HH Community Care Limited

Helping Hands - East Northumberland

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16, 17, 18, 20, 23 and 24 April 2018 and was announced. This was the first inspection of the service since changing the branding and moving into new premises in Cramlington under a new registration.

This service is a domiciliary care agency based in Cramlington, Northumberland. It provides personal care and other additional support to people living in their own homes throughout the east of Northumberland. Services were provided to adults with a wide range of health and social care needs including physical disabilities, sensory impairments, learning disabilities, mental health needs and dementia.

At the time of our inspection there were 597 people receiving a service which was regulated. Not everyone using Helping Hands – East Northumberland received a regulated activity; The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where people receive other support we do take this into account as part of any wider social care provided.

The service had a registered manager in post. The registered manager has been in post since before the service first registered in November 2017 and was well established. A registered manager is a person who has registered with the CQC 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.

Medicine management had improved in some areas with the implementation of new paperwork, but we found further issues that needed to be addressed, including for example, the accurate completion of medicine administration records.

There was no travel time between care calls and missed calls could not always be monitored robustly. We had previously spoken with the provider about this at their other location in the West of Northumberland and they were in the process of purchasing a new upgrade to their IT system which would address these issues.

People told us they felt safe with the care staff who supported them. Staff told us they would report any concerns about the people they cared for and staff had received suitable training. Any safeguarding incidents had been fully recorded and investigated.

There were enough staff employed and the provider had continuous recruitment drives in place to maintain this. People reported that continuity of staff was an issue on occasions, but from the records we checked, scheduling staff had tried their best to main the same care staff. The provider also said the new IT system will further improve this.

Risk assessments and care plans were not always up to date, but the provider was aware of this and were working their way through people's care records to ensure new paperwork and all relevant documentation was in place. The newer paperwork, however, was much more person centred and enabled staff to have more individual information about each person they cared for.

Accidents and incidents were recorded and monitored for any trends and further discussed at management meetings.

Recruitment of care staff was continuous and the new HR team were working their way through staff records to ensure all relevant paperwork was in place, including three yearly renewed DBS checks. We found some gaps in staff training, supervision and competency checks, however, the provider was aware of these and had employed a new trainer who had already started updating staff training. Key management staff were working their way through the rest of the backlog.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us they were not always asked if they were happy with staff shadowing other staff during visits to their homes. We have made a recommendation about this.

Where food and refreshments were part of a person's care package, people told us they were happy with the way staff supported them. Where a person needed additional support from outside healthcare professionals, they were supported by staff at the service and we saw evidence of this.

People and their relatives were very complimentary about the care staff who supported them. People were respected and their dignity and independence maintained by staff who cared. We saw examples of the caring relationship which care staff had developed with people and their families and we were given lots of examples of good practice.

People and their families knew how to complain and complaints we reviewed had been dealt with in a timely and proper manner.

The provider had a clear vision for the service and had introduced as part of this; rebranding, including new uniforms, new office environment, new website, new paperwork and a range of new processes. The more complex people who were cared for, were managed by the specialist team. This team now had newly appointed manager's which included the head of the team and a manager for its day to day operation.

Audits were in place but they were behind in their completion for medicines and therefore had not found the issues we had during the inspection.

Policies were in place and some were still under review. We have made two recommendations regarding the accident and incident policy and the receiving of gifts policy and procedures.

The results of a survey had been just recently sent out to people and showed that generally they were satisfied with the service. However, where issues had been raised, the provider gave reassurances that action would be taken.

We found one breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment

You can see what action we told the provider to take at the back of the full version of the report.

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.

Medicines management needed further improvements and risk assessments needed to be brought up to date.

Travel time needed to be incorporated into staff rotas. Missed calls were unable to be fully monitored.

Safeguarding concerns, incidents and accidents were reported and investigated. People told us they felt safe with the support of care staff.

Recruitment processes were in place and there were enough staff employed currently.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training, supervision and competency checks had some gaps, however a new trainer had been appointed and the provider was working their way through these.

The Mental Capacity Act 2005 was applied. Consent was sought in relation to people's care and treatment. However, we have made a recommendation.

People were supported with nutrition and hydration where this was part of their care.

Is the service caring?

Good

The service was caring.

People were complimentary about staff and said they were 'perfect' and 'spot on'.

Staff treated people with dignity and respect and maintained their independence as much as possible.

People were involved in their care planning.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

New paperwork had been implemented and care records were more person-centred but needed to be completed for everyone using the service.

People told us they would raise any complaint with the provider if they needed and where they had, these had been addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had made many improvements to the organisation, but said they were not quite there yet.

Audits took place, but they had not been robust enough to find the issues we had during our inspection.

Feedback was sought from those who used the service to ensure continued improvements were made.

