Goodhands Commcare Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Goodhands Commcare Ltd is a domiciliary care agency registered to providing personal care. At the time of the inspection three people were receiving care.

People's experience of using this service and what we found
Medicines were not managed in a safe way. There continued to be no risk assessments about people's health conditions or concerns even though we specifically wrote about this in our previous inspection report. This meant people were not kept safe as staff did not know about risks to them. There had been one incident since our previous inspection, but it had not been recorded appropriately. Not all staff had completed safeguarding training. Staff recruitment application forms lacked information such as their employment histories. There was little documentation in relation to Covid-19. What there was, was inadequate and the provider was unable to evidence learning around pandemic specific infection control with neither updated risk assessments for people or staff.
Oversight of staff training had been neglected and records were out of date, though these were updated during the inspection. Staff had not completed training the provider deemed mandatory. Staff were relatively new and there was no record of their having been supervised or properly inducted into the service. Daily notes were completed when staff cared for people, however, we found one instance when this had not occurred.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. The provider had completed consent agreements with people but there was a lack of information in people's care plans about their ability to make choices for themselves. People's preferences around food and drink were recorded and people were supported by staff to eat, though not all staff had received training in this area which the provider had deemed mandatory.

There were numerous shortfalls in the service the provider had failed to address. Care plans were not up to date and had not been reviewed for six months prior to our inspection. They were updated during the inspection. Quality assurance processes, including audits, surveys and spot checks, were not completed regularly. The provider had told us at our previous inspection they would employ a registered manager and had failed to do so. Meetings had ceased to occur frequently and actions arising from them were not recorded properly with no staff being held responsible for them. The provider had failed to draw up a contingency management plan after being specifically requested to do so and had failed to register their service location correctly. The service had drawn up a service level agreement with another provider so as to evidence their working with others but had not joined any forums or organisations to support innovation at the service and had not recorded details of some health care professionals who supported people using the service.

Relatives told us staff were caring and thoughtful when supporting people. Following our inspection, the

provider decided to voluntarily cancel their registration as a health and social care provider and subsequently supported people to transfer their care to other providers.

Rating at last inspection and update
The last rating was inadequate (published 01 April 2020) and there were multiple breaches of regulation. The provider failed to complete actions set out in an action plan that we requested after the last inspection to show what they would do and by when to improve. At this inspection we found only minor improvements had been made and the service remained inadequate.

This service had been in Special Measures since 01 April 2020 and remained so until their registration was cancelled on 19 November 2020.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
Please see the action we have told the provider to take at the end of this report. We will not be pursuing regulatory action as the provider has cancelled their registration.

Follow up
The overall rating for this service is 'Inadequate.'' As the service is no longer registered to provide a regulated activity we are not pursuing further enforcement action.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Goodhands Commcare Ltd

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. The service did not have a registered manager in place. 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.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and staff are often out and we wanted to be sure there would be people there to speak with us.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the sole director for the service. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment and

staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included speaking to two relatives about their experience of care provided.

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At the previous inspection the provider hadn't taken steps to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● There were shortfalls in the management of people's medicines. Whilst relatives told us they were content with how staff administered medicines, we found that medicines were not managed appropriately. One relative told us, "No issues or concerns with them doing medicines. As [previously] stated it's not complicated and [person] has never missed out." However, although people told us this, we found errors on people's Medicines Administration Record (MAR) sheets.
● One person's MAR sheet lacked the frequency with which to take a specific medicine. This meant it was not clear how often a person should take their medicine. We also found a gap on the same MAR sheet where staff had not recorded whether a person had taken one of their medicines or not. Daily logs indicated the person had taken their medicine, but this information should have been recorded on the MAR sheet.
● As highlighted in our previous report, the service was still not following their own medicines administration policy. This policy stated people should have medicines needs and risk assessments. These assessments would provide beneficial information to support people with their medicines. However, medicines needs and risk assessments were not in place for people.
● At our previous inspection we found medicine audits did not include auditing MAR sheets. At this inspection we saw MAR sheets had been audited but this had not done since August 2020. This meant the service had not picked up on errors or omissions which potentially put people at risk of harm.

We found no evidence that people had been harmed, however medicines were not being managed safely. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We told the provider about our concerns about medicine management on the first day of our inspection and they corrected errors by our second day and also completed a further MAR audit.
● Since our last inspection improvements had been made to care plans with respect to medicines people took. Each care plan contained detailed information about the type of medicine people took, why these

types of medicines were prescribed and their side effects.

Assessing risk, safety monitoring and management

At the previous inspection the provider hadn't taken steps to fully assess and mitigate risks to people's health and safety. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 due to their lack of risk assessment and safety monitoring.

