Heart to Heart Care NW Limited

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Inspection report

Unit 6
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Date of inspection visit:
13 October 2021
14 October 2021
15 October 2021

Date of publication:
29 November 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
Heart to Heart NW Ltd is a domiciliary care service that provides support and personal care to adults in their own homes. At the time of our inspection 155 people received support from the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
This was a focused inspection looking at the domains of safe and well-led only. At the last inspection, the provider was rated good in the safe domain, and requires improvement in well-led. At this inspection, both of these domains had deteriorated to inadequate.

Medication management was not safe. There were no adequate systems in place to check that people's medicines were administered as prescribed. Medication administration records contained gaps indicating that some people had not received the medicines they needed to keep them safe and well.

People's needs and risks had not been adequately assessed. Staff lacked sufficient guidance and information on what these needs and risks were. Some people had specific dietary requirements that needed to be followed to protect them harm. Records showed these people had not received safe and appropriate care at all times.

The visit times people had agreed with the service, were not always respected. Visits were sometimes much later or earlier than agreed. There was no effective system in place to ensure staff attended when they should.

Incidents of a safeguarding natures such as unexplained bruising or inappropriate care had not been identified by the manager or provider. This meant they had not been properly investigated and reported to the local authority or CQC.

The provider's policies and procedures for COVID-19 were too brief and failed to clearly identify how risks associated with the virus would be mitigated against. The risks of COVID-19 had not been assessed or planned for, in respect of, the welfare of people using the service and staff. This was not good practice and did not adhere to government guidelines.

There were limited systems in place to monitor and audit the quality and safety of the service. The audit systems in place had not identified the concerns we identified during the inspection. The systems were poor and did not ensure risks to people's health, safety and welfare were managed and safe care provided.

Staff were recruited safely. Staff told us they felt supported by the manager and able to raise any concerns.

The manager and assistant manager told us the service had experienced staff shortages as a result of COVID-19 which had placed extra pressure on the service.

People and their relatives said staff were kind, caring and supportive. They told us staff wore appropriate PPE to prevent the spread of infection during their visits.

During the inspection, the manager and assistant manager were open and approachable, but were unable to explain concerns identified during the inspection. They did not demonstrate they had a clear understanding of the management requirements of the service in order to ensure people's care was safe and the service well-led.

Rating at last inspection and update
The last rating for this service was good (published 10 October 2019). At the last inspection the domain of safe was rated good and the domain of well led was rated requires improvement. At this inspection, these domains had deteriorated to inadequate. A breach of regulation 12 (Safe care and treatment), regulation 13 (Safeguarding service users from abuse and improper treatment) and regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

Why we inspected
We received concerns in relation to the quality and safety of the service both from people or, relatives of people using the service and the Local Authority. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Heart to Heart NW Ltd on our website at www.cqc.org.uk

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

Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will work with the local authority to monitor progress.

Special Measures
The overall rating for this service is 'Inadequate' and the service has been placed 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?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Heart to Heart Care NW Limited

Detailed findings

Background to this inspection

The inspection
We carried out this focused inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act under the domains of safe and well-led, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team
This inspection was undertaken by two inspectors and two Experts 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was announced on the morning of the inspection. This was because we needed to be sure that the office would be open and that the manager or other senior person would be in the office to support the inspection.

What we did before the inspection
We reviewed information received about the service since the last inspection. We contacted the Local Authority Commissioning Team and Local Authority Quality Improvement Team and gained their feedback. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We

contacted the local authority to gain their feedback on the service. We used all this information to plan our inspection.

During the inspection:
We spoke 17 people using the service and/or their relatives. We spoke with the registered manager, the assistant manager, a senior carer and two care assistants. We reviewed a range of records including six people's care records, a sample of medication records, six staff recruitment files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management

- Risks associated with people's care were not properly risk assessed or managed. For example, risks associated with nutrition, choking and pressure sore development were not assessed and people's moving and handling assessments were unclear.
- Records showed that staff did not always provide people's care in a safe way. For example, some people required a specialised diet to prevent them from choking, but they were given meals by staff that were unsafe for them to eat.
- Care records in people's homes showed that visits were sometimes late or earlier than expected. One person told us, "I've given up trying to tell carers not to be late because there's always an excuse. I ask am I getting a visit today? Am I getting lunch today? Reception say - sorry the girl forgot but is on the way -she's walking to you". Late or missed visit place people at risk of not having their needs or wishes met.
- The manager and provider had not ensured that staff had travel time between visits to enable them to complete them on time. NICE guidelines state that provider should schedule "Sufficient travel time between visits". The manager and provider had not followed this best practice guidance.
- The electronic system in place to monitor people's visits was not fit for purpose. It did not work in certain postcode areas in Warrington. This meant visits in these areas could not be monitored in real time. The system also allowed staff to log in and out of visits remotely using their mobile phone, without actually being in the person's home. This meant it was impossible for the manager and provider to know, with any degree of certainty, if staff were completing visits as planned.

People's risks were not adequately assessed, monitored and managed to prevent avoidable harm. The care provided was not always safe. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People's medication records were not always completed properly and showed significant gaps in administration. This indicated that people did not always receive the medicines they needed to keep them safe and well.
- The medicines audits in place showed people missed doses of their prescribed medication on a regular basis. This placed people's health and well-being at risk of avoidable harm. Despite this, little effective action had been taken to ensure staff administered medicines safely and as required.
- It was not clear whether the provider, person, or other representative was responsible for ordering people's medication. This resulted in some medicines not being available at the time of their administration which meant people went without them.
- Staff did not have access to any guidance on how to administer as and when required (PRN) medicines

such as prescribed creams. Records showed that these topical medicines were not always applied.