Helping Hands - East Northumberland

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 visit took place over 16, 17, 18, 20, 23 and 24 April 2018. We visited the provider on 1 May 2018 to provide feedback to the management team. The inspection team consisted of a lead inspector and a pharmacist inspector who visited people in their homes and visited the provider's office; two inspectors who made phone calls to people and staff and an assistant inspector who also called people in their own homes.

Before the inspection we reviewed information we held about the service, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We contacted the local authority contract monitoring and safeguarding teams and the local Healthwatch to obtain their views about the service before our visit. Healthwatch is the local consumer champion for health and social care services. We also contacted the local Clinical Commissioning Group lead and local authority team managers, social workers and care managers involved with the service. Where we received a response, this information helped to inform our planning of the inspection.

We visited 10 people in their homes. We also spoke with 18 people and seven relatives to gather their views about the service.

We spoke with 12 care staff. We also spoke with two care and support officers, a scheduling officer, the HR manager, the registered manager, the nominated individual (also the clinical lead), a newly appointed lead for the specialist team, a newly appointed manager for the specialist team and the managing director. The specialist team consists of staff who support people with more complex care needs.

We reviewed a range of 45 care records, some of which were held electronically. We also viewed medicine records for all the people we visited in their homes plus a sample from the office records. We looked at six staff personnel records. We also checked records relating to the management and governance of the service.

Requires Improvement

Is the service safe?

Our findings

The service had recently changed its registration, but since the last inspection under the old registration positive changes and improvements had been made. However, further work was required.

The lead inspector and pharmacy inspector visited people in their own homes and checked medicine procedures were followed by care staff. Some improvements had been made but staff continued to make errors in recording and the provider had not fully implemented best practice from the National Institute for Health and Care Excellence (NICE) guidelines for medicines management in this type of service.

Medicines records completed by staff were not always accurate and up to date. For example, one person we looked at had been prescribed a 12 week course of a medicine from their hospital consultant in January 2018. At the date of our visit the course should have been completed, but we found four tablets remaining and the medicine administration record (MAR) had not been completed fully for this and three other medicines the person should have received. Another person's MAR record we looked at had 53 missed doses over a 3 week period. We looked at the medication records for one person prescribed a medicine with a variable dose depending on their regular blood tests. Staff had completed additional MARs for this medicine but we found they were not always completed accurately. For example, over the last 20 days we found four duplicate entries on two separate administration records and five missed doses with no further explanation. Although in many cases, people could confirm they had received their medicines as prescribed, not all could and we were therefore unable to fully confirm if medicines had always been administered as prescribed.

Staff had not accurately documented the type of support that individual people needed in their care plan or risk assessments. For one person the medication risk assessment stated they required their medication to be 'administered by staff', but we saw on their MAR and daily notes that on some occasions one medicine was left out for the person to take later or the person had already taken their medicines themselves.

We saw that staff were not following their medicines policy in relation to covert medicines (this is when medicines are given in food or drink to people unable to give their consent to refuse treatment). For example, one person who was prescribed medicine covertly had not had this considered by anyone other than the person's GP.

Several people were prescribed creams and ointments (topical applications) that were applied by care staff. Topical medicine application charts were mostly in place but staff had not always used them to record applications they had supported people with.

We looked at how the service managed application of patches to people and found they were not following their current medicines policy. A patch is a medicated adhesive patch that is placed on the body to deliver a specific dose of medicine through the skin into the bloodstream. We looked at two records for people with patches and found both to be incorrect. For example, for one person the patch for pain relief, should have been rotated to different locations on their body, but there were no records to support this.

We found out of date medicines in people's homes which should have been returned to the pharmacy for destruction.

One person we visited received a medicine which should have been taken 30-60 minutes before food. We observed staff supporting this person to take their medicine with their breakfast. There was no risk assessment to ensure any issues identified in relation to this were mitigated against and no record to confirm this had been agreed with the person's GP or pharmacist. There was also no record to confirm if the local authority had been contacted to confirm if the care call was appropriate in its length or if it needed to be extended. We discussed all the issues we had found with medicines with both the provider representatives and the registered manager and they were extremely disappointed and said they would address them straight away.

These issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment.

People told us they felt safe with the staff who supported them. Comments included, "The staff are absolutely great and I feel safe"; "Yes, the staff are great"; "I do feel that I can trust the carer's"; "Most times, if they felt something was not safe or not suitable they (care staff) would say. I do take advice from the carer's if they say anything" and "Completely and utterly safe with them." One relative said, "Two carer's come in, [names of two carer's] who are fab and if I were to go on holiday and leave [person], I would not worry as I trust them 100% to know that [they] will be clean, happy, well-fed and looked after."

