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 2 April 2015 and it was an announced inspection.

The overall rating for Angel Heart Home Care is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action

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

Summary of findings

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 staff 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 18 people and employed four members of staff.

The owner (provider) of Angel Heart Home Care was also the registered manager. A registered manager is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People spoke highly of the care staff and felt they were kind and caring. However, people commented there had been significant issues with the time-keeping of care staff; not being aware of when their next care call would be or experiencing missed calls. One person told us, "Not sure how things are going to be from one day to the next."

Staffing levels were stretched. The provider had experienced high level of staff turnover in a short period of time. On the day of the inspection, the provider only had three care staff working and themselves to cover the care calls. People and their relatives reflected that staff shortages meant the care staff were often rushed or commenting on how busy they were. One relative told us, "They're very quick; they want to get the job done. They need to slow down."

Recruitment practice was not consistently robust and mechanisms were not in place to assess care staff's competency with medicine administration or moving and handling. The provider had not been providing carers with formal supervision and systems were not in place to assess whether training was embedded into practice.

Where people were prescribed topical creams, daily recordings not did consistently reflect when or if the prescribed cream was administered.

People told us care staff always gained their consent before providing personal care; however, care staff had not received training on the Mental Capacity Act 2005 (MCA) and were unaware of their legal responsibilities under the legislation.

Risk assessments were not consistently completed and did not reflect the actions required to minimise the risk of any potential harm. Care plans lacked information on the person's preferences, life history or how they wished to receive their care and support. Mechanisms were not in place for the formal reviewing of people's packages of care to ensure that staff had up to date guidance on changes in people needs.

The provider had not ensured there were effective systems in place to monitor and improve the quality of the service provided. Therefore they were not meeting the requirements to protect people from the risk and unsafe care by effectively assessing and monitoring the service being provided.

People confirmed care staff respected their privacy and dignity. Care staff had a firm understanding of respecting people within their own home and leaving people's property secure at the end of a care call.

Care staff commented they felt valued as employee's but also recognised the impact of the staff shortages and the challenges they had been facing. One carer told us, "It's been a hard month, covering all the care calls."

People and their relatives felt the recent shortfalls within the service were associated with staff shortages rather than neglect on the part of the care staff or the agency. One person told us, "Have some really nice, excellent care but the last month have not felt so secure."

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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. There were insufficient care staff to cover all the visits scheduled. Consequently people had experienced missed calls, care staff were often late and people did not consistently know when the care staff would arrive.

Risk assessments were not consistently completed. The few completed risk assessments failed to record the measures required to keep people safe. Care plans also failed to reflect the level of support people required with their medicine administration.

Recruitment practice was not consistently safe. References from care staff previous employers were not consistently obtained before staff were offered employment.

Is the service effective?

Requires improvement

Angel Heart Home Care was not consistently effective. People and relatives had contrasting views about care staffs training and skills. Some people felt care staff were sufficiently skilled and trained. Whereas, others raised concerns with the training of care staff.

Care plans did not consistently reflect the level of support required to maintain people's nutritional and fluid intake. Documentation was not always completed when healthcare professionals had been contacted for advice or input.

The provider did not have formal mechanisms in place to assess the competency of carers. Although care staff felt supported by the registered manager, care staff did not receive formal supervision.

Is the service caring?

Requires improvement

Angel Heart Home Care was not consistently caring. People and their relatives felt care staff were kind and caring. However, there was a consistent view that the lack of staff was impacting on the delivery of care.

People and their relatives were not consistently aware of their care plans. Care reviews did not take place on a formal basis and there was a lack of documentation to confirm when people had received or required a care review.

Care staff demonstrated a good awareness of how they should respect people's choices and ensure their privacy and dignity was maintained.

Is the service responsive?

Inadequate

Angel Heart Home Care was not responsive. Care plans lacked personal information about the person.

Summary of findings

People and their relatives found the agency had recently been unreliable with care staff arriving late and not being informed when care staff would arrive.

People felt confident approaching the registered manager with any concerns or queries. However, concerns were not consistently treated as complaints and documentation failed to reflect what action had been taken following any concerns being raised.

