Heart to Heart Home Care Agency Ltd

Heart to Heart Home Care Agency

Inspection report

The Bungalow
Whitwell Street, Reepham
Norwich
Norfolk
NR10 4RA

Tel: 01603871903

Date of inspection visit:
18 December 2018

Date of publication:
26 February 2019

Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection visit took place on 18 December 2018 and was announced. The service started to provide care in February 2017 and this was the first time it had been inspected.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of the inspection 12 people were using the service.

Not everyone using Heart to Heart Care Agency receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. Ten people were receiving personal care.

There was a registered manager working at the service. A registered manager is a person who has 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. The registered manager at this service was also the provider and will be referred to as such throughout this report.

Systems were in place to protect people from the risk of abuse. People were assessed to establish whether they were at any particular risk and staff provided care which mitigated any risks. More detailed documentation relating to risk management was needed in people's files though to reduce the likelihood of harm occurring. The service demonstrated that it responded to, analysed and learnt from unexpected incidents.

Medicine administration and recording was not undertaken in a consistently safe manner. Staff were not competency assessed to manage people's medicine and medicine management was not audited. The service committed to making the necessary improvements. Staff helped people to receive medical assistance from healthcare professionals.

Staff were recruited safely and provided with a robust induction. They had enough training and supervision to provide people with effective care. Staff worked flexibly to ensure continuous care provision and visits were consistently covered. The service had contingency plans to ensure continuity of care in the event of an adverse event, such as bad weather.

People were supported by people who were kind and caring. They treated people with dignity and respect. Staff ensured that people were given support to eat and drink in line with their health needs and their preferences. People were involved in their care planning and staff delivered care that responded to their needs and wishes. Staff routinely sought people's consent before undertaking tasks and they offered people choice. Staff supported people to be independent where possible. Where people were unable to make their own decisions, staff provided the appropriate support. The files we reviewed lacked information concerning

best interests' decisions taken under the Mental Capacity Act 2005 (MCA).

Management strove to ensure the service was well led. They created an open and trusting culture. Staff and people felt they could raise concerns without fear. People knew how to complain if they wanted and felt confident that management would resolve any issues arising. Staff were happy working at the service and they felt supported.

The service's governance systems required some improvement to ensure the quality of care delivery was routinely and formally monitored. The documentation in people's care files required additional information to inform staff how to manage risks safely. Formal feedback systems were also required. The service advised they would implement these improvements as soon as possible.

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 consistently safe.

The systems in place to ensure the safe administration and recording of medicines were not routinely effective. Medication errors were not routinely reported in line with local authority requirements.

People's safety was risk assessed but care records did not contain clear information on how to mitigate identified risks.

Staff demonstrated an understanding of how to recognise and report potential safeguarding concerns.

The service ensured there was consistently sufficient staff to cover visits.

Checks on staff before they started working for the service were robust.

Care staff maintained good infection control.

Is the service effective?

Good

The service was effective.

People's needs were routinely holistically assessed.

Staff training and supervision enabled effective care to be given. Competence assessments and observations were not being routinely undertaken though.

People received support to eat and drink in a way that met their needs.

Support for people's healthcare needs was provided.

Consent was obtained in line with the relevant legislation. Record-keeping relating to people who lacked capacity needed to be improved.

Is the service caring?

Good

The service was consistently caring.

People were treated with kindness and respect.

People were supported to communicate their care choices.

People's independence was encouraged and their dignity was upheld.

Is the service responsive?

Good

The service was responsive.

The service demonstrated that care was routinely delivered to meet people's individual needs and preferences.

People were involved in the assessment of their care.

People's complaints and concerns were investigated.

The service should ensure initial discussions about end of life care and wishes are held and recorded.

Is the service well-led?

Good

Management created an open and inclusive culture of care delivery.

Staff felt valued and involved in care delivery.

The governance systems in place to monitor the quality and safety of care needed development in some areas.

Some improvements were needed to the information held in people's care files.

The service sought to improve and learn from incidents arising.

Service users and relatives felt comfortable to provide comments about their care.

The service was involved in partnership working.