Staff had received safeguarding adults training and were aware of how to report concerns. During conversations with care staff they told us, "I haven't had any concerns but I would feel confident in raising these if I had to"; "I haven't really had any safeguarding concerns. If there were any I would report this to the office so that they could come out and update the risk assessment" and "If I thought anyone was in any danger I would do this (report concerns), I've never had to make any whistleblowing concerns. I have phoned the office before if I have thought that the carer who has done the call before me has not done their job properly." The registered manager had processes in place to investigate all safeguarding incidents we viewed. Actions taken were seen, including for example sharing lessons learned through staff team meetings and discussions with individual staff.

We asked care staff how risks were managed. One staff member said, "In every home there is a risk assessment, every visit I always check the file to see if there has been any changes. If we notice a change that is not in the care plan we would report this and one of the community support officers would visit to reassess this." To maintain people's safety, one staff member told us, "We follow care plans and what is recorded in moving and handling care plans. We always do everything 'by the book'." Risk assessments were in place but not all of them had been updated in a timely manner. However, the provider was aware of this and as part of the full reviews that were being completed, these were in the process of being updated.

Incidents and accidents were recorded and monitored. Where necessary actions had been taken, including for example reviewing care records. Trends were monitored via the provider's quality monitoring checks.

Staff felt able to deal with any situations that may arise, including emergencies, and were supported by management. Comments from care staff included, "There is policies for everything. If I had to leave (a person because of an issue) I would contact the office to update them. I do feel supported if I had to make a decision to do this, as we are taught this in training"; "We would phone the doctor if we were worried about hydration or nutrition but we also record this in the care notes. There is also a body map form so we can record any bruises and I would report this to the office" and "There has been a few (situations) where we

have had to call an ambulance and there was an incident where a gentleman passed away during a call. The persons wife was very thankful for everything we had done but I didn't think I had done that much. It was quite distressing how quickly it happened. The managers were supportive and did ask if we wanted our calls covered but we took some time out and then went back to work."

Office opening hours had been extended to cover the hours from 8am until 8pm with an on-call service operating outside of these hours. This meant people and staff could contact the provider 24 hours a day and any emergency action could be taken quickly. Several people and staff we spoke with raised an issue over the telephones not being answered in a timely manner. The provider had told us they had been having some issues with the telephones but that this was now resolved and new numbers were now in use and had been communicated to everyone necessary. This included a separate number for the specialist care service which was part of the overall service. The specialist team are staff who deal with the more complex people registered for care with the provider. We phoned the provider a few times to check if there were problems with the phones and found that they were answered in a timely manner. The provider made assurances that any calls coming into the building would be directed to the right staff member now and dealt with as soon as possible.

Staff used personal protective equipment, for example gloves and aprons, when completing particular tasks for people. This was in line with infection control procedures and we observed staff on several occasions following safe working practices.

Continuity of care staff at care calls was raised as an issue by some people, with others being very happy with the care staff who attended to their needs. We checked a number of people on the providers IT system to see how office staff calculated which care staff would be attending each person's care calls. All the people we checked had a core set of staff who attended regularly. However, at times, there had been other staff who attended due to sickness or holidays. For example, one person over a period of time had 264 visits with the majority of calls being covered by the same staff member, other than on 23 occasions where other staff had covered due to holidays. When we asked a member of care staff if they would change anything about the service, they told us, "I think for me it would be getting fewer carers into a package so that people get consistency of care and for facial recognition for people." The provider said, "When we get our new system, this will also help even more to maintain better continuity."

People sometimes had the perception that staff did not have enough time and were often rushed. Comments included, "I'm sometimes not happy. The carer's come in to do what they have to do but don't have enough time"; "I feel like they [care staff] are rushing" and "I do feel safe with the care but it's not relaxed, its rushed." One person thought that staff were "Under a lot of pressure trying to cope" and said they thought some care staff had left the employment of the provider. The majority of care packages with the organisation were funded via the local authority and therefore staff had limited time which had been deemed adequate to complete the care needs of individuals. One person said, "There was only one time when a carer was late and tried to leave without finishing her jobs but it got sorted." We found no further evidence to suggest that care tasks people needed were not completed. However, we found some issues with travel times which may have meant staff were under pressure to get from one person to the next in no time at all.

We checked the rotas for staff and found there was no time given for travel to the next person on their list. For example, one person's ½ hour care call was from 7.30am and the next person was due their ½ hour care call at 8am. These people did not live next door to each other and staff travel would have been approximately 10 minutes. We also found two staff who had two people on their visit lists to cover at the same time, meaning staff had to be in two places at the same time. We discussed these issues with the

registered manager, nominated individual and managing director. They told us this should never have happened and would investigate these. They also said they were looking at a brand new IT system to replace the current one and travel time would be incorporated into this. We confirmed that staff had recently visited to view this new system and we were told it would be implemented in the very near future.

