Tender-Hearted Limited

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Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Tender-Hearted Care Limited is a domiciliary care agency and provides personal care to adults 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. 13 people were receiving personal care at the time we inspected.

People's experience of using this service and what we found
We found not enough improvements had been made, the service continued to be in breach of regulations and people had been placed at risk of significant harm.

Medicines were not always managed safely. When people had missed medicines, the service had not always reported this to the local safeguarding team and had not instructed staff to monitor the person for any signs or symptoms they may be unwell. Audits had identified that medicines were not always signed as administered. Actions had not been taken to investigate why there was no signature, and if the person had taken their medicine.

The recording of accident and incidents had been improved; however, the provider/registered manager told us accident and incidents were still not reviewed on a regularly basis to identify themes and trends and ensure the correct actions had been taken. This had resulted in reportable incidents not being notified to the local safeguarding team and to CQC.

Governance systems were either not in place, or robust enough to identify and improve the quality of the service. Audits had not always been completed or, when they had, no actions had been taken to improve the areas of concern found. Governance systems had not always identified when people's health, safety and well-being were at risk and people had been placed at risk of significant harm.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

At our last inspection we identified people did not always have the paperwork in place to demonstrate their capacity to make specific decisions had been assessed and that the least restrictive decision had been made in their best interest. We found no improvements to the provider/registered managers understanding of the Mental Capacity Act 2005 (MCA) and no improvements to the systems and processes had been made placing people at risk of significant infringements to their rights and/or welfare.

The provider had relocated to a new address and had failed to notify CQC. The registered manager had not taken action since our last inspection to improve their competence, skills and experience required to manage the carrying on of the regulated activity and people had been placed at risk of significant harm.

Feedback had been sought from people using the service and from the staff, results had not yet been reviewed. Since our last inspection improvements had been to ensure staff were recruited safely into the service.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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 and there were breaches of regulation (published 22 February 2023). At this inspection we found not enough improvements had been made and the provider was still in breach of regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and Regulations 15 and 18 of the Registration Regulations 2009 Notifications of other incidents.

Enough improvement had been made and the service was no longer in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met and to follow up on the breaches we identified at our last inspection due to the concerns we found. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement and Recommendations
We have identified breaches in relation to the requirements of registered managers, safe care and treatment, good governance and notifying CQC of reportable incidents and reportable notice of changes.

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
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.and

Tender-Hearted Limited

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 Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by 2 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.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

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 registered manager would be in the office to support the inspection.

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 service improvement and safeguarding teams. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed written feedback records from 9 staff and 6 people who use the service. We received written feedback from 1 relative of a person who uses the service. We reviewed a range of records. This included 17 people's care records and 7 medication records. We looked at 6 staff files in relation to recruitment and a variety of records relating to the management of the service.

Inspected but not rated

Is the service safe?

Our findings

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

At our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe management of medicines and people had been placed at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our last inspection the provider sent us an action plan and told us they would complete actions to make the service compliant with regulation 12 by 31 March 2023. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- Medicines had not always been managed safely. We identified one person did not have their antipsychotic medicine for 7 days and another person did not have their antidepressant medicine for 14 days. This meant their prescribed medicine had stopped suddenly and had put them at risk of complications to their health and well-being.
- The service told us they were not responsible for ordering the person's medicines and had made attempts to get new stock delivered however, did not take steps to prevent the risk of harm to the person. Their GP was not informed of how many times the antipsychotic and antidepressant medicine had been missed, and staff had not been provided with instructions to monitor the person for any signs or symptoms they may need a healthcare professional. This had placed people at risk of significant harm.
- Staff dispensed and left out medicines for one person to take independently before they went to bed. We asked to see risk assessments to demonstrate the person had been supported to do this safely and were provided with a risk assessment that identified the person was at risk of saving the medicines and overdosing however, did not provide instructions to staff to reduce the likelihood of harm.
- The risk assessment stated: "[Person] can be forgetful and needs prompting to take medication. Yes [they are at risk of overdosing], as medication is left out in a pill box on the side of bedside table. There is a risk of overdose if they were to take them all at once." The risk had been identified; however, staff were not provided with any instructions to reduce the likelihood of an overdose. This had placed the person at risk of significant harm.
- Four people's electronic medication administration records (MAR) had not been signed daily by staff to confirm the administration of medicines. A daily audit had identified this however, actions had not been taken to ensure people had received their medicines and confirm the error was only a recording issue. This

was a repeated concern from our last inspection. The provider had failed to improve the service and people had been placed at risk of harm.
● We spoke with the registered manager about our concerns who told us they were assured people were receiving their medicines. We asked the registered manager to demonstrate how they were assured by providing us the records to confirm staff had administered medicines. The registered manager was not able to provide records for every medicine error. For example, one person's MAR had 22 days of missing signatures and we only received care records for 3 days.
● The records we did receive did not always state which medicines were administered and at what time, this meant the service could not be assured people were receiving their medicines as prescribed which placed people at risk of harm.

