Hearts At Home Care Limited

Fordingbridge

Inspection report

29-31 High Street
Fordingbridge
SP6 1AS

Tel: 01425657329
Website: www.heartsathomecare.co.uk

Date of inspection visit:
16 October 2018

Date of publication:
27 November 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 16 October 2018. We gave the provider 24 hours' notice that we would be visiting the service. This was because the service provides care to people living in their own homes and we wanted to make sure staff would be available to speak with us.

We telephoned staff members and people who received a service from the provider and their relatives on the 17 and 18 October 2018. We only contacted people who had agreed to give us feedback.

The service currently supports 32 people living in the areas surrounding Fordingbridge including Downton and Ringwood.

The service has no registered manager, however the manager in post has recently submitted their application to CQC to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The last inspection of Hearts at Home, Fordingbridge took place on 25 and 26 July 2016 and rated the service as requires improvement. We found concerns in both the safe and well-led domains.
At this inspection we found that the recruitment procedures were not safe and that staff had commenced in post before references and DBS checks had been completed.

The service did not have adequate auditing systems in place to identify missing documents in people's files or to check that processes such as recruiting staff were being adhered to

At this inspection we found that concerns we had about people's safety and staff competency in medicines had been addressed and a robust training and competency system was now in place.

A monthly external audit ensured that medicines records were accurate and complete.

Most people told us they received their rotas on time.

The provider had a scheduling system that would ensure staff had sufficient travelling time so that they arrived at people's homes when expected.

Accidents and incidents were recorded and the provider was introducing a new form including a section to note actions taken to minimise future incidents.

Risks were assessed and all possible actions were taken to mitigate risks and promote the safety of individuals.

A business continuity plan was in place.

Staff received an induction and completed shadowing shifts before commencing caring for people. People told us they believed staff were well trained. Training the provider considered to be essential was updated annually. Staff were encouraged to complete training which would offer them qualifications.

Staff received regular supervisions and had an annual appraisal. Spot checks on staff when completing care tasks were also undertaken by the provider and feedback from these checks aimed to improve staff performance.

Quarterly staff meetings ensured that staff were informed and felt part of the team. Other essential information was shared using a confidential social media application that all staff could access.

People told us that staff were caring and ensured they provided care that enabled them to retain their dignity.

Care plans were holistic and detailed how people wanted their care to be provided.

The provider was seeking information on people's personal histories to add to their care files to enable staff to have relevant conversations with them.

Staff knew people they supported well and the provider endeavoured to maintain continuity of care by having a team of regular staff supporting people.

The provider had monthly conversations with people to gather feedback on their care package and to ascertain if changes were needed.

Care plans were regularly reviewed and support decreased as well as increased whenever possible as the provider promoted people's independence whenever possible.

The manager had a plan in place to address concerns and ensure that tasks were completed on schedule.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not fully checked as to their suitability to work with people before commencing in post.

Staff were trained in managing medicines and checked to ensure they were competent before they supported people without supervision.

There was a business continuity plan in place.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and who received regular updates to ensure they were working in line with current best practice.

Staff were clear as to their responsibilities in terms of people's mental capacity.

Is the service caring?

Good

The service was caring.

People were supported by staff over a long-term basis so they could forge relationships with them.

Staff sought peoples consent before providing care and ensured that people retained their dignity at all times.

Confidential information was stored in line with current data protection regulations.

Is the service responsive?

Good

The service was responsive.

The provider spoke to people about their care plans on a regular basis to ensure they was fully meeting their needs.

There was a complaints policy and procedure in place and concerns were dealt with in the specified time.

The service provided both palliative and end of life care and prided itself on going the extra mile for people both before and after loss.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not have a robust auditing process in place identifying shortfalls in areas such as recruitment which could have a significant impact on people they supported.

Staff, people and their relatives told us they found the directors and manager of the service to be supportive and responsive to their requests.

The manager had compiled an action plan to ensure that records and procedures were current and people and staff were receiving the support they needed.