Missed calls were a problem area in as much as the provider was unable to confirm fully when a missed call had occurred, unless a person called in or a staff member reported this. We looked at a missed calls report from the providers IT system for the period since registration. The figure it showed did not match with our findings. We found other missed calls on the IT system which had been logged as, for example, 'concerns' logs or 'on call' logs rather than missed calls logs. We could confirm that no person had come to any harm from the information available. The managing director told us, "The new system we are getting will sort all that out, with staff having to log in and out."

We considered the service had enough staff to operate, although more staff were continually being recruited. The provider's HR team worked out of the Cramlington office and we listened to one of the team as they held a screening interview over the telephone with a potential member of care staff. We found their questioning and approach to be very good and it was clear to see that this method would filter out potential staff who were not suitable to work in this caring environment. We asked people if they thought the provider employed suitable staff. One person said, "Recently there has been a lot more new young carer's. I do feel that they are good and that they catch on quickly." One relative told us, "I would say that over the 15 years that Helping Hands have supported my [person] there have only been two staff who have not been suitable to work with him."

Safe recruitment practices were followed, including completion of enhanced checks with the Disclosure and Barring Service (DBS). DBS check potential staff are suitable to work with vulnerable people. The provider was in the process of ensuring that all staff now had three year follow up checks on their DBS made. A new staff personnel file format had been implemented to ensure that all key documentation was in place. The provider had recognised that documentation had not always been as robust as it should have, but with the employment of a new HR manager, they told us, "We have already seen some marked improvements and any issues will be fully addressed."

Where issues had arisen with staff performance, the provider had dealt with this correctly. For example, one member of care staff had been reported to the provider by the local authority. Measures were put in place until an investigation had been completed. Actions had been taken which included, for example, staff dismissal or other disciplinary actions.

Requires Improvement

Is the service effective?

Our findings

Referral to the service was generally made via the local authority as the provider was the authorities preferred provider. This meant that the service had an obligation because of their contract to take on all the referrals made, unless there was an extreme reason for not doing so. The service also had a number of 'private' people who paid for their own care packages.

An assessment of people's needs was completed, including gathering information from the local authority. From this information a care plan was drawn up to support the service meet the person's care and support needs. Care plans were reviewed. We saw evidence that the provider was in the process of updating every person's paperwork. Although they were not up to date with this, the registered manager had lists of which records needed to be reviewed and updated, and were working their way through them. One person told us they would welcome a discussion about their care as they felt their needs had changed. We were aware from information that this person was due to have a review of their care.

People and their relatives thought that the staff team were well trained. Comments included, "One particular carer is really good; she has high standards when looking after me"; "The carer's do a pretty good job for what they get paid, I could not fault them one bit"; "They know what they are doing"; "Very nice and efficient" and "Excellent one word". We reviewed staff training and saw that staff had received a range of training, including food hygiene, medicines; however, there were a few gaps particularly in refresher training.

Staff told us, "You can ask to go on further training and you can ask for other things. I have had additional training for PEG feeding (A PEG is a medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate)" and "We have mandatory training for medications as well as updates for this. If I had any concerns or questions about medication I would always ring up and ask about it. I have made a medication error, I phoned the office, rang 111 for advice and also rang the pharmacy. Advice from the 111 service was followed. I knew the process but because I had made a mistake a report had to be completed."

A new trainer had been employed to further tailor the providers training programme and this had already started. A new small training room was available within the providers offices and the provider had also sourced a new training venue nearby to manage larger groups of staff. The provider recognised after our feedback that they needed to provide some further detailed updates with regard to medicines management for care staff. They confirmed that the first of these sessions would be held soon and would include practical work and be held in smaller groups to facilitate better discussion. The provider was aware of the gaps in training and assured us that now the new trainer was in post this would be their priority.

All staff new to the care industry should complete the 'Care Certificate'. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviour's that are required by people to provide safe, effective and compassionate care. We found this to be part of the training staff had undertaken. One staff member also told us, "I had a week's induction where we covered different categories

and I also did shadow shifts. I could have done shadow shifts indefinitely until I felt confident working on my own."

Competency checks were completed on staff who conducted care tasks. This included various procedures in connection with medicines (i.e. eye drops/ear drops) or nutritional support. This formed part of the quality assurance checks at the service, however, we found these had not always been completed as often as they should have been. One member of staff said, "Yes, there are spot checks completed to make sure that equipment is being used properly. Spot checks can happen where they just turn up." The provider was aware of this as changes to the management team had taken place over the last few months which had led to a back log.

Staff records showed that supervision meetings and annual appraisