

CARE IS WHERE THE HEART IS LTD

CARE IS WHERE THE HEART IS LTD

Inspection report

117 Bodenham Road
Oldbury
B68 0SF

Tel: 07306055082

Date of inspection visit:
02 June 2021

Date of publication:
28 June 2021

Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

About the service

Care is Where the Heart Is Ltd, is a domiciliary care agency providing personal care to people in their own homes. The service was supporting 13 people from the location, with personal care at the time of our inspection.

The provider had moved office when we last inspected however, they had not notified us in advance of this change. They began the process of registering the new location after the last inspection, but they had not completed the registration process correctly. This location still remains un-registered as the provider has not submitted a new application to register the location.

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

There continued to be a lack of provider oversight which meant risks to people's safety had not been identified and responded to appropriately. Systems to monitor the quality and safety of the service were not effective and placed people at the risk of harm. Systems in place had failed to identify the areas for improvement found at this inspection including care planning, risk management and safe administration of medication.

Care plans were not in place for known health conditions to provide staff with the information they needed to mitigate risk and meet or respond to people's needs.

People and relatives, we spoke to said they felt safe and care staff knew them and their needs.

Medication administration records (MAR) were held on the electronic care planner. However, this did not include all medications prescribed for people using the service. This meant care staff did not have accurate records to refer to, ensuring they were giving the correct medication at the correct time.

Audits had been implemented however, they were not yet established enough to see if they will provide clear and robust information and evidence of outcomes for people.

Systems and process which were in place were not robust to protect people from potential harm.

Staff we spoke to told us they understood their roles and responsibilities, had received some training and felt supported by the management.

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

Rating at last inspection (and update)

The last rating for this service was inadequate (published 21 April 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and

by when to improve. At this inspection we found some improvements had been made, however, the provider was still in breach of regulations.

Why we inspected

The inspection was prompted in part, due to concerns received about the safe care and treatment and governance. We received concerns about the providers ability to support people effectively, concerns included; infection control practices, staffing including poor recruitment practices, lack of induction and training, poor medicines management and concern about the ability to support people who had care packages in place. Conversations with the provider prior to our inspection, did not give us assurances in relation to these concerns. A decision was made for us to inspect and examine those risks.

We reviewed the information we held about the service.

The overall rating for the service following this inspection remains 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, and well-led sections of this full report to see what actions we have asked the provider to take.

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 identified breaches in relation to Regulation 17 Good governance due to the lack of provider oversight, systems and process' in place to assess, monitor and improve the quality and safety of the services provided. Regulation 12 Safe care because people were exposed to the risk of harm as their care needs and risk associated with their care were not identified and recorded. Regulation 19 Fit and proper persons employed due to not following safe recruitment practices.

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

Follow up

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

CARE IS WHERE THE HEART IS LTD

Detailed findings

Background to this inspection

The inspection

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

The inspection process was hindered by the provider not supplying us with the documentation required, in the specified time frame.

Inspection team

The inspection was carried out by two inspectors.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. At the time of the inspection there were 13 people using the service.

The service did not have a manager registered with the Care Quality Commission at the time of inspection. The provider had recruited a new manager. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

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

Inspection activity started on 01 June 2021 and ended on 08 June 2021.

We visited the office location on 02 June 2021.

What we did before the inspection

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

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

We used all of this information to plan our inspection.

During the inspection

We spoke with four people who used the service and two relatives about their experience of the care provided. We spoke with six members of staff including the provider, manager, senior carer and care workers. We reviewed a range of records. This included seven people's care records. We looked at five staff members 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, medication records, policies.

We requested call records to review, these were not provided.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

- Staff files did not have the full employment history had not been provided and dates of employment were not clear. Gaps in employment had not been explored.
- Two suitable references had not been obtained prior to care staff members commencing work. The provider told us they had attempted to obtain references, we asked for evidence of these requests but were not provided with this. They had not ensured references were in place or risk assessments completed prior to the staff members commencing employment. There was no evidence that alternative references had been sought. This meant that the provider did not follow their own recruitment policy or adhere to regulations to ensure that people employed were suitable to work with people.
- Risk assessments were not completed where required for care staff who had known health conditions.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safe recruitment. This placed people at the risk of harm. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We spoke with a care staff member who told us about their recruitment and induction process. They told us, "I had to wait for my criminal records check to come back before I started. I had some shadow shifts, working with other staff members as part of the induction. I completed training online which included things like safeguarding, fire, Manual Handling, there's been lots."

Assessing risk, safety monitoring and management

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- The provider did not have robust care plans or risk assessments in place which detailed the full support people required. Although there was improvement within the care plans since the last inspection, these were still not sufficiently detailed. This meant people were at risk of not receiving care that meets their

individually assessed needs. We found one person using the service did not have enough detail in their mobility care plan about how to safely use the sling. One person had bed rails but there was not a risk assessment in place to alert care staff of the risk associated with the use of these. Another person who required support with their catheter did not have a detailed plan in place to guide care staff or to alert them to potential signs of infection. One care staff member told us, "Care plans and risk assessments have enough information in to help us care for people."

- People's care plans still did not mention when they had a health condition. This had been identified at the last inspection and still had not been actioned. Care records did not reference the treatment required for these conditions or how these conditions may affect how care staff needed to provide support. Staff we spoke with were aware of people's health conditions but had not always been provided with training or written guidance from the provider to be able to meet these needs safely. This included people who had Parkinson's disease, diabetes, dementia, asthma, recurring infections, diagnosed mental health conditions and those who were at risk of self-harm.
- The lack of written information about how to support people was unsafe. If the current staff became unwell during the pandemic and agency staff needed to be relied on, there was insufficient information for them to meet people's needs.
- People we spoke with told us, they felt safe. One person told us, "I feel safe. I don't feel threatened or anything."
- During the inspection we spoke to the provider and manager about how late, missed and short calls were monitored. We saw from the electronic call system that the provider is able to monitor the calls and they are alerted to any missed or late calls. The Provider is now also monitoring the length of the calls using the electronic auditing system. However, this audit had only been implemented in the last month by the provider, so it has not yet been embedded and analyzed for the effectiveness of this.
- We requested call records for all people who were using the service to review the length of the calls and identify if there had been any missed calls. These records had not been provided within the set timeframe, so we were unable to review if calls were the length they were commissioned for, if they were late or if there were any missed calls.

Using medicines safely

At our last inspection the provider failed to monitor the safe administration of medications. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- We looked at the electronic system used for the documentation of the administration of medication, which was much clearer than at the last inspection. However, the provider had still not implemented guidance for staff to follow so they would know when to offer people's medicines, which were to be administered on an 'as and when required'. This meant there was the risk 'as and when required' medication might not be given in a consistent and safe way. Medication Administration Records (MAR) should specify the maximum dose of tablets in a 24-hour period. For example, a maximum of eight paracetamol in 24-hours. This meant there was a potential risk for overuse of these medications.
- Some prescribed creams were recorded but there were no clear instructions of when, where and how these prescribed creams should be applied. This meant there was a potential risk of incorrect administration.
- We spoke to people about the medication they receive, one person told us, "The main medication is for [known health condition] and they have to be given on time. I have had to contact the office as they were late; I had to take the medication myself. They know how important this is." Another person told us; they always get their medication on time.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were always safe and received appropriate care and treatment. This placed people at the risk of harm.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People we spoke with told us they were happy with their call times. One person told us, "They [care staff] stay the correct length of the call, sometimes they do more. My carers go above and beyond."
- One care staff member told us, "We have enough time to spend with people."
- Staff we spoke with told us that they had received training in the safe administration of medication and that checks were carried out by the management team to ensure they were following correct practice. We saw evidence of these checks taking place.

Learning lessons when things go wrong

- The provider told us they had not received any complaints at the time of the inspection. We discussed this with the provider as they told us they had received calls from people using the service to raise concerns. The provider told us the people said they did not want to record these as a formal complaint. The provider said they would start to record these concerns and the actions they had taken to address these to show they have listened to people and taken action to improve the service.
- The provider had sought feedback from people using the service. There were positive comments which we were shown by the provider, in text messages and e-mails. There was no analysis of these comments and no evidence that this feedback had been shared with people using the service. No formal feedback through the use of questionnaires had been sought from staff, relatives or health professionals. Gathering this information would provide them with information on how to improve the service they provide.

Preventing and controlling infection

- We saw individual risk assessments relating to the current pandemic for people using the service had now been implemented. However, these did not always refer to the individual's known health conditions to assess the risk to each person using the service. They also did not refer to care staff wearing Personal Protective Equipment (PPE). PPE includes items such as gloves, aprons, masks and eye protection. This was discussed with the Provider during the inspection who said they would review the risk assessments.
- During the inspection people told us that care staff wore the correct PPE during their care calls.
- The correct use of PPE was monitored by the completion of spot checks when senior staff monitored the care staff.
- Records showed that care staff members had received training in the correct use of PPE and COVID-19 specific infection control training.
- The Provider has arranged for staff to carry out weekly COVID tests and has a specific area in the office for this to take place.
- People attending the office are also asked to have their temperature checked prior to entering and evidence of a recent COVID test.
- The most up to date guidance is also available for staff to follow.