Fordingbridge

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 inspector took place on 15 October 2018 and was completed by one social care inspector. In addition, the inspector telephoned people and staff on 16 and 17 October to obtain feedback on the service they received.

Before our inspection we looked at information we held about the provider. This included notifications from the provider. Notifications are specific events that the provider is required to tell us by law.

We reviewed the Provider Information Return (PIR) submitted by the registered managers. This tells us what the service has achieved over the past year and what they intend to develop. We require the provider to submit this annually and it provides us with information to plan our inspection.

We visited the providers offices and looked at documents held there including nine care files, six staff recruitment and supervision files and we asked the provider to supply us with copies of policies and procedures. We looked at audits and other records including accident reports and safeguarding logs.

We spoke with eight people or relatives of people receiving a service from the provider and spoke with two directors, the manager, care co-ordinator and four care staff.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. The provider had not completed thorough checks before staff began to work with people. The provider had not obtained full employment histories from all staff. One staff recruitment file contained no work history, one had a seven-year gap in work history and two other files were missing more than 20 years of work history. Of the six staff recruitment files we looked at, only one had a full work history.

References had not always been obtained prior to staff commenced in post. One staff file had a reference received nine weeks after they started working for Hearts at Home and a second that was applied for three and a half months after they commenced which was not received until almost nine months after they had started to provide care. Another staff member had references that were received one month and three months after their start date with the provider.

Staff recruited by Hearts at Home Care had been checked by the Disclosure and Barring Service(DBS). The DBS check highlights potential issues around criminal convictions and shows if someone is barred from working with vulnerable people and helps employers make safe recruitment decisions. Though checks had been completed in all the staff files we looked at, checks were not always applied for before staff commenced in post and results were not always received before they started working with people in their own homes. A risk assessment had been completed for one staff member who started working before their DBS check results had been received. This had been completed even though an initial check of the barred list had advised waiting for the full check to be completed before making recruitment decisions. The risk assessment 'in-house' form also stated that it should not be used unless clearance had been obtained at the initial barring list stage. The provider was not following their own policy which put people at risk.

Failing to have a robust recruitment process was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and Proper Persons Employed.

At our last inspection we had concerns about medicines. Staff had received training to administer medicines however their ability to safely give medicines had not been checked. At this inspection we saw a competency check had been introduced for various areas of care delivery including medicines. Aspects of staff practice were assessed once they had participated in training and, after being observed three times and showing they were competent, staff would be signed off as competent by a team leader.

We had also noted concerns on medicines administration records (MAR'S). These concerns had been alleviated as the provider had introduced a three-stage system to manage errors and omissions which escalated if errors were repeated. MAR's were audited monthly by an external auditor and any errors or missing signatures were investigated and dealt with by the management team.

We found, at our last inspection, that rotas were not being sent to people using the service in time, causing them to be concerned about whether anyone would come to provide their care and worry about who might come. We spoke with the provider about this and they told us that they had addressed the problem and that

rotas were mainly being received by people on time. There had been a recent computer problem and the provider, knowing they would not be able to send rotas, had issued a letter to everyone using the service to tell them of this and had either emailed or phoned rotas through to the people who would be most worried by this. The provider had invested in a new system that, they told us, made producing rotas easier and more reliable. We received mixed feedback about whether rotas were received in time, most people told us they were happy with the service however one person said there had been no improvements in when they received their rota.

The provider had taken appropriate steps to protect people from the risk of abuse, neglect or harassment. When asked if being supported by staff from Hearts at Home made them feel safe one person told us, "Yes, and they make me feel cared for". People were supported by staff who had been trained in safeguarding, knew the signs and symptoms of abuse and what actions they should take if they were concerned about someone they cared for. The provider had only dealt with one safeguarding concern since we last inspected. They retained a safeguarding file with details of incidents and a clear process for alerting concerns.