Is the service well-led?

Inadequate

Angel Heart Home Care was not Well-led. The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service. Systems were not in place to ensure the agency was safe and being run in the best interests of the people who used it.

Feedback from people, relatives or care staff was not obtained on a formal basis to help drive improvement and improve the running of the agency.

People and their relatives felt communication within the agency could be improved.

Angel Heart Home Care Limited

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection began with a visit to the services office which took place on 2 April 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 then contacted people, relatives and staff by telephone on the 7, 8, 9 and 10 April 2015, to obtain their views and feedback. On the 15 April 2015, we visited two people in their own homes to gain their views.

The inspection team comprised of one inspector 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 13 relatives by telephone and one member of staff. On the day of the office inspection, we spoke with the registered manager and one field care supervisor. Over the course of the day we spent time reviewing the records of the service. We looked at five staff files, complaints recording and accident/incident files and. We also reviewed four 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. We last inspected Angel Heart Home Care in July 2013 where we had no concerns.

Inadequate

Is the service safe?

Our findings

People told us they felt safe with care staff coming into their home and providing care. They explained care staff were easily recognisable due to their uniform and they felt safe in the company of the care staff. However, people and their relatives reflected that insufficient staffing numbers meant care staff were often late, missed calls occurred or they were unaware of when their next care call would be.

Staffing numbers were stretched. The provider informed us that unfortunately staffing numbers had dramatically dropped due to care staff unexpectedly leaving, sickness and annual leave. The provider was open and informed us that recently, only two care staff were available to work and themselves to cover the care calls. People and their relatives felt staffing numbers were at a push. One relative told us, "They can often be half an hour late or sometimes two hours late." Another person told us, "The times of the calls vary; they don't always tell me if they are running late." Another person told us, "They just haven't got the time to sit down with me and have a cup of tea." For people who required the assistance of two care staff at every care call due to reduced mobility, concerns were raised regarding the timings of the care staff arriving or only one care staff arriving. One relative commented how they have had to assist when the other care staff hadn't turned up.

We asked the provider how staffing numbers were calculated and how many care staff were required to safely meet the care needs of people. The provider had an informal system in place which could not be demonstrated to us and acknowledged that a formal system was required. The lack of a formal system meant we could not ascertain how the provider ensured their staffing numbers were based on the individual care needs of people and how staffing levels accommodated for any sudden sickness or sudden leave. The provider told us, "Through knowing all of the clients, I know their level of need and what staffing we need; however, this isn't then transferred onto paper to demonstrate how I calculate my staffing levels."

The provider was open and transparent that staffing levels had been problematic. While new care staff were in the process of being recruited, the provider had not taken on any new packages of care and had informed the local authority of the staff shortages. One care staff told us, "The staff shortages have been hard. We get the calls done but it means we don't have time to sit and chat with people or spend that additional five minutes having a cup of tea with them."

Formal mechanisms were not in place to monitor or identify whether care calls were missed and if people received a reliable service. At each care call, care staff were not asking people to sign their time sheet; care staff were also not consistently recording the times in people's daily notes when they left the care call. Therefore the provider had no system in place to monitor if care staff were staying the allocated time or if they were late. The provider told us, "We are a small team and because I'm out providing the care as-well, I'm regularly checking with people if carers are late and staying the allocated time." However, people confirmed some care calls had been missed, which had not been identified by the provider. One person told us, "I've had eight missed calls in the past month, it's quite upsetting when they don't come, especially at it means I may not see anyone that day." Where people had experienced missed calls, it also met their care and support needs had not been met and placed them at risk of harm.

Where missed calls had occurred, we could not locate any documentation or investigation into why the call was missed and the actions taken by the registered manager. The provider told us, "I usually just speak with the client and make amendments immediately, however, this isn't documented." Where people had received a missed call we could not be certain whether a welfare telephone call had been made to see if the person was safe and well. People who had experienced missed calls were unable to recall receiving a welfare telephone call. People commented they had been able to manage but felt disappointed in the agency.

Due to the above concerns, we have identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to poor staffing levels. .