● At our previous inspection risks to people were not recorded. At this inspection we found some improvement with risks noted for people's mobility, potential environmental risks and nutrition and hydration, but these assessments still lacked mitigating factors to support staff should things go wrong, and some risks were omitted entirely.
● For example, although specifically mentioned in our previous inspection report, there were still no risk assessments for people's health conditions. For example, one care plan stated a person had a cardiovascular disease resulting in their taking blood thinning medicines. Risk assessments for this person neither specifically highlighted the risks around the person's cardiovascular disease nor their blood thinning medicines.
● Similarly, another person had a condition which resulted in low counts of all blood cell types. The person's care plan merely listed the condition but did not explain what it was or what it could mean to the person and what the risks were of having the condition. This meant that people were not kept safe as staff would not know how people's health conditions affected their lives and the risks associated with their conditions.
● Care plans and risk assessments had not been updated for six months. People's health had changed during this time with one person beginning to use an assistive aid and another person having had a hospital admission. Care plans and risk assessments did reflect any changes in people's health and risks to them.

We found no evidence that people had been harmed however, the provider had not assessed the risks to the health and safety of service users of receiving care or treatment. This was an ongoing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the first day of our inspection the provider told us their inability to maintain up to date information on people was due in part to their taking on caring responsibilities and not being able to focus on management tasks. They wished to show they were receptive to improvement and sought to update care plans and risk assessments by the time we returned for the second day of inspection. However, they had not completed risk assessments for people's health conditions.

Learning lessons when things go wrong

At the previous inspection the provider had not learned lessons when things went wrong. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 because they hadn't made improvements when things had gone wrong.

● At our previous inspection we found the service had not always acted upon incidents and accidents

appropriately. Repeating what we discovered previously, we were told by the provider there had been no incidents or accidents since our last inspection.
● However, we asked whether the provider had needed to call emergency services at any point, and they told us they had to call an ambulance for one person who was subsequently hospitalised. This was later confirmed by a relative who told us, "Once [provider] called an ambulance for [person]."
● Whilst we commend their support of people and seeking the right assistance for them, staff neglected to record this incident either as an incident or in the daily logs. There was no record of accidents or incidents being discussed in team meetings. As a result, lessons could not be learned and the potential for reoccurrence of things going wrong was not mitigated.

We found no evidence that people had been harmed however, the provider had failed to ensure incidents that affect the health, safety and welfare of people using the service had been reported and reviewed. This meant lessons would not be learned when things went wrong. This was an ongoing breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● There was little evidence the provider had introduced additional measures to support people and staff during the Covid-19 pandemic. We saw one template which the provider stated they could use to monitor people's potential Covid-19 symptoms however this needed modification due to General Data Protection Regulation (GDPR) considerations. Following our advice, they changed this template.
● During the recent pandemic we had asked the provider to ensure people's risk assessments were updated to reflect potential impact on them, their health conditions and whether they needed to shield due to increased risk of infection. This had not happened.
● Similarly, we noted they were no Covid-19 specific risk assessments for staff even though they could potentially be at more risk due to their ethnicity.
● There was no record of staff having undertaken Covid-19 specific training or correct Personal Protective Equipment (PPE) training, though one staff member did complete some infection control training during the inspection which contained information about Corona Virus. Whilst we saw there was PPE available at the service, we were unable to establish whether all staff were aware of the potential risks of Covid-19, knew about the need to wear PPE when providing care or whether they knew how to wear PPE correctly.

We found no evidence that people had been harmed however, the provider had not ensured there were infection prevention and control measures in place This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels
● At our previous inspection we found staff recruitment practices were not robust. At this inspection, similar to the previous one, we found incomplete application forms and gaps in people's employment history. Staff were recently employed and had little experience working in the adult social care sector. The provider had not assured themselves whether employees were suitable to work with people.
● Staff had completed Disclosure Barring Service (DBS) checks. DBS checks assist employers by providing information about potential employee's criminal histories and help prevent unsuitable people from working in care services. The provider had also completed identification checks on all employees.
● Relatives told us there were enough staff and that they were punctual. One relative told us, "They have never let us down. Even [provider] coming in and makes sure they are on time." We saw the staff rota and saw all calls were covered. We completed this inspection over two days to support the provider who themselves provided care to people using the service.

Systems and processes to safeguard people from the risk of abuse

● One staff member was providing care having had no safeguarding training. We pointed out to the provider the risks inherent in allowing staff who had no knowledge of safeguarding to provide care. The provider ensured the staff member completed their training during the inspection.