The management of medication was not safe and placed people at risk from serious harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider's policies and procedures relating to infection control and COVID 19 were brief and did provide sufficient guidance on how the risk of COVID-19 would be managed by the provider.
● The individual risks of people using the service and staff contracting COVID-19, had not been assessed in order to mitigate its impact during the delivery of support. This was not in accordance with government guidelines or the provider's own COVID-19 policy.

The arrangements in place to assess, monitor and mitigate the risk of infections such as COVID-19 were not robust. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and the relatives we spoke with told us, that staff members wore appropriate PPE when providing support.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong.
● Safeguarding, accidents and other incidents that had occurred were not always properly recorded, investigated and reported. For example, one person had unexplained bruising that had not been reported to the local safeguarding authority or CQC as required by the manager. The bruising had also not been adequately investigated or followed up with health and social care professionals to establish a cause.
● Consistent and persistent patterns of late or missed visits, which increased the risk of people's needs not being met, had not been identified or reported as a potential safeguarding event. One person told us, "They failed to turn up on three occasions., the first time 11th September, the excuse was I wasn't on the App, the second time was 15th September, all the staff were out on call and they were short staffed. The third time was the girl had a flat tyre, nobody rang to let me know. I just managed myself. I felt upset".
●Guidelines issued by the National Institute for Social Care Excellence (NICE) advises home care providers to "Closely monitor risks associated with missed or late visits and take prompt remedial action". We found little evidence that the manager and provider had done this to protect people from potential harm.

People were not adequately protected from the risk of abuse and neglect. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were recruited safely. The manager told us that they had experienced staff shortages, especially over the weekend period as a result of COVID-19. They told us they had helped out to cover these shortages with the help of the assistant manager.
● When asked, staff told us they felt able to do their job and felt for the most part, there were enough staff. One staff member said, "Yes thinks so [enough staff], it was difficult during lockdown but better now".
● The majority of people and the relatives told us that staff stayed for the length of time required and did not rush them when support. This suggested the staffing levels were sufficient to be able to maintain people's care.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The governance arrangements in place to audit the quality and safety of the service were not sufficient. The systems were poor and ineffective. They failed to identify the serious concerns with risk management, medication management, safeguarding, record keeping and governance found at this inspection.
- There was little evidence that people's care records were audited properly to identify patterns of late or missed visits. There was little evidence that people's care was monitored to ensure it was safe. During our visit we had to refer the care of three people to the local authority due to serious concerns around their safety.
- The provider's electronic system was not fit for purpose. It did not enable to the manager or provide to track staff movements, the timeliness of people's visits or the delivery of their care with any degree of accuracy. Despite this, they had not ensured alternative monitoring systems and safety checks were in place to mitigate any risks. The manager told us a new electronic monitoring system was due to be implemented at the end of October which would enable them to track and monitor visits and people's care in 'real time'.
- There was little evidence that the provider had oversight of the service. The manager and assistant manager of the service were open and approachable. They were however, unable to explain the failings of the service and why they had not been picked up and addressed.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong

- The manager had not always reported notifiable events to CQC in accordance with the regulations.
- People's care was not always provided in accordance with their needs and wishes. Visits did not always take place at the times agreed. Some people and their relatives told us they had complained about this, but nothing changed. One person said, "I phoned the manager and told then the situation. They said leave it to me and I think okay great, but then two weeks later it goes back to normal. Sometimes I feel that staff take no notice". Another person told us that "They always say it won't happen again. Things always run well for a bit then falls back again".
- People did not always have familiar staff supporting them which impacted on the continuity of people's care. One person told us, "I used to have regular carers to shower wash me till they got whisked away and I was told I couldn't pick and choose. To that comment I responded, you say you provide continuity and I am not getting that. I'm a woman of 76, being washed by a girl of 18 and it's very unpleasant. They say they take no notice, but it's embarrassing". Another person said, "It would be nice if we could have more of the same people regularly. Lately seem to have new girls every five minutes". This did not demonstrate person centred

care was promoted.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People's feedback on how the service engaged with them and sought their feedback was mixed. Two relatives told us that they had been sent questionnaires to complete for their feedback. Whereas two people using the service told us they had not been asked for their opinion about the service or the support they received. One person said, "I have never been sent a questionnaire" and another told us, "I haven't spoken to anyone for a long time and not had a general review with Heart to Heart". It was unclear therefore how well the manager or provider engaged with people using the service.

● From people's records the involvement of other health and social care professionals, or medical professionals in people's care was not always evident. Where advice from other professionals had been given, this had not always been followed.

The governance arrangements failed to ensure people received safe, person centred care which mitigated risks to their health, safety and welfare. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The people and the relatives we spoke with told us staff providing support were kind, caring and patient. Their comments included, "Carers are very nice"; "I think the staff are approachable, they do their best" and "The girls are all very good".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not adequately protected from the risk of abuse and neglect.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance arrangements failed to ensure people received safe, person centred care which mitigated risks to their health, safety and welfare.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not adequately assessed, monitored and managed to prevent avoidable harm. The care provided was not always safe. The management of medication was not safe and placed people at risk from serious harm. The arrangements in place to assess, monitor and mitigate the risk of infections such as COVID-19 were not robust.

The enforcement action we took:

We have issued the provider with a warning notice. This will be followed up and we will report on any action when it is complete.