Risks to people were not consistently assessed and risk assessments were not always implemented. Risks assessments are integral to providing safe care. They consider the measures required to reduce the risk whilst also respecting the person's autonomy and right to take day to day risks. The provider told us, "When I go and meet people for the first time, I assess the environment, any equipment, medicine, nutrition and personal care;

Inadequate

Is the service safe?

however, this is not consistently transferred onto a risk assessment." The provider acknowledged that for new packages of care, risk assessments had not been completed. A lack of risk assessments means people could be at risk of receiving inappropriate care and treatment and could place people at greater risk of harm.

We were informed of one incident whereby concerns had been raised regarding the safety of a hoist (moving and handling equipment). No harm had occurred to the individual, but there was the potential for harm. We requested copies of the risk assessment and updated risk assessments following the incidents. These could not be provided and the provider commented they had not been reviewed or updated. We were informed the Occupational Therapist had been involved and implemented a risk assessment. However, this had not been incorporated into Angel Heart Home Care own assessment in order to safeguard the person when being moved using a hoist.

For people with long standing packages of care, individual risk assessments were in place. These considered the risks associated with the activity, level of risk and how the risk was to be reduced. However, they lacked detail and did not describe what actions should be taken to reduce the risk of harm. For example, one person was identified at medium risk of malnutrition. The risk assessment documented 'contact the dietician and monitor tissue integrity'. Information was not available on when the dietician should be contacted or what to look for when monitoring skin integrity. We also found risk assessments were not reviewed and updated on a regular basis to ascertain the effectiveness of the assessment and if the person remained happy with the risk assessment. There was also the danger that appropriate guidance and support would not be available for care staff on how to provide safe care. For example, one person's care plan stated they should not be hoisted until a piece of equipment arrived and to receive all care in bed. The moving and handling risk assessment had not been updated to reflect that change or how to safely move and transfer them in their bed.

Due to the above concerns, we identified a breach of Regulation 9 & 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to poor risk assessments and people being placed at risk of harm.

Most people commented they managed their medicines independently or their relative provided support. The provider informed us care staff only supported a handful of people with their medicines One person told us, "They help me apply my cream when needed."

Although people told us the care staff helped them apply their topical cream (creams, ointments and lotions which contain steroid medicines), Medicine Administration Records (MAR) charts were not used to record the administration of prescribed topical creams. MAR charts are the formal record of administration of medicine. The registered manager told us, "The girls write in people's daily records when creams are applied." We found recordings did not consistently reflect when creams were applied. For people experiencing incontinence or reduced mobility, the administration of topical cream is imperative in reducing the risk of skin breakdown. Omissions in recording can place people at risk of not receiving their topical cream.

Care plans did not consistently reflect the level of support people required to safely manage their medicines. One person's care plan documented they required support with medicine administration. However, information was not readily available on the dosage, what the medicine was for or where the medicine was stored. Information was also not available on what the impact would be if the person didn't receive support with their medicine. Care staff commented they felt confident in the administration of medicines and were aware of the level of support people required. One care staff told us, "If anyone refuses their medicine, I always record this and inform the manager". The provider told us, "As we are small team and I'm regularly out providing care as well, we have a firm understanding of people's medicine regime." However, the lack of documentation could place people at risk of not receiving the level of support they required. For example, for new members of staff, support and guidance would not be in place.

Due to the above concerns, we have identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to the absence of a quality assurance framework.

The recruitment and selection of care staff required improvement. Potential care staff completed an application form along with a full employment history. A Disclosure and Barring Service (DBS) check was received. A DBS check allows employers to check whether the

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Is the service safe?

applicant has any convictions that may prevent them working with people. The contact details for two references were also provided. References are a mechanism of obtaining information from the person's previous employer regarding the skills, competency and calibre of the potential employee. However, for two members of staff the provider did not obtain references. The provider told us, "I tried getting in contact with the references but they did not get back to me." Documentation was not available on 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. This is not a breach of regulation, but we have therefore identified this as an area of practice that needs improvement.

People told us they felt safe in the care of the care staff who cared for them. One person told us, "I trust them completely." Care staff were able to tell us how they would put their training on safeguarding adults into action, and raise any concerns with the registered manager or the local authority. Care staff recognised that adult abuse can take many forms and felt confident that any concerns raised would be responded to and acted upon.