● The provider had completed a one-day training course titled Mandatory and statutory training. This covered numerous topics including health and safety, the Care Act 2014, and safeguarding as well as many others. We advised the provider seek further training from the local authority and/or other sources to ensure they knew what to do to ensure people in their service were kept safe and staff were supported to do the same.

People had not been protected from abuse and improper treatment. 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.

● Relatives told us they thought staff support people to stay safe, One relative said, "Yes I think so [staff keep people safe]." The provider had raised one safeguarding alert since the previous inspection. They had notified CQC about the alert.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff skills, knowledge and experience

At the previous inspection the provider hadn't taken steps to ensure their staff had the knowledge and skills they needed to fulfil their roles. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation.

● Staff were not always provided with the right training to do their jobs, though relatives thought them knowledgeable. One relative said, "They were knowledgeable for [person]'s care." The provider had a list of training subjects they considered mandatory for all care staff. On the first day of our inspection we saw the provider had not kept an up to date record of people's training. This meant they did not have a clear overview of what training staff had done. They updated it by the time we returned on our second day.
● When the provider had updated their training record it showed that no staff had completed all their mandatory training, including the provider themselves, who was also providing care duties. There was no action plan to ensure staff would complete training though we were given assurances by the provider these would be done by the end of the week of the inspection. The provider cancelled their registration following the inspection, so this did not happen.
● Two staff members had not completed training on first aid, health and safety, fire safety awareness, food hygiene, equality, diversity and human rights. One staff member had not completed any safeguarding training. This meant staff may not always have known how to care for people correctly as they had not been trained to do so.
● We asked the provider about new staff induction and we were told staff had received an induction by shadowing the provider, but this had not been documented. This meant it was not clear whether people had received a consistent standard of care as new staff may have learned different things when they began work. People receiving care could not be assured staff knew what they were doing when they started work.
● The provider told us no current staff had received supervision and only one former member of staff had received one supervision. The provider's two staff had been employed for under two months but there was no record of any guidance received directly from the provider to ensure they were supported in their roles.

We found no evidence that people had been harmed however, the provider had not ensured all staff were competent and skilled to complete their roles. Staff were not supported with their development. This was an

ongoing breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We noted a concerted effort was made to complete some training during the inspection.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.
● At the time of the inspection care plans identified no one receiving care had dementia or had conditions which would affect their capacity. This was later confirmed by relatives. However, people's capacity to understand and make decisions was not overtly recorded in care plans. This meant staff would not always know whether someone had capacity or not.
● Care plans recorded whether people had given Power of Attorney (POA) to others, such as relatives. However, we saw no actual evidence of POA in people's files. On the first day of inspection we told the manager it was not apparent whether people had been involved in the creation and review of care plans as they had not signed them. Care plans were updated and signed as reviewed during our inspection.
● We saw care plans captured what people said directly in quotes which indicated their input in the completion of care plans. There were consent agreements for people and also signed Do Not Attempt Resuscitation (DNAR) documentation. This meant people had agreed to receive care from the service as required by law and the service had recorded their future wishes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● When the provider had bought the service from the previous owners in February 2020, they had reassessed people's needs. Assessments covered what was in people's care plans at the time and recorded people's needs. They also determined whether the service could meet those needs.
● Care plans focused on health needs such as people's mobility and communication skills. People's protected characteristics were recorded ensuring the service provided care in line with the law.
● There had been no new people admitted to the service since our previous inspection. The provider told us they did not have an assessment template though we signposted them to where they could obtain one.

Supporting people to eat and drink enough with choice in a balanced diet
● Relatives told us people were supported to eat and drink. One relative told us, "They feed [person] food I prepared. No issues with that." People's food preferences were written in their care plans including whether they had special requirements with their diet. However, we noted two staff had not undergone the specific training around nutrition and hydration, which the provider deemed necessary. However, fluids and nutrition are a component of the Care Certificate, a nationally recognised qualification for staff who are new to working in the care sector, which staff had completed by the end of the inspection. This meant staff were able to support people with their dietary needs.

Staff providing consistent, effective, timely care within and across organisations; Supporting people to live healthier lives, access healthcare services and support

● Relatives told us there was effective communication with staff. One relative said, "They wrote in a book and I saw the times the carers came and what they did." Staff recorded information in daily notes and the communication book so other staff and relatives knew what care had been provided. However, we found one instance where this did not occur, when emergency care had been sought by the provider to support someone using the service. The provider told us they had not completed the daily note as they were preoccupied supporting the person.