Heart to Heart Home Care Agency

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 team consisted 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 care service.

On 17 December 2018 our expert by experience rang people to obtain their feedback about the service. On 18 December 2018 an inspector visited the office to speak with the registered manager and view certain records. We gave the service 48 hours' notice of the inspection visit to the office because we needed to be sure that the registered manager would be available to talk with us. Follow-up communication with the registered manager relating to the inspection occurred on 19 December 2018.

Prior to this inspection we reviewed the information we held about the service. This included important events the service must tell us about by law and feedback we received from the commissioners of the service. We used information the provider sent us in the Provider Information Return. This is 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 spoke with four people who used the service and five relatives, one senior care assistant, two care assistants, the registered manager and the office manager.

The records we viewed included four people's care records, three people's medicine records, two staff recruitment records and staff training records. We also viewed policies, complaints, compliments and quality assurance documents.

Requires Improvement

Is the service safe?

Our findings

We have rated this area as requires improvement. This is because the service did not consistently manage safety risks, including those relating to medicine management and administration. We also found that safeguarding issues were not reported in line with local authority policy.

Care files demonstrated that the service had explored areas of potential risk to people's safety such as communication, use of equipment, medical conditions, dietary requirements and mobility. There was, however, a lack of detail provided about the identified risks people faced and how these should be mitigated. For example, one care plan stated that a person had a condition affecting their eyesight. The extent to which the person's eyesight had deteriorated was not clear though. A risk assessment indicated the name of the condition they were living with but it did not clarify the potential risks this created for the person's safety. There was no information to inform staff of the measures they should take to enable them to safely manage the person's care.

In spite of this, a care assistant was able to describe in detail the measures they took to provide safe care to this person. We spoke with two members of staff about another person who was at risk of falls. They both demonstrated a good understanding of the measures needed to ensure this person did not come to harm. The registered manager told us they were clear how safe care should be provided to each of the people using the service. They told us that they relayed this information to staff verbally and it was discussed when staff were introduced to the person. The registered manager acknowledged that this information should be documented fully in people's care files. They advised that all care files would be updated promptly.

We viewed the Medicine Administration Record (MAR) charts and associated records for three people. These showed that the service did not routinely support the safe administration and management of medicines. They demonstrated that staff did not routinely comply with the service's medicine policy or with the local authority medication policy.

One person's MAR chart showed poor recording practice as it contained many gaps and crosses, as well as signatures. Recording instructions state that a cross should only be used when a person is due their medicine but refuses to take it. Such occurences should be accompanied by a record of the date, the medicine and an explanation for the refusal. The registered manager confirmed there were four instances when the person had refused to take a prescribed medicine. It was, however, not possible to establish when this was. This was because there was no documented record of the date and reason for the refusal. It was also due to staff entering a cross when the prescribers instructions stated there was no need to administer the medicine. In this event, a gap should have been left on the chart. This meant that the chart was not a reliable record of the person's medicine history for that month.

One of this person's medicines was a once weekly dose and it should not have been given at the same time as one of their other daily medicines. This person's MAR chart indicated that for one week both medicines were given at the same time. The registered manager recognised this was an administration error. Another medicine was once not signed for or documented in the accompanying visit sheet. There was a gap on the

chart. It was therefore not clear if the person had received the medicine at this time.

The MAR chart of a second person indicated they had been incorrectly given two doses of a blood thinning medication in September 2018. The registered manager said they were certain this was a recording error. There were no signs that the person had suffered harm and records showed that their subsequent blood results remained constant. This situation could have posed difficulties had the service needed to investigate the matter. The registered manager was aware of the need to speak with a healthcare professional if errors occurred which posed a risk.

People's care files contained information about people's health conditions and the medicines they were taking. This included medicines which were to be taken as required. The service had an appropriate policy in place relating to this type of medicine. Records viewed did not reveal any concerns about medicines administered in this way. People's care records also indicated whether staff should prompt people to take their medicine or whether it would be administered. They also stated when family members would assist with medicine.