Care staff recognised the importance of leaving people's property secure at the end of a care call. One carer told us, "Always making sure doors are locked and keys are back in key safes." People expressed confidence in the care staff always leaving their property safe and secure. The registered manager demonstrated an on-going commitment to the safety of care staff working alone. On-call support was provided by the provider and care staff were encouraged to make contact if they were working late or felt unsafe.

Requires improvement

Is the service effective?

Our findings

Most people felt confident in the skills of the care staff. Some people and their relatives commented that some care staff would benefit from further training. One person told us, "Some are well trained but one or two need a bit of extra training with handling patients who are bed bound and need pads under them."

Care staff told us they felt supported and received an effective induction. The provider told us, "Following success interview and offer of employment, the carers come in and I go over everything in a presentation. The presentation considers safeguarding adults, person centred care, reflective practice and confidentiality." The registered manager also provided carer staff with an induction handbook to complete which was based on the common induction standards as identified by Skills for Care (now replaced by the care certificate), an organisation that works with adult social care employers and other partners to develop the skills, knowledge and values of workers in the care sector. Alongside this, care staff worked alongside experienced care staff to observe them working with people. However, the provider was unable to demonstrate any completed induction handbooks. The provider told us, "Staff take them away to complete but haven't returned them." In the absence of the completed induction handbook we asked the registered manager how care staff demonstrated their understanding of how to provide high quality care and support. The provider acknowledged this was an area of practice that required improvement.

Training was provided to care staff upon commencement of employment. This included e-learning topics such as medicine administration, moving and handling, basic first aid and fire awareness. Alongside the e-learning, the provider undertook care calls with new care staff to provide face to face training. However, the provider had no formal mechanism in place to assess the competency of care staff (new and currently employed). For example, moving and handling competency assessments were not completed and signed off by the provider to confirm they had observed the care staff using the equipment and they were competent and safe to do so. The provider, "As I'm out doing the care calls with the carers, I'm always assessing their level of competency; however, I acknowledge I don't record this."

People and their relatives had mixed views about the level of training the care staff received. One person told us, "Some staff seem better trained than others. They could do with more basic training." A relative told us, "Following a recent toilet accident, the place was left in a complete and utter mess." A further relative told us, "Nine times out of ten the walking stick is left on the other side of the room (instead of by the side of the bed)." However, some people felt the care staff were extremely skilled.

The provider lacked formal systems to assess and monitor whether the delivery of care was in line with the training provided, whether training was embedded into practice and if the quality of care was in line with best practice. Spots checks were not completed and care staff had not received formal supervision. Supervision is a system to ensure that carers have the necessary support and opportunity to discuss any issues or concerns that they may have. Care staff told us they felt supported by the registered manager/provider and felt able to approach her with any questions or queries. The provider told us, "I haven't been having formal supervisions with the carers, but we always chat informally."

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. The emotionally charged nature of care work can place particular demands on people in the field. It is therefore important to provide regular opportunities for reflective supervision.

Due to the above concerns, we have identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to the on-going training and support of care staff.

Training schedules confirmed not all care staff had received training on the Mental Capacity Act 2005 (MCA). The principal of the MCA 2005 is that every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. The provider told us, "Although not all carers have had training, we always discuss on care calls the importance of gaining consent from people." We asked the provider whether the legal framework of the MCA 2005 and the five principles were discussed and explored with care staff. The provider confirmed she had not and primarily focused

Requires improvement

Is the service effective?

on the importance of gaining consent. Care staff recognised the significance of consent. One care worker told us, "You always ask the person if it's ok to provide help, you don't just assume." People and their relatives confirmed carers always obtained consent before providing any care.

To understand the concept of consent and how people's ability to provide consent, understanding of the legal framework of MCA 2005 is required. On the day of the inspection, we were informed that Angel Heart Home Care provided care and support to people living with dementia. Good dementia care also involves a clear and robust understanding of the MCA and paid staff who provide care and support are legally required to work within the framework of the MCA and have regard to the MCA Code of Practice. We have therefore identified this as an area of practice that needs improvement.