The provider had not improved the service and medicines were not always managed safely. People had been placed at risk of significant harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We reported our concerns to the local safeguarding team and the service is now working with the local authority to ensure the safe delivery of care and treatment for people using the service.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

At our last inspection systems and processes were not robust to identify where quality and/or safety was being compromised and appropriate safeguarding action taken. This was a breach of regulation 17 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

● Since our last inspection improvements had been made to the recording of accidents and incidents and the provider had a tracker in place for each occurrence. However, the registered manager told us they did not review accidents and incidents on a regular basis to identify for any themes or trends. The provider had failed to improve the service and had placed people at risk of harm.

The provider had not improved the service and had failed to establish robust systems and processes to identify where quality and/or safety was being compromised. People had been placed at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We reviewed the accidents and incidents and found 1 reportable incident of potential harm had not been referred to the local safeguarding team.
● We discussed our findings with the registered manager who told us they had not raised the incident to safeguarding, "as no harm came to the person". The registered manager later acknowledged this should have been reported, "I am now thinking I should have raised a safeguarding as there was potential harm, as [person] could have fallen."
● The service had failed to share information with the local safeguarding team related to missed medicines because their oversight of incidents was not robust.

People had not been protected from abuse because the provider did not implement robust procedures and processes to make sure people are protected. This was a breach of regulation 13 of the of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to robustly check staff employment history and references prior to employing staff. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After our last inspection the provider sent us an action plan and told us they would complete actions to make the service compliant with regulation 19 by 20 May 2023. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● We reviewed 6 staff recruitment files. Appropriate checks had been completed including a full employment history with any gaps explored. Reasons for leaving health and social care roles and references had been sought to ensure the member of staff was of good character.
● Appropriate Disclosure and Barring Service (DBS) checks had been made. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staff's health had been assessed to ensure any reasonable adjustments had been considered to support them to carry out their role.
● Staff had received regular spot checks from the management team to assess their competence to fulfil their roles.

Inspected but not rated

Is the service effective?

Our findings

At our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the effective key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

At our last inspection systems and processes were not robust to maintain accurate, complete and contemporaneous records regarding decisions taken in relation to the care and treatment provided. This is a breach of Regulation 17 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

● Mental capacity assessments and best interest decisions had not been completed in accordance with the requirements of the MCA and we found no improvements since our last inspection.
● For example, 1 person had been assessed as having capacity however was not present at the assessment and 1 person had been assessed as not having capacity however a best interest decision had not been completed.

The provider had not improved the service and had failed to establish robust systems and processes to maintain accurate, complete and contemporaneous records regarding decisions taken in relation to the care and treatment provided. This was a continued breach of regulation of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection we identified one person had CCTV in operation at their home. Tender-Hearted Care had not sought their consent or assessed their mental capacity to consent. A best interest decision had not been completed. At this inspection we found no improvements and the person's capacity had still not been

assessed or best interest decision completed.

● We then reviewed the MCA records for all 17 people using the service and found every person had a partial mental capacity assessment in place for the generic decision of daily living regardless of their health diagnosis. This is not in line with the MCA which states people's capacity can only be assessed because of an impairment or disturbance in the functioning of the mind or brain and assessment should be made for specific decisions.

● Mental capacity assessments and best interest decisions had not been completed in accordance with the requirements of the MCA. 1 person had been assessed however was not present at the assessment and 1 person had been assessed as not having capacity however a best interest decision had not been completed.

Care and treatment of people using the service had not always been provided with the consent of the relevant person. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found the Mental capacity assessments that had been completed were not always decision specific. For example, one person had an MCA in place for daily living covering a number of different decisions. This is not in line with the mental capacity act which applies to a singular decision.

● We discussed this with the registered manager who confirmed every person using the service had been assessed. The registered manager continued to show a lack of understanding of the MCA.