The registered manager told us that they checked medical records to ensure they were being completed correctly when they undertook care visits. We saw evidence of this in extracts from a 'communication log', which is used by staff and kept in the person's home. These showed that staff had been reminded by the registered manager to use their signatures and to provide an explanation if a medication was refused. Minutes from a team meeting also showed that the registered manager had reminded staff to sign charts with their initials. Routine and documented medicine audits were not taking place though. The registered manager also told us they checked the storage and stock levels of medicines during their care visit. There were no records to reflect this activity either.

The lack of regular documented checks on medicine administration, recording, storage and stock levels in people's homes presented a potential risk. The registered manager acknowledged this shortfall and committed to the prompt development of a formal system of auditing.

Training records showed that all members of staff had received recent medicine training. Staff had not, however, been competence assessed in their administration of medicines or recording practices. The registered manager acknowledged this needed to be undertaken urgently and said they would start assessing staff.

None of the medicine errors we discovered had been referred to the Local Authority Safeguarding team. The registered manager was unaware this was a Local Authority requirement. They said they would ensure medicine errors which represented a potential risk to people's safety would be referred to the Safeguarding Team. They also confirmed they would notify the CQC of all safeguarding referrals.

The service had processes in place to help protect people from the risk of abuse. Each member of staff we spoke with could describe the signs or symptoms that may indicate a person was being abused. Staff had received recent training on safeguarding and understood that any concerns needed to be escalated immediately in line with the service policy. The contact details of the safeguarding team were visible on the notice board in the office. We reviewed the minutes of a team meeting during which there was a discussion about a potential case of abuse. The minutes demonstrated that staff had recognised possible signs of abuse and that the registered manager understood how to deal with the concerns raised.

We reviewed the details of staff files for two members of care staff. These demonstrated that there were processes in place to help ensure that only staff with suitable background, experience and skills were

employed. This included the use of a suitable application form, interview, the review of the applicant's identity, employment history and the review of two references. The service also undertook appropriate checks with the Disclosure and Barring Service (DBS) prior to the offer of a position. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

We spoke with two members of care staff and they both told us they were given a good induction to their role. They were able to shadow other care staff so they could meet and get to know the care needs of the people they would be caring for. They also undertook initial training in medicines, safeguarding, moving and handling and data protection. A new member of staff told us they were completing the Care Certificate. This applies across health and social care and sets a minimum standard that should be covered as part of induction training of new care workers. The registered manager confirmed that all new staff were inducted in this way.

People's care files showed that any risks associated with staff carrying out their roles had been assessed and managed. In one person's care file it stated, "Carers to take torch in winter advised to turn around in driveway instead of reversing out." The service had a lone-working policy and all staff were provided with a mobile phone.

The registered manager told us it was a challenge to maintain staffing levels but they were always able to meet their client's needs. There were no missed calls reported. The registered manager undertook some care visits them self. They said it was important to regularly see people being cared for so they could speak directly to them if they wanted to. The service did not use agency or bank staff. We viewed staff rotas which showed that there was consistently enough cover for the visits. Staff rotas were created a month in advance which helped ensure all care visits were always covered. Care staff told us there were enough staff in place across each of the shifts to meet the needs of the people. People we spoke with told us that they felt safe being cared for by staff from the service. One person said, "These staff are very nice and I feel safe, they always phone me if they are going to be late."

The service had a contingency plan in place to counteract adverse events such as bad weather or widespread illness. Each person was risk-rated according to their dependency level to ensure those with the highest needs and without a relative nearby were prioritised. The registered manager stated that wherever possible they sought to appoint staff who lived in one of the two areas of service provision. This meant that in the event of bad weather they would not have too far to travel to ensure care delivery remained uninterrupted.

Each member of staff we spoke with said they routinely used appropriate personal protective clothing including gloves, aprons and shoe covers. They all demonstrated a good understanding of infection control procedures.

Care staff were not sure if there was an accident and incident reporting procedure but each person we spoke with said they would report such events to the registered manager immediately. The service held an incident log which we viewed. The log clearly summarised relevant information relating to reported incidents. This included who and when it was reported by, who was involved, the implications of the incident, the method of resolving it and the outcome. Furthermore, the office manager sought and documented feedback from the person or their relative on the actions taken in response. The layout of the log sheet enabled the registered manager to easily gain an overview of issues arising or people involved. This meant they could quickly identify any patterns or trends.