We saw detailed assessments of risk in people's care records. Assessments were regularly updated, usually every three to six months and covered aspects of risk that were relevant to each individual. One person had a detailed risk assessment covering medicines, moving and handling and transfers, falls history, skin risks, environmental risks and an assessment for lone working. These assessments contained information on the type of risk, a plan to reduce risks as far as possible and a desired outcome. Staff told us that though they aimed to protect people by minimising risks they would also enable people to take risks that would be beneficial to them.

The service maintained a record of accidents and incidents. Forms were completed by team leaders using information provided by care staff who had witnessed incidents. There was no learning and actions taken from reports. The provider had, on the day of our inspection, decided to update the form and add a section for actions and review so that learning could be taken from events. They also called in staff that had been present at accidents or incidents in the 24 hours after the event and provided a debrief. If the event had been distressing they also supported staff with counselling.

Staff told us they believed there were sufficient staff on duty to cover all care tasks. The provider had a scheduling system that incorporated travelling time based on a well-known route-planning tool so that staff did not have to rush between people's visits. People were also advised that staff may arrive up to fifteen minutes before or after their allocated time due to delays in travel or at their previous appointments.

People had clear medicines care plans and details of people's medicines were retained by the provider even when they self-medicated or were supported by a family member. People were assessed to see if they could self-administer their medicines and a care plan devised according to the outcome. Where possible, the provider enabled people to self-medicate so that they retained their independence but would provide different levels of support from advice through to full support as needed.

Staff were trained in infection prevention and control and were given the necessary personal protective equipment (PPE) to ensure that risks of infection were minimised. The provider gave staff gloves, aprons, shoe covers and hand cleaning gel to use when delivering care. Face masks were given to staff to wear if they had cough or cold symptoms to minimise the chance of passing their symptoms on to people. We asked if people minded staff wearing face masks and were assured that people had been supportive of this as staff told them why they wore masks when they arrived at their homes.

At our last inspection the provider did not have a business continuity plan. We were provided with a plan

that had been implemented in March 2018 that was updated in October 2018. The plan was comprehensive covering possible occurrence's that may affect provision of care both in the office such as power or computer system failure or inclement weather such as floods or snow that would affect care delivery in the community. Each instance had been considered and a reasonable plan of action recommended with the overall aim to maintain the safety of people and staff and to minimise risks of harm.

Good

Is the service effective?

Our findings

People's needs were assessed in line with the provider policy on assessment of needs and care planning. At referral, people's needs were assessed and if the service could offer a care package, a care plan would be developed. Staff were encouraged to write notes on the care plans and share information and new learning about people in their end of day reports. These notes would be checked and added to the care plan by team leaders as and when they reviewed files. Every month team leaders collect care notes from people's homes and while they deal with paperwork, one of the directors spends time chatting with the person to ensure they have anything to report, or a complaint or compliment to make.

People told us that they believed staff had been trained to support them effectively. One person told us, "They really know [person], they see when I need to provide extra care and let me know". Another person told us, "On the whole I'm treated quite well. You have to say if you want something done…. but if it's not good, I say".

Staff participated in training sessions for a week when they commenced working for the service. Two shadowing shifts were then completed before staff could start supporting people without supervision. The providers mandatory training courses included first aid, food hygiene, safeguarding, moving and assisting, dementia care, medicines management and fire safety. These and other courses were completed during the staff members induction and then updated annually to ensure that staff remained competent and current in their knowledge. Training was provided mainly by one of the directors of the service who had completed 'train the trainer' courses with additional courses from an online training system. The provider was looking to include training from different agencies in future and developing the range of opportunities offered. Staff were encouraged to complete training that led to qualifications. All staff were enrolled on level 2 and level 3 social care diplomas.

Staff participated in regular supervisions with their line managers. Staff met with their supervisor to discuss areas of improvement, their well-being and how best to support people in their care. Supervisions were held on a three-monthly basis and every fourth meeting was an appraisal. In appraisals, performance for the previous year was reviewed and targets set to achieve in future. In addition to supervisions, staff were subject to 'spot checks'. These were unannounced visits by the team leaders to care visits where they checked on staff to ensure they provided quality, safe care, wore appropriate personal protective equipment wrote in care files and administered medicines as per peoples care plans. Team leaders would feed back their findings to staff members so they were able to improve their practice as a result. The provider told us they were improving the supervision and spot check frequency by allocating people to team leaders each week to complete checks on thus ensuring that all staff were checked regularly and at the same frequency.

Staff meetings were held quarterly and all staff were expected to attend unless they were on annual leave or unwell. Additional information was shared with staff via a business media application on mobile phones and computers which was confidential but easily accessible to staff. Handover information was shared through the application as well as messages for individuals and updates to care information.

Staff provided different levels of support to people in terms of their nutritional requirements. People had different levels of needs and for some, staff would support them to heat a meal and other people needed staff to either prompt them to eat or assist them by feeding them their meal. Staff were aware of peoples need to maintain their fluid intake and could tell us signs and symptoms they may see if someone were becoming dehydrated. One relative told us they were impressed as staff would contact the persons GP if they were concerned about them. People's care plans reflected the input they required and for people who had swallowing difficulties or had their nutrition delivered via a percutaneous endoscopic gastrostomy (PEG). care plans had clear guidelines in place.

People and their relatives told us that staff knew people well enough to recognise when they may be unwell and take actions to support them with this. One person needed to have regular checks of their temperature to ensure it was always within a safe range. Staff told us that they would also ensure the environmental temperature was maintained and that food and drinks were provided at a suitable temperature. The persons relatives told us that the care staff had called the GP about the person as they had concerns, then called them to advise they had done so as per their arrangements. This enabled the person to receive timely medical attention.

Staff ensured that relevant people within the service were also informed if a person was unwell. They would contact the office staff to inform of concerns and add the information to daily care records and to the information sharing application.

Care records held copies of signed consents for care to be delivered. In some cases, consents were signed on behalf of the person by a relative some of whom were recorded as having a Lasting Powers of Attorney (LPA). An LPA is a legal document that allows someone you have nominated to make decisions for you or act on your behalf if you no longer have the capacity to do so. In some records there were copies of LPA's which confirmed that consents had been given by someone who was authorised to do so. In two of the nine records we checked there were no LPA's to support consents given by relatives and in another record, there was no evidence that a relative had guardianship for a person. There had been no negative impact to peoples care as a result of the missing evidence so we told the provider to obtain copies to confirm the consents were lawfully signed.

Staff's knowledge was variable about the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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. Most of the staff we spoke with were knowledgeable about the five principles of the act.

Good

Is the service caring?

Our findings

People and their relatives told us that the service was caring. One relative told us, "The carers are very pleasant, nice girls, pleasant and professional". A person using the service told us, "Yes, they make me feel cared for…. I would recommend the agency, they are good". Another person told us, "I am pleased with the carers, they give 100%. I have one girl in particular who comes in and I couldn't keep my head above water without her. She's caring and gentle and gives you the respect that you would give them if the situation were reversed".

Staff told us that they were confident that the whole team were caring and that they would not tolerate poor practice. One staff member told us, "I've never met anyone [staff] that isn't caring. They aren't just carers, they are a team, a family. If we saw someone take an inappropriate approach we would speak to them and report them". People and their relatives echoed the views of staff and described carers as friends or like extended family. One relative said that the relationships between carers and their family member were really positive, "The carers are really good, he refers to [care staff] as 'granny', she has a soft spot for him. This really stands out for me".

Care plans were holistic and detailed how each person liked to receive their care rather than just specifying tasks to be completed. Though care plans were person-centred in their descriptions of care to be provided, they lacked information about who people were in their life before needing care. Information about people's personal history would be beneficial, particularly when supporting people who are living with dementia. The provider was aware that people and staff would benefit from having access to such information and had made plans for care staff to communicate all learning about people in their end of day reports so it could be added to care records.