Where required, care staff supported people to eat and drink and maintain a healthy diet. One person told us, "They always make me a hot drink." Another person told us, "If I'm out of food, they always go to the shop for me."

Although people spoke positively of the care staff ability to meet their nutritional needs, people's care plans lacked detailed information on the level of support required to maintain their nutritional health and wellbeing. Information was not readily available on what the person could do independently and what support would be required from carers. For people with specific dietary requirements such as diabetes, care plans failed to reflect how to provide a diabetic diet or the signs and symptoms of high and low blood sugar. The lack of documentation could place people at risk of not receiving the level of support required to safely and effectively meet their nutritional needs. We have therefore identified this as an area of practice that needs improvement.

Despite the above concerns, care staff recognised the importance of ensuring people remained hydrated and drank sufficient amounts to maintain their health and wellbeing. One care worker told us, "Before we leave the call, we leave drinks within reach and if required make sure they've had something to eat." People who required support with meal preparation felt confident in carers preparing their meals. One person told us, "They always ask me what I want to eat." Training schedules showed all care staff had received training in food hygiene.

People and their relatives felt they received support which effectively managed their healthcare needs. One person told us, "They look after me well". A relative told us, "They always keep me updated regarding any healthcare issues." Care staff recognised the importance of obtaining medical advice or help if someone looked unwell. One care worker told us, "If I was really concerned, I would contact the GP or 999." Although people felt confident in the skills of carers meeting their healthcare needs. Care plans failed to reflect when care staff had obtained medical attention; the outcome of the medical attention and what healthcare professionals were involved in the care of the person. The lack of documentation could mean care workers next visiting the person would be unaware if the GP had been contacted or whether any changes were required to the delivery of care. The provider told us, "Because we are so small, we communicate verbally any changes or any input from healthcare professionals; however, this is not always documented." We have therefore identified this as an area of practice that needs improvement.

Requires improvement

Is the service caring?

Our findings

People and their relatives felt care staff were kind, caring and compassionate. One relative told us, "They are very kind." Another relative told us, "They are very efficient, caring and obviously know what they are doing." Despite the high praise for the care staff, we identified areas of practice which required improvement.

Angel Heart Home Care had been experiencing problems with staffing levels and the retention of staff. Everyone and their relatives reflected that staffing had been a problem, primarily in the month of March 2015, but despite the concerns they remained primarily happy with the care workers and the level of care provided. One relative told us, "They are very good, but they do rush." A further relative told us, "I've found cobwebs in the bathroom, which may mean they aren't giving my relative a regular bath but despite this I am happy."

Due to staff shortages, we identified concerns that not all care tasks as identified in people's care plans were being undertaken. One relative told us, "My loved one hasn't had a bath in ages." They also added, "Support with shaving is omitted and I think they often only stay 15 minutes when they should stay 30 minutes." A further relative told us, "We need assistance of two carers, however, sometimes the carers arrive at different times and this affects how long my loved one remains in bed." Therefore, we raised concerns that people's dignity was compromised and people did not consistently receive care in line with their care plan.

People and their relatives commented they had not consistently been involved in the care planning process and the design and formation of the care plan. People confirmed that before receiving care the registered manager completed an assessment, gathering their views and what support they would like. People commented the level of care had been discussed with them, but people were not consistently aware of their care plan. One person told us, "The girls write in the folder before they leave, but I can't recall the care plan."

The provider informed us that people received regular reviews of their package of care. This included a two week review after the start of the care, followed by a six week review and subsequently three monthly and six monthly. The purpose of a care review is to assess whether the package of care is meeting the person's needs, whether the timings of the carers are sufficient or whether the package needed to be increased or decreased. People commented that the provider regularly asked them if they were ok with everything or if they required any changes to their package of care. One person told us, "The Manager is very friendly and will adjust things if necessary e.g. if I want to go out will adjust time of visits." However, people and their relatives could not recall a formal care plan review taking place, whereby the registered manager sat down with them to discuss the effectiveness and safety of the package of care. Documentation was also not completed to demonstrate when people required a care plan review, when a review had taken place and the outcome of the review. Therefore for people with a long standing package of care (over a year), we could not ascertain when they had received a care review or how the provider ensured they were involved in the care and support they received.