The service took appropriate actions to respond to the incidents raised. The registered manager told us that incidents were discussed with staff to ensure they did not reoccur. This was confirmed by the minutes of a team meeting we reviewed. We could see that the manager learnt lessons if things went wrong and shared the learning with staff.

Good

Is the service effective?

Our findings

We have rated this key question as good.

We saw detailed pre-admission assessments in each person's care files which contained information about people's physical, mental and social needs. We also received positive feedback from a local authority commissioner, for whom the service has taken on care packages. They told us, "[Registered Manager] and their team have been very helpful and professional visiting the clients and ensuring that they can meet the individual needs before accepting the provision of care."

We reviewed staff training records and spoke with care staff about their training and professional development. A training log showed that experienced members of staff had undertaken recent re-fresher training in each of the areas covered by the Care Certificate. One relatively new member of staff was working towards completion of this Certificate. The staff members we spoke with told us they felt the training they received was good and gave them the skills they needed to provide people with effective care.

People we spoke with felt the staff employed by the service were well trained. One person told us, "Staff often said they would be going on a training course.". A relative said, "I have no worries, and I feel the staff are trained."

The registered manager told us that they encouraged staff to request training to help their development and skills. Staff said they felt able to ask for additional training and were confident it would be arranged for them. The registered manager had been proactive in attending training courses so they remained up to date with data protection and governance legislation.

The office manager and registered manager jointly held supervision meetings with each member of staff every three months. The staff we spoke with said these were helpful and that they could speak openly about any support they felt they needed. Supervision records showed that the meetings followed a structured approach and that discussions were documented. Staff told us that the registered manager observed them delivering care but it was not clear how frequently this occurred. Medication competence assessments and care observations should be routinely undertaken and recorded.

Where the service supported people with their meal preparation, people told us this was done to their satisfaction. People's care plans confirmed that their eating and drinking needs had been assessed and their preferences were documented. For example, one person's plan stated, "I am not a big eater so I need encouragement to eat, if carers could ask me what I want, as sometimes I don't fancy a big meal just soup or sandwiches or if I feel hungry I might want two hot meals lunch and evening.' The comments from one relative indicated that the service gave effective support to meet their relative's dietary needs. The relative told us, "The care for [person] by the manager and staff around meals is very good. It has to be home cooked as [person] has allergies and the item can be found in most foods. I feel the agency goes the extra mile to support [person] as far as food is concerned."

Staff routinely encouraged people to maintain a healthy intake of food and fluid. All members of staff we spoke with were aware of the importance of people eating and drinking enough. One care assistant told us, "We always make sure there are plenty of fluid and snacks." The office manager also told us that they shared relevant health and safety advice with the people and staff. This included advice on how to maintain hydration levels during the hot summer months. A member of staff explained one of the ways they encouraged people to eat, "I like to make sure the meals are nicely laid out so it looks more appetising." A person's visit log sheets showed that they were routinely asked by staff what they would like to eat. They also revealed that the person benefitted from a varied and healthy diet.

The service supported people's health needs by working with healthcare professionals. The staff we spoke with demonstrated that they had a good understanding of people's individual health conditions. One member of staff told us they liaised with a district nurse and an occupational therapist to arrange for a person to have a more suitable pressure mattress. Another member of staff told us they knew how to monitor potential problems associated with a person using a catheter. If they had any concerns, they would advise the person's next of kin to call the district nurse immediately. People and their relatives confirmed that staff assisted with external health care support. One person spoke about staff accompanying them to see the GP when they needed them to. Another relative told us, "Staff will call health professionals if needed." People's care files did not contain a 'transfer record', which would facilitate a safe transfer should the person suddenly become hospitalised. The manager said these would be created.

