
- A relative described how carers were always in a rush and needed to give more care and attention to people. Another relative told us, "Some [staff] do care, some don't care."
- Not all staff had received equality and diversity training as there had been a number of new staff to the team. However, the care manager told us how people's cultural needs were considered. For example, a person whose first language was Punjabi was supported by Punjabi speaking staff.

Supporting people to express their views and be involved in making decisions about their care

- People consistently told us they had not been involved in reviews of their care. Some people told us concerns about the outcome should they express their views. A relative told us, "You have to be very careful about what you say or before you know it you're in the dog house." Following the inspection, the provider took immediate action to gain feedback from people using the service.
- Feedback from people and relatives informed us that communication with the service was inconsistent. Some people were not updated about changes to their care calls or informed about delays. However, some people had seen a positive change with the new manager in post and were hopeful that communication would improve.

Respecting and promoting people's privacy, dignity and independence

- People did not always feel respected by carers entering their home. One person described how staff members would enter their home without knocking and would go straight to read the care notes. They told us, "None of them appreciate they're going into someone else's house." They added, "It's like being an animal in a zoo."
- One person described a bad experience when a new carer had not been respectful in their home. However, they told us that their regular carers had supported them to increase their independence. They said, "Their patience has been incredible. They've helped improve my quality of life."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider was still in breach of Regulation 17.

● The provider's systems and processes in place were not effective in highlighting or preventing shortfalls in the quality of the service provided. At the last inspection we found the provider had failed to continuously and effectively monitor the quality of the service as they had not completed audits on any aspect of the service. During this inspection we found this failure continued. Any audits implemented were ineffective in identifying the concerns we highlighted about safety, people's experience of care and the governance of the service. We found no improvements had been made.
● The provider continued to fail to ensure all staff had been safely recruited. Recruitment processes were not implemented safely and governance systems did not identify the concerns we found.
● Systems and processes to oversee individual staff skills and experience in moving and handling techniques were not in place. This meant there was no system for ensuring suitably skilled staff were allocated to service users with specific moving and handling needs.
● Governance processes had failed to ensure effective infection control measures were in place to keep people and staff safe and actions taken to implement Government Guidance COVID-19: how to work safely in domiciliary care were not effective.
● The provider failed to establish an effective system to track care calls and highlight instances where calls were late, missed or attended by a single carer when two staff were required. This meant learning from incidents was not gathered to drive improvements.
● The provider had failed to implement effective systems to monitor and audit incidents and escalate as appropriate. This failure to learn from accident and incidents meant opportunities to prevent risks to service users health and safety had been missed.
● Quality assurance systems were not effective in identifying learning to drive improvement. For example, there were no audits of people's medication charts. This meant potential medication errors could not be highlighted and learned from.
● Staff competency in areas such as medication management, moving and handling or infection control was not regularly monitored. As a result, any potential performance issues could not be identified and

addressed.
● This is the second consecutive inspection that Blessed Hearts Home Care has failed to reach an inspection rating of good. Since the service registered on 16/07/2018 there have been two inspections; both inspections identified improvements were required and identified breaches of regulations. Both inspections found a breach of Regulation 17.

Improvements had not been made in regard to systems and processes to drive the quality and safety of the service. Therefore, the provider is still in breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives consistently told us they didn't feel the service was well led. One person said, "To be perfectly frank, the people in the office have no experience of organising things." Another told us when they raised a concern, "No (they didn't ask for feedback). I think they knew; it was quite clear it wasn't well run."
● The system in place to monitor feedback and complaints from people was not robust. The process in place was not consistently followed or reviewed in line with the provider's own timescales.
● The management of people's care was not always person centred. People told us they were not informed or consulted about changes to call calls that affected the quality of their experience.
● The manager was new in post and was open about the areas of improvement required. They recognised that robust systems needed to be put in place to regain the trust of people using the service.
● Staff told us there was good communication with the new manager and felt able to raise any concerns they had.

Working in partnership with others
● External agencies were not always contacted when it was appropriate to do so. We were informed of incidents of potential abuse that were not raised with the safeguarding team. The Nominated Individual has now addressed this.
● Staff were knowledgeable about the professionals involved in people's care and would ask the manager to make contact should the need arise.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their responsibility in relation to duty of candour.
● There has been no registered manager in post since February 2021. At the time of our inspection there was a manager in post who intended to register with CQC in due course.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We placed conditions on the registration of the location.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure systems were robust enough to demonstrate staff were safely recruited. This placed people at risk of harm. This was a breach of regulation 19 (Fit and Proper Persons) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We placed conditions on the registration of the location.