Due to the above concerns, we have identified a breach of Regulation 17 of the Health and Care Act 2008 (Regulated Activities) Regulations 2014 which relates to poor record keeping and the absence of a quality assurance framework.

People commented that care staff respected their privacy and dignity. One person told us, "They always make sure I'm covered up." Another person told us, "They always check if I'm happy for them to be in the bathroom with me." Care workers understood the principles of privacy and dignity. One care worker told us, "I always think how, would I want to be treated?" Another care worker told us, "It's about ensuring they are always covered, door isn't wide open and we are not talking over the person." For people who received assistance from two care workers, they and their relatives confirmed carers respected their privacy and dignity when providing personal care. One relative told us, "They always make sure the bottom half is covered when washing the top half." Another relative told, "They always explain what they are doing."

Care workers we spoke with had compassion for the people they supported. One care worker told us, "I love working for Angel Heart Home Care, I couldn't imagine working anywhere else." Another care worker told us, "I love going to see people in their own homes."

People and their relatives commented they felt comfortable in the company of the care staff. One relative told us, "I'm very happy with the company and the care given to her." One person told us how through having the

Requires improvement

Is the service caring?

same carer, they had got to know one another. Everyone spoke highly of the carers. One relative told us, “They do everything well. Whatever my wife asks them to do, they do.”

Inadequate

Is the service responsive?

Our findings

People and their relatives told us they felt Angel Heart Home Care was responsive to their individual needs. One person told us, "They do everything you want done and they're very obliging. They will also do the odd small thing like hospital cover if you need it." Although people felt Angel Heart Home Care was responsive, we identified areas of practice which required improvement.

Each person had an individual care plan which considered their individual needs, allergies, current health status and past medical history. Information was also available on the individual's level of mobility, the support they required and the frequency of the support. The tasks required at each care call were listened which included detailed information on how to provide individual care to the person. For example, one care plan recorded 'Use light flannel for most of the body. The dark flannel is for the undercarriage and bottom area.' However, information was not readily available on the person's preferences, interests, hobbies or personal life history. There was also a lack of information on how the person liked to receive their care.

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. People and their relatives felt the agency had taken account of their preferences, life history and what was important to them. However, care plans failed to consistently demonstrate this. For example, one person's care plan documented 'I would like to remain in the comfort of my own home. I would like to live the life I choose. I would like to promote my health and safety'. However, information was not available on how to achieve this.

Information on people's medical history was documented; however, care plans lacked detail on how people's medical conditions presented or any key issues carers might need to be aware of. The provider commented that most people were supported by their family to manage their healthcare needs. But the, care workers had also built up a good understanding. However, this level of understanding was not transferred into people's care plans. For care staff supporting people, this information plays an important part in how they carry out their tasks and without it, care workers could fail to recognise the signs and symptoms that may indicate people's health and welfare is deteriorating.

Care workers confirmed they kept regular daily records of care and support provided. On the inspection, we were only able to review a small sample of daily records as the provider acknowledged daily records were not regularly brought back to the office for reviewing and filing. The daily records we reviewed lacked detail on how the person was and how they presented during the care call. One person's daily notes, the care staff had not written entries for certain care calls. We questioned whether the person had received care that day or if they cancelled the care calls. The provider confirmed the calls had not been cancelled but it was most likely the care staff had not completed the daily records. People and their relatives commented that often care staff wrote on scraps of paper or envelopes as they had run out of daily records. One person's daily visits for five days had been recorded on a piece of paper. We questioned why it had taken the care staff five days to obtain daily record sheets and place them in the care plan. The provider was unaware of why it had taken so long.

Poor recording keeping can be seen as poor communication and can put both care staff and people at risk. Recording on lose pieces of paper poses the risk of records going missing or care staff not recording each care visit. As daily records were not monitored by the registered manager on a formal basis, there were no mechanisms in place to assess the standard of record keeping and drive improvement when record keeping falls below good practice.