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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Care staff we spoke with told us that most of the people they supported were able to consent to their care and make their own decisions. One member of staff recognised that people's ability to do so could fluctuate. They said that in this event those involved in the person's care would need to meet to review their care needs. Staff we spoke with understood what capacity meant. A member of staff told us if someone did not have capacity, they would give them choice and help to them reach their own decisions. One staff member explained how they supported a person who lacked capacity. They told us. "I ask them to repeat themselves, or I speak slowly, sometimes we point to things. I spend time with them so we get to know each other better" This evidence suggested that care staff were aware of and worked in accordance with principles of the MCA.

The service supported three people who had a legal power of attorney in place to make decisions on their behalf. The registered manager confirmed that the legal power of attorney related to health and welfare in each case. We were told that none of the people using the service were subject to a Court of Protection order to deprive them of their liberty. We viewed the care file of one of the people who lacked capacity. Records showed that that an assessment of their capacity had taken place where it was felt they may require support to make decisions. The registered manager confirmed that best interest decisions had been made with the relevant people involved. However, there was a lack of information to support this. The care plan also required more detail to explain how staff could support a person who lacked capacity or whose capacity fluctuated.

Good

Is the service caring?

Our findings

We rated this key question as Good.

The registered manager told us that as far as possible, people using the service were allocated staff to match their personalities and gender preferences. They wanted people to feel comfortable and at ease with their care assistants. The people and relatives we spoke with told us that they found the staff caring and kind. People appreciated the fact staff spent time to get to know them and said their care was not rushed. One person said, "The staff are nice, I am happy with the care I am given and we are building a good relationship." A relative told us felt that their family member was happy with the staff relationship. A further relative said, "[Person] is very happy with the care that is given."

The staff we spoke with valued the fact they had long enough during visit times to get to know people well. One care assistant also commented on the benefits of regularly caring for the same person. They said, "Because I'm not visiting a wide range of people, it's nice, you get to know them, it's lovely that you get to know what they like." Staff completed visit sheets and communication sheets in people's homes and we saw examples of both. They were thoroughly completed and served to update care assistants about what had happened during the previous visit. This system helped enable the person to experience continuity of care.

A member of staff told us the registered manager encouraged sensitive and thoughtful care delivery. This was demonstrated when describing how they cared for a person with a visual impairment. They told us, "I tell [Person] what I'm doing because they can't see. They might wonder what the noises are so I tell them everything I am doing. I always say who it is when I walk in the door. It must cause them anxiety otherwise."

All the staff we spoke with, spoke about people with affection. One care assistant told us. "I try my best to make people feel how I would like to be treated by someone. We're in their home, their safe environment, we need to respect that." The registered manager said that the people the service cared for were like family to them. Staff described with pleasure how one person was enjoying using virtual assistive technology. This device had been suggested to them by the registered manager who recognised that it might widen their world. The person was housebound. One member of staff told us, "[Person] loves music. We set up different stations on their radio for them but they couldn't change stations. But with this device, they can ask for different stations. [Person] was so grateful.". A relative we spoke with complimented the staff on their caring approach. Another relative spoke of the dedication of the staff. They told us, "[Person] recently needed an ambulance. I do not live locally. I immediately contacted the agency and they went to [Person] and made sure all was well. The carer sat with [Person] for two hours waiting for the ambulance to come."

People's care plans were personalised and supported the delivery of individualised care which was sensitive to people's wishes. One care plan said "when assisting [Person] with personal care in the bedroom use bowl near bed… [Person] also likes talc on their back. [Person] likes to look nice, they choose their clothes and like things to match." Staff demonstrated that they treated people with respect and were understanding of people's different personalities and wishes. One member of staff told us, "We talk to the person about their

religion, we never stop them from following their religion."

We heard examples from the staff we spoke with of dignified care delivery. The registered manager told us about one person who had become immobile following an accident. They discussed with the person if they would prefer an alternative approach to one aspect of their care. The suggestion offered a more dignified solution to the person's toileting needs. With the consent of the person, the registered manager arranged with the district nurse and an occupational therapist for the changes to be made. A care assistant told us, "Respecting people's dignity is so important, if they are on the bed, you make sure doors, curtains closed, bottom half covered if doing the top. It's so important. If anybody knocks, you say just wait a little while."