Systems and processes to safeguard people from the risk of abuse

- Staff members had a good understanding of how to safeguard people from abuse, they were able to explain how to protect people they supported. Staff had received training in this area.
- Staff were aware of the whistleblowing policy and told us how they would raise concern, ensuring people were protected.

- People told us they knew how to raise concerns or make a complaint. One relative told us, "I am able to express myself on behalf of [relative] and they [provider] does act upon it." Another relative told us, "Anything the carers report, they [the provider] will be on the phone." One person told us, if they had any issues, "I would phone the office and speak with [the provider], she will get on with the job."

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

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. 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

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

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

- At the time of our inspection there was a manager in post, but they had not started the application process with the Care Quality Commission to become the registered manager.
- The management of safety, risk and governance had not been effective. We identified concerns about people's safety during the inspection.
- Although an auditing system had been implemented since the last inspection this had only been in place for a month. As audits had not been implemented sooner, this meant it was too soon to establish if it would be operated effectively and identify the concerns.
- The provider's system had failed to identify that accurate records relating to people's care were in place, to ensure staff had access to accurate information about people's support needs. For example, they had failed to identify there was a lack of information in care records, such as the support people needed especially with known health conditions. This could have resulted in people receiving incorrect support and treatment.
- The provider's systems had also failed to identify risk assessments for known risks to people were not consistently in place. Although there had been some improvement since the last inspection there had not been enough to provide us with assurances that the care plans provided enough guidance and detail for care staff to support people, in the way they wanted.
- After the previous inspection the provider gave us an action plan detailing what improvements they planned to make. However, the provider told us this had not been revised and updated to reflect the current, outstanding areas of action required nor the timeframes for completion.

Continuous learning and improving care

- Moving and handling training for staff was identified as needed at the last inspection. However, this had still not been provided and the provider did not, when asked, provide us with evidence to demonstrate they were arranging this training.
- We saw from the training matrix provided; care staff had now completed some areas of training specific to people's known health conditions. However, there are still some areas in which they support people with

known health conditions that need to be explored for staff to ensure they have the knowledge and skills to support people. These conditions include; Parkinson's disease, continence care, asthma and the use of bed rails; to name a few.

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

This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The Provider told us they had completed a level three risk assessing qualification online, since the last inspection, to help them to improve their knowledge and skills to carry out risk assessments.

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

- People and relatives said they felt able to speak with the provider and care staff members at the service when needed and they felt listened to and concerns were acted on.
- People we spoke with told us they were asked their views of the service. One person told us, "We did receive a questionnaire some time ago. No suggestions were made but, they definitely need more staff, the pressure is on staff and it is a shame." A relative told us, "I don't believe we have done a questionnaire, but they have asked what we would like carers to do for my relative."

We saw evidence of compliments from people using the service and their relatives about the care and support they receive.

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

- We were aware that concerns had been raised by the local authority and members of the public about the conduct of the provider and their knowledge and systems in place to ensure people are supported in a safe way. The concerns raised by members of the public were discussed with the provider prior to the inspection but we were not given assurances that these concerns were incorrect. These concerns were explored during this inspection.
- The provider and manager told us they understood their responsibilities about duty of candour and promoting an open and honest culture.
- The staff members we spoke with told us that they felt supported by the management team and said if they made suggestions they would be listened to. One care staff member told us, "[Name] the provider and [Name] manager, are absolutely fantastic, they're firm but fair. If something is not right, we are all bought together as a team and not told in a nasty way. I've the utmost respect for them both. They want the best for the company." Another staff member told us, "[Name] the provider is a good. They are organised, caring and a kind person. She is firm but fair."
- People we spoke with told us that they knew how make a complaint and they would ring the office if they had any problems.

Working in partnership with others

- We saw from records that they had engaged with other health professionals to support people with their changing needs.

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

We could not improve the rating for safe from inadequate because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure that people using the service received safe care and treatment.</p> <p>The provider failed to ensure care plans and risk assessments were in place and completed with enough detail to give care staff the knowledge and information they needed, to be able to support people safely. This included the lack of care plans and risk assessments for people with known, complex, health conditions.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had failed to implement robust systems and processes to ensure they had oversight of the service and identify where improvement needed to be made.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>The providers systems and processes did ensure they had oversight of the service and identify where improvement needed to be made.</p> <p>The provider failed to ensure they carried out audits of staff files thus failed to identify the</p>

concerns we found during the inspection.