Due to the above concerns, we have identified a breach Regulation 17 of the Health and Care Act 2008 (Regulated Activities) Regulations 2014 which to inaccurate, poor record keeping and the absence of a quality assurance framework.

People commented that at times, Angel Heart Home Care was not consistently responsive as the agency was often unreliable. One relative told us, "Not sure how things are going to be from one day to the next." Another relative commented, "The evening call is sometimes over an hour late. Should arrive at 6pm and don't turn up until 7.30pm." For people who are bed bound or require assistance of two carers, the impact of a late care call or unreliable service can people them at risk of harm. It may mean they spend

Inadequate

Is the service responsive?

longer in bed, increasing their risk of skin breakdown or spending too long in the same position. When visiting people in their own homes, we asked if they would be aware of when their next call would be. We were informed that the carers would relay a generalised time of when they would next be returning. Daily records indicated that the call times varied on a day to day basis and were not set for each day. The registered manager told us, "When we visit our next call will then normally be four hours later if the person requires assistant of two carers." However, this meant people did not receive set care calls and the times varied between each day. Daily records for one person reflected there had been a gap of seven and half hours between their lunch and evening care call.

We asked people if they were informed the care staff would be running late. We received mixed responses. Some people confirmed they were always notified, whereas some people and their relatives commented they had to phone the agency to ascertain what was happening. One relative told us, "It's a bit of a bugbear."

The impact of an unreliable service can 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.

Due to the above concerns we have identified a breach of Regulation 9 of the Health and Care Act 2008 (Regulated Activities) Regulations 2014 which relates to people not receiving a person centred service.

Despite the above concerns, people felt the agency tried to be flexible as possible. One person told us, "Although they've had staffing problems, if I need anything or an extra call, they will always do this for me." Another person told us, "They are very good if you have a sudden request." A relative told us, "They have shown initiative by doing some food shopping (when Dad has eaten all the food in the house)."

The agency had a complaints policy and information regarding complaints was given to people when they started receiving the service. People and their relatives told us they felt confident approaching the registered manager/ provider with any concerns or queries. One person told us, "She is very approachable and you can always contact her."

The provider had not received any formal complaints since opening the agency in 2012. However, one person informed us that they had experienced a couple of missed calls in February 2015. They brought this to the attention of the provider who consequently reduced their bill. We could not locate any documentation to confirm why this concern had not been investigated as a complaint.

Where people had raised concerns such as the timings of missed calls or carers not arriving, documentation failed to reflect what action had been taken by the provider, if an investigation had taken place, the outcome of the concern and how similar concerns would be prevented from occurring.

Due to the above concerns we have identified a breach of Regulation 17 of the Health and Care Act 2008 (Regulated Activities) Regulations 2014 which relates to poor record keeping and the absence of a quality assurance framework.

Inadequate

Is the service well-led?

Our findings

People and their relatives spoke highly of the registered manager/provider. One person told us, "The manager asks all the time if everything is OK. The whole experience is good and they do everything very professionally." Despite people's high praise for the manager, we found Angel Heart Home Care was not well-led.

The registered manager was also the provider/owner. A registered manager is a person who has registered with the Care Quality Commission to manage the service. People commented that they regularly saw the registered manager as she often undertook the care calls. However, people felt that the registered manager was over-stretched, trying to run the business and complete care calls. One person told us, "She's trying to do too much."

The agency had no formal computer 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. The provider commented they had downloaded a management system called Citrix where everyone's details, care plans, rotas and information could be stored centrally and accessible to all carers. However, this had not yet been implemented. Currently, all information was stored on the provider's laptop on word documents. The lack of a data management system also meant there was no central documentation which included a list of everyone they supported. In the event of an emergency or adverse weather and care calls needed to be prioritised, the absence of a data management system meant there would be no central location whereby everyone's information was stored along with information on their level of care and support.