Staff respected people's privacy. We noticed that all care files and staff files were kept confidentially in a locked cupboard in the office. A member of staff told us, "If they have family visiting, we act as a guest in their home." and a person said, "The staff treat me with dignity and respect when supporting me with social care."

Staff told us that they routinely gave people choice relating to their care. For example, one care assistant said they would ask the person which shower gel they wanted for washing, what they would like for dinner and what activity they would like to do that day. They said they always checked how the person would like tasks to be undertaken. We viewed the visit logs for one person which confirmed they were offered choice regarding their food and their personal care. A person told us, "The staff always ask me what I would like them to do and we do get on very well.".

Staff told us that they helped people to communicate their choices and decisions about their care. We heard about a person with neurological difficulties who struggled to engage in conversation. The registered manager told us the care assistant needed to listen carefully and wait patiently for them to respond. It was important that they did not try to talk for the person or interrupt them. A member of staff we spoke with confirmed they understood this person's communication needs and supported them as the manager had described.

One of the people we spoke with told us, "I like to be independent when having personal care but I always ask if I need the support of the staff." Staff members recognised the importance of encouraging people to be independent wherever possible. One care assistant told us, "We will let them put their socks on themselves if they can, cut their food up, put their shoes on, choose something on the tv. The main goal is to maintain independence."

Good

Is the service responsive?

Our findings

We rated this key question as Good.

People received care that was person-centred and responsive to their individual needs. The local authority commissioner told us, "[Registered Manager] ensures that the care plans are appropriate and meeting the individuals' outcomes."

Staff we spoke with were aware of how to meet people's needs. They said they gained this knowledge from reading care plans, speaking with team members and the people they cared for. One member of staff was able to clearly explain how to meet the moving and handling needs of one person. They also described how they reduced the risk of the person developing pressure sores. Another member of staff told us that a change in a person's care needs would result in updates to the person's care files. They said smaller changes would be reflected in the person's communication log. All the staff we spoke with commented on the excellent communication between team members.

The care and support plans we reviewed were detailed and reflected people's needs, choices and preferences. People were involved in the creation of their care plan folders. The registered manager told us,"I sat with daughter, wife and [Person] when we were doing the assessment, the daughter was saying, 'You're getting things from them I've not heard before!" All the files we reviewed contained a document entitled 'About Me' which gave staff an overview of the person's likes, dislikes and interests. A document entitled 'Day Support Plan' provided detailed, person-centred information about the person's daily routines. One plan we viewed explained when a person liked to have their daytime meals, their various meal preferences and how to support them to eat enough.

Files also contained documents which detailed medical, communication, mobility and dietary needs and preferences. These documents served as both risk assessment and care plan. In some cases, there was insufficient information to tell carers how to mitigate identified risks. The registered manager said whilst this information was known by all staff, it would be added immediately to care files. An overarching care plan detailing key information about the care to be provided at specific visit times was also needed.

People told us they were aware they had care plans. A relative told us their family member's care was reviewed on a regular basis. We did not see evidence of care plans or risk assessments having been reviewed in the care files we looked at. However, these people had commenced receiving care from the service during 2018. Therefore, their needs may not have needed to be reviewed at this point. The registered manager told us that annual reviews would take place, or sooner if necessary.

Staff encouraged people to pursue their interests and avoid social isolation where possible. We heard about staff enabling one person to be able to listen to a range of music. The registered manager also told us that staff spent extra time with another person to help them get ready for a celebratory outing. They told us that care assistants helped the person with their hair, make-up and jewellery so they felt happy to go out.

The service had a complaints policy which was included in people's handbook. The care staff we spoke with were aware of the complaints procedure. They said they would encourage anyone to document their concerns and or speak with the registered manager. We saw that two complaints received had been investigated and responded to properly. Team meeting minutes showed that learning from the complaint investigations had been shared with staff.

The people we spoke with said they had no reason to complain but knew how to, should the need arise. One relative said, "I would speak to the manager, there are no complaints or concerns about the care that is given." and another relative told us, "I've got no complaints at all. Any concerns, management sort out as soon as possible. They are brilliant."