People received care that ensured they retained their dignity, that was respectful and private. One staff member told us they would ensure that curtains were pulled and doors were closed before commencing care. They also described how they would keep people covered in towels while they washed them, uncovering just an arm or a leg at a time so that people did not feel too exposed and vulnerable.

People's care plans were reviewed regularly and on a monthly basis care records were taken from people's homes to be audited and filed. When staff were dealing with paperwork, one of the directors would spend a short time with people, chatting, checking the details of their care plan and ensuring they had no complaints about their care. If someone was unable to comment about their care, perhaps due to having more advanced dementia or complex needs, the director would speak with a relative to check that the care delivered was appropriate and that the person was happy with it. Engaging with people and their relatives enabled them to be more involved in decision making and devising their own care plans.

Staff told us they would seek permission before completing care tasks. A staff member told us, "I would get consent from the person but if they couldn't tell me then there would be a consent in place from a relative or something in the care file signed by the person.

The provider had a clear awareness of people's needs in terms of communication. When discussing care records both directors were clear as to how best to communicate with people, for example, they told us that one person may seem to not be responding due to a long delay however advised that we wait as due to their condition they needed additional time to process information and respond to it. A relative told us, "They [care staff] don't have any problems with communicating with [person]. They know if he has a temperature he won't be as able to communicate. The girls know what to do and have no problems with communicating if he is well".

As far as possible people had regular carer workers This enabled people and their carers to develop relationships so they felt comfortable with the care provided. At times, due to staff changes and pressure on the service, new staff or unfamiliar staff would attend calls. Most people accepted this as new carers would attend with another staff member before completing the call alone. One person told us, "If there are different carers they usually come in with another person that has been here before. They don't send staff in willy, nilly". A relative told us they had been able to get to know all the persons carers which gave them comfort knowing someone familiar would be supporting them. One person was not happy with the amount of different staff that had attended to support their care, they told us that 17 different staff members had supported them during their two years with the service.

Peoples care records and staff files were stored in locked cabinets in the office of the provider. Storage was compliant with current General Data Protection Regulations (GDPR). Care files were seen only by staff authorised to see them and information was shared with staff via their phone applications to ensure confidentiality was maintained.

Staff told us that they felt cared for by the directors and manager of the service. Support was provided in the form of regular supervisions and staff were informed in plenty of time so they could ensure they could attend.

Good

Is the service responsive?

Our findings

People and their relatives were involved in assessments and care planning as far as they were able. Monthly informal conversations with people and their relatives enabled the directors of the service to ascertain if people were happy with their care and to develop their knowledge of people so that care plans could be adjusted accordingly. Care plans contained details of how people wished to receive their care and as new learning was made about people, plans were updated.

People were provided with appropriate levels of support. The directors were clear that they would provide people with the necessary support and aimed to promote people's independence. The care provided wasn't to do everything for the person, but to enable them to do as much as possible for themselves so that they maintained skills and abilities. The director was particularly proud to have managed to reduce a person's care package from four calls with two carers at each call daily, to three calls per day with just one carer. This was due to staff supporting the person to regain their mobility and relearn their self-care skills. The provider was keen to enable people and this was prioritised in care plans.

The provider had a complaints policy and procedure. Concerns raised with care staff were passed to team leaders or the management team who would, if possible, use the informal procedures to deal with the matter. More serious or longer-term concerns would be dealt with using a formal procedure. The providers policy also stated they would provide complainants with contacts for advocacy services so they could be supported with their complaint and if the person was not happy with the outcome, contact details for regulatory bodies would also be supplied.

Records were retained of complaints received and when we looked at these we saw that most complaints were acknowledged by letter from the manager and were recorded with actions to be taken as part of the investigation. Most complaints were dealt with within 28 days with more complex issues involving other agencies taking longer. One complaint was still outstanding from May 2018. This was a complex and ongoing complaint, however the provider told us that they and the funding authority along with the person were almost at a point of resolution. They supplied us with all communication records of the complaint which evidenced that the complaint had been investigated and as far as possible the provider was meeting the requirements of the person.