During the site visit to the office, we were informed that hard copies of people's care plans were not stored in the office, but care plans and risk assessments could be viewed on the computer. In the event of IT failure, we questioned how people's care plans could be accessed if hard copies were not stored in the office. The registered manager acknowledged our concerns and recognised that in the event of IT failure, records would not be accessible. We discussed with the provider what would happen if they were unable to work. We were informed the field care supervisor would be in charge. However, it was acknowledged the field care supervisor had not received training for the role and the lack of a central database meant they would be unable to access people's information. We therefore raised concerns that if the provider was unable to work, this could place people at risk of harm, as no other employee of Angel Heart Home Care could run the agency.

Systems were not in place to monitor or analyse the quality of the service provided. The provider was not completing internal quality assurance checks, such as audits. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people who receive care. The lack of quality assurance checks meant the provider had no mechanism in place to review and analyse their internal systems and processes. The registered manager acknowledged they were not completing any audits such as care plans, medicine administration, staff files or record keeping audits. The lack of quality assurance checks demonstrated the provider had no formal governance framework in place to assess, monitor and improve the quality and safety of the service.

Feedback from people, relatives and care staff on the quality of the service had not formally been obtained or collected. Feedback from people, relatives and carers is integral to the development of services, how to drive improvement and involve people in the running of the service. People confirmed the provider always asked them if everything was ok and whether they were happy, but people commented they had never received any surveys or satisfaction questionnaires. The provider told us, "I'm continually obtaining informal feedback from people about the service as I'm out providing the calls and seeing people and their relatives on a regular basis, however, I have not formally been obtaining feedback, such as telephone surveys or questionnaires." The lack of formal feedback meant the provider had no mechanisms in place to monitor the overall satisfaction levels with the quality of the service along with people's views on Angel Heart Home Care.

As the registered manager was also the owner (provider), we queried what mechanisms they had in place to develop and improve their own learning and regulate their own organisation. The provider recognised they had not joined or participated in any local care agency meetings to discuss practice issues or legal issues. It was recognised by the

Inadequate

Is the service well-led?

provider that currently they had a significant lack of systems and mechanisms in place to regulate Angel Heart Home Care and were unable to demonstrate how as an organisation they strived to make improvements.

Due to above concerns we have identified a breach of Regulation 17 of the Health and Care Act 2008 (Regulated Activities) Regulations 2014 this relates to the absence of a quality assurance framework and lack of governance.

Systems were in place for the recording of incidents and accidents. Documentation included the time and date of the incident/accident, what happened and details of the injury. However, documentation failed to record what happened after the incident/accident, what action was taken, any investigations and how learning derived from the incident and accident. We brought this to the attention of the provider who was able to explain the action taken following any incident and accidents but acknowledged this was not recorded. We have therefore identified this as an area of practice that required improvement.

People felt communication within the agency could be improved. One person told us, ""The office is a bit of an odd ball. No use phoning the office because the mailbox is always full." People commented that if they needed to get hold of the provider, they rarely were able to speak with her on the first instance; they usually had to leave a message (unless the voice message facility was full). People commented the registered manager usually phoned them back within a reasonable timescale (within the day). However, one relative commented they had been experiencing significant difficulty in getting hold of the registered manager/provider. We have therefore identified this as an area of practice that needs improvement.

Care staff commented they felt supported and valued as employees. One care worker told us, "She's the best manager I've ever had." Care staff recognised the agency had been experiencing difficulties and were aware of the challenges. One care worker told us, "The lack of staff has been our biggest problem but I feel gradually as an organisation we are getting more organised."

People and their relatives spoke highly of the agency and recognised that the agency had been experiencing difficulties due to insufficient staffing numbers. People commented that they felt things would improve once more staff were recruited. One person told us, "Things have been unsettled but this has only been recently and I'm sure they will improve." The registered manager was open and responsive during the inspection and acknowledged that due to insufficient staffing numbers this had taken her away from the day to day running of the agency as she was often out covering care calls.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 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.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing 18(1) - The provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons. 18(2)(a) – Staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

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 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. Regulation 9 (3) (a) – The provider had not carried out collaborative assessments of the needs and preferences of the service user.

The enforcement action we took:
A warning notice has been issued. The service is to be complaint within one month of receipt of the warning notice.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance 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;

The enforcement action we took:
A warning notice has been issued. The service is to be complaint within two months of receipt of the warning notice.