Care files we reviewed indicated whether people wished to be resuscitated in the event of a cardiac arrest and contained relevant paperwork. They did not contain specific information relating to end of life care or wishes. We reviewed the service's 'End of Life Care Planning Policy and Procedure'. This indicated that individualised assessment, care planning and review should take place as end of life approaches. The registered manager told us that they would discuss end of life care with people if they started to receive palliative care. They described a situation where this had happened. The registered manager said they were committed to respecting the person's wish, which in this case was to stay at home. The registered manager said they liaised closely with a district nurse to ensure appropriate drugs were available. This ensured the person was as comfortable as possible. A member of staff demonstrated an understanding of how to care for someone who was approaching the end of their life.

Good

Is the service well-led?

Our findings

We have rated this key question as Good.

The staff and people we spoke with talked positively about the management at Heart to Heart. One person told us, "Management looks after its staff. It's run well." and a relative said, "Everything I ask for happens so I am more than happy with the care given." People said they were visited by the registered manager and had confidence in them. It was clear that all staff we engaged with understood and shared the values of the service. We heard from staff who were committed to providing person-centred care with compassion and respect. One care assistant told us, "The number one thing is to have duty of care, that the person is cared for as they should be." People told us staff worked flexibly to meet their needs and they were very content with the service provided.

The staff we spoke with said they the team worked very well together. They showed enthusiasm and dedication to their roles. One staff member told us, "I really do love it. It's the first time I've done care. It's the best thing I've ever done." Another member of staff said, "If I've needed some advice I can talk to other staff members, everyone really supports each other." There was daily contact amongst staff and management by telephone and in person. The service also used a secure method of communicating electronically. This enabled messages, suggestions or concerns to be relayed quickly and it promoted discussions. The staff we spoke to all said how much this helped them in their work. A care assistant told us, "The communication between the team is amazing. Just at the end of the phone. I check the teams forum. I've never seen anything like it. I can catch up with everything when I've not been at work. The communication logs are really good too."

Staff felt supported and said they could talk openly with management. A member of staff told us, "I love my job, my opinion is respected and I feel valued." Team meetings were usually held monthly and were well minuted. They showed that staff and management were regularly discussing care delivery, training, updates and sharing ideas. We saw evidence from the minutes that lessons learnt from incidents arising were shared with staff.

The registered manager was experienced in care provision and understood their regulatory duties. They had reported a notifiable event correctly to the CQC and sought advice if they had concerns. This demonstrated a responsible approach to managing the service. They had alerted people and relatives to any issue arising, explained their investigation and outcome reached. This showed they understood and were meeting their duty of candour.

Everyone we spoke with said they felt comfortable to raise concerns with management or make suggestions. People and relatives said they were asked for their views about their care verbally. The service had not sought formal feedback from people, their relatives, staff or health care professionals. The registered manager explained this was mainly because the first year of operational care delivery had been very busy. They said they would start collating documented feedback this year.

Quality management processes were not fully developed and formalised. There was an absence of regular, documented auditing of medicine administration and records, visit sheets and communication logs. The registered manager undertook checks on medicine and visit records but these were sporadic and not documented. The registered manager planned to commence regular audits to check care is being delivered in accordance with care plans and safely. The audit results would be regularly analysed to drive improvement.

We identified that some improvements were needed to the content of people's care files. They did not contain clear information about how to manage people's risk or give a clear overview of people's care package. They also needed to contain information relating to decisions made in people's best interest if they lacked consent. A record detailing initial discussions about end of life care was also needed. The registered manager informed us these improvements would also be acted upon promptly.

The registered manager was committed to attending training and support sessions to ensure the service delivered quality care and was well managed. Management staff kept up to date with changes in legislation and industry best practice. For example, attendance at data protection training ensured the service complied with recently introduced regulations. This training resulted in improvements being made to staff employment and recruitment files. We saw evidence that the service adopted good practice in respect of maintaining people's confidentiality. Care files contained the minimum amount of personal data required and appropriate caution was taken with electronic communication.

Management staff and the senior care assistant attended Norfolk and Suffolk Care Support meetings. They found these a useful way to gain and share knowledge. We heard that the service worked well with other agencies. The local authority commissioner commented on their collaborative working relationship with the service.