● We asked the registered manager what they had done since our last inspection to improve their understanding of the MCA. The registered manager told us they had been reading lots however, had not attended any MCA training sessions.

Robust systems and processes had not been implemented to make sure people were protected and ensure the service worked within the requirements of the Mental Capacity Act 2005. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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 our last inspection this key question was rated inadequate. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

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 systems and processes had not been established and operated to ensure robust governance and oversight of the service. This was a breach of Regulation 17 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

● System and processes were either not in place, or effective, at identifying areas of improvement we found throughout this inspection. This meant quality performance had not always been assessed, potential risks to people not always identified and lessons learned to drive improvements had not always been possible. People had been placed at risk of significant harm.
● Medicines management systems and processes were not robust and had failed to identify and explore reasons medicines were not administered. Near misses and/or missed medicines had not been recorded as incidents, this meant the service had been unable to identify any risk to people's health and welfare and had placed people at risk of significant harm.
● After our first inspection on 22 July 2021 CQC applied conditions to the registered providers registration. One of the conditions required the registered provider within 28 days to devise and implement effective systems to review and analyse medicine administration and management and accident and incidents ensuring any identified risks was assessed and mitigated. The registered provider had failed to do this which meant a condition of their registration was not being met.
● The provider had failed to learn from our previous inspections and had not improved the service placing people at risk of significant harm.

The provider failed to improve and establish and operate robust systems and processes to ensure robust governance and oversight of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure notifiable incidents had been reported to CQC. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

After our last inspection the registered provider sent us an action plan to tell us they were now compliant with regulation 18. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● The service failed to notify CQC of notifiable incidents as part of their regulatory requirements including incidents reported to the police. This meant external scrutiny was not possible to ensure people were not being neglected or receiving care or treatment that would place them at risk of harm.

The provider had failed to improve and ensure notifiable incidents had been reported to CQC. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● Inspectors arrived at the registered location to conduct the announced inspection to find the location was empty. The registered manager informed inspectors they had relocated however had failed to notify CQC of the change of address.

The service failed to notify CQC of reportable notice of changes. This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

● The registered manager told us they understood their regulatory responsibilities however, failed to show they had the competence and skills required to manage the carrying on of the regulated activity.
● After our last inspection the registered manager told us they intended to recruit an experienced person to help with the running of the service. However, they had stopped pursuing this and had not recruited an experienced person into the service.
● We asked the registered manager what they had done to improve their skills and knowledge since our last inspection. The registered manager told us they had not attended any additional training to support them with their competence, skills and experience required to undertake the role.
● The registered manager, who was also the provider, had failed to improve the service following a warning notice served in respect of regulation 17 leading to continued and new breaches of regulations found at this inspection and people had been placed at significant harm.
● The registered manager demonstrated a lack of knowledge regarding the safeguarding of adults and the requirements of the mental capacity act which had resulted in breaches of regulations at this inspection.

The registered manager did not demonstrate that they had appropriate knowledge of applicable legislation and failed to take action on set requirements. This was a breach of regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Since our last inspection the registered manager had sought feedback from people using the service and from staff. The results showed people felt safe and felt staff were happy and treated them with dignity and respect. The registered manager told us the results had not yet been analysed.

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 15 Registration Regulations 2009 Notifications – notices of change The service failed to notify CQC of reportable notice of changes.

The enforcement action we took:

Notice of proposal to cancel the provider registration

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service failed to notify CQC of notifiable incidents as part of their regulatory requirements.

The enforcement action we took:

Notice of proposal to cancel the provider registration.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not always ensured care and treatment was provided with the consent of the relevant person and staff had not always acted in accordance with the requirements of the mental capacity act 2005 and associated code of practice.

The enforcement action we took:

Notice of proposal to cancel the provider registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely.

The enforcement action we took:

Notice of proposal to cancel the provider registration.

Regulated activity	Regulation

Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not always informed the local safeguarding team of incidents where people had been placed at risk of harm.

The enforcement action we took:

Notice of proposal to cancel the provider and registered managers registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to improve and establish and operate robust systems and processes to ensure robust governance and oversight of the service.

The enforcement action we took:

Notice of proposal to cancel the provider registration

Regulated activity	Regulation
Personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager did not demonstrate that they had appropriate knowledge of applicable legislation and failed to take action on set requirements.

The enforcement action we took:

Notice of proposal to cancel the registered managers registration