Complaints logs were not audited with a view to finding common themes. Common themes may identify actions that the provider could take in terms of policy, procedure or service delivery that could, if adjusted, improve the service for people and reduce future complaints. Complaints forms had sections for actions by the provider and a follow up review records which were completed following resolution of the complaint.

The provider supported people with both palliative and end of life care. A director told us they supported people in partnership with GP surgeries and district nurses. Once end of life medicines were required, medical professionals would manage these while the agency provided care. If someone was close to the end of their life and they or their relatives needed support, staff would be there for them. The director had stayed with a person until the early hours offering support. After a person had died, the provider ensured they

offered relatives support if needed. Staff were informed in a sympathetic way and management staff were training to support staff members with loss and other stressful situations using mindfulness techniques.

Requires Improvement

Is the service well-led?

Our findings

The service had been created to achieve the directors vision of providing an 'outstanding service of Domiciliary Care'. The provider was attempting to achieve quality care for people. The values of the service included treating people with dignity and respect, providing positive outcomes and person-centred services. These were embedded into care staff practice. Staff we spoke with were respectful of people they provided care to, and the care they described providing and care plans were person-centred. The provider was committed to enabling people to have choice and remain independent. This was evident when they described people they had supported who had managed to reduce their care packages significantly.

The provider sourced policies from a well-known social care quality management company. Policies which are purchased should be personalised with information such as provider names and specific details for the service. Of 11 policies we saw, only three appeared to have service specific information, the rest showed the company logo without the service name or any adjustments to the text however the provider could show us all the policies we requested.

The service had been without a registered manager for over twenty weeks. A new manager started in post in September 2018 who has since submitted their application to the commission to be registered.

There was a clear structure within the service. Two directors, one of who was the Nominated Individual, worked alongside the manager and were supported by team leaders and a care coordinator. The office based team supported with care visits and ensured they stayed familiar with people's needs. This also enabled them to deal more effectively with any concerns or problems with care packages.

The manager had devised a plan of action giving them a clear overview of the service and allocating various tasks to ensure that records, procedures and systems were current and working effectively. The manager told us that due to the changes in manager over the past year, some tasks had been started and not finished so they were fully auditing all records to benchmark and highlight areas of concern to prioritise. The manager had set up new staff files and was producing a template file for the team to use to ensure there was consistency. A sample client file was also being produced to ensure that all files had all required information.

MAR's and care recordings were audited regularly by an external auditor employed specifically for that purpose. They checked for gaps and errors in recording, and missing or incomplete care notes. These checks effectively audited direct contacts with people.

Wider care records were not effectively audited. Missing documents such as copies of Lasting Powers of Attorney had not been sought from people. In addition, one person's file stated they had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form but the location was unknown. Auditing this file and following up on this could mean that the persons DNACPR was located or, the provider could support them in obtaining another.

Staff files were also not audited. The provider informed us they had recently reorganised the supervision of staff. They saw, when the manager checked staff files, that some staff received supervision more regularly than other staff. To offer all staff the same supports, named staff had been allocated to team leaders with schedules for supervisions. The provider had a computer system that alerted them when tasks were due such as care plan reviews and staff training updates.

We received positive feedback from most people about the directors and the manager. They were supportive and went over and above to support staff even when their problems were not work based. Staff told us they would be able to approach them with anything and believed there would be no reprisals if they had to inform on poor practice of colleagues. They also felt able to take suggestions to the management team and they would be considered and welcomed.

The provider had good relationships with health and social care agencies and GP surgeries. The provider was known locally, they had a distinctive image and had used it during charity events locally. They also supported fund raising initiatives for local and national charities.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not fully checked as to their suitability to work with vulnerable people before commencing in post.