● People were supported to access healthcare when necessary, though the provider could improve their working in this area as they had failed to record the details of professionals in people's care plans. We saw evidence of people being supported by other health and social care professionals, such as district nurses and social workers. However, care plans did not always contain contact details for these professionals. This meant potentially important information might not be shared among professionals. The provider updated this information during the inspection.

Inadequate

Is the service well-led?

Our findings

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. 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 are clear about their roles, and understand quality performance, risks and regulatory requirements

At the previous inspection the provider had failed to maintain accurate records in relation to the management of regulated activity. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

- The service did not have a registered manager. Following the previous inspection, the provider had told us they would apply to be a registered manager, but this had not been successful, nor had a manager been employed.
- Shortfalls in the service were found at the previous inspection, following which a letter was sent to the provider specifically requesting an action plan detailing what improvements they would make to the service. Although the provider sent us a action plan, we found it was no longer being followed.
- The desired outcomes in the action plan had not all been achieved or had not been maintained. This included quality assurance audits not being completed or kept up to date nor care plans being reviewed for six months. For example, monthly medicine audits had not taken place for past three months nor had any audits been completed on care plans or staff files, which may have highlighted the omissions we found.
- During the inspection the provider told us of numerous actions which they had completed but had not recorded - as best practice would dictate. These included calling an ambulance but failing to record it as an incident and also failing to record inductions for new staff. As these were not in written format we could not confirm what had taken place or when.
- CQC completed an Emergency Support Framework (ESF) call with the provider during the first lock down of the Covid-19 pandemic. This call was to receive assurance people at the service were being cared for in line with pandemic government guidance. The provider agreed at the ESF call in June 2020 to draw up a written contingency plan, this was still not in place at time of inspection. This was particularly concerning given the risks of the pandemic. The provider agreed to draw up a contingency plan following this inspection though this did not occur due to cancellation of their registration.

We found no evidence that people had been harmed however, the provider had failed to maintain accurate records in relation to the management of regulated activity. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they believed many of the concerns we found at inspection arose from staffing issues. They told us the deputy manager who had previously been in place had left at short notice which resulted in the provider undertaking care responsibilities for people. Their departure had a detrimental impact on completion of management tasks. The day following our inspection the provider decided to cancel their registration. They ensured people were cared for until transfer to new services.

● During the ESF call CQC made to the provider they had been reminded about their location being incorrectly registered. Providers have a statutory duty to notify CQC when they change location address. This reminder was in addition to numerous emails which had been sent to the provider reminding them to officially notify CQC of their location change. The provider had made an attempt to complete this registration but failed to complete this process.

This was a breach of section 33 of the Health and Social Care Act 2008.

Engaging and involving people using the service, the public and staff; Continuous learning and improving care

At the previous inspection the provider had not ensured there were sufficient quality assurance measures to assess, monitor and improve the quality of care provided. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

● We saw the provider had completed some spot checks, but these appeared infrequent and had not been completed since August 2020. Whilst the provider themselves was providing care for people and therefore in regular contact with them, they had not observed new staff completing their roles.
● We saw people had completed surveys or service review forms, however as with other quality assurance processes these were not done routinely and regularly. These forms were also not always completed correctly with dates and time often not filled in.
● Staff meeting minutes had been regularly kept until July 2020 but these had ceased to be recorded from that point on. There were no standard agenda items on minutes, such as safeguarding and incidents and accidents, and there was no record of whether actions were followed up by staff.

We found no evidence that people had been harmed however, the provider did not ensure there were sufficient quality assurance measures to assess, monitor and improve the quality of care provided. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong; Working in partnership with others
● Following this inspection the provider cancelled their registration with CQC. They supported people to transfer to new care providers and ensured care was provided to them until they were transferred.
● The provider was able to evidence their working with others. This included a service level agreement with a fellow care agency. There was evidence in daily notes of supporting people with other professionals. However, the service had not always recorded contact details for other professionals and had not joined any networks or organisations as advised at the previous inspection. This was obviously hampered in part by the Covid-19 pandemic.

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	Section 33 HSCA Failure to comply with a condition the provider had failed to register their location correctly.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not kept safe; medicines were not managed safely. Risks to people were not assessed. Safeguarding training had not been completed. Accidents and incidents were not recorded appropriately. Regulation 12

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff caring for people had not been trained in Safeguarding. Regulation 13 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had not maintained contemporaneous records. The service had not completed required actions. The service had

not maintained quality assurance processes.

Regulation 17 (1)(2)(a)(b)(c)(d)(3)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Oversight of training was insufficient and staff had not completed training the provider deemed mandatory. Staff induction was not recorded and staff had not received supervision. Regulation 18 (1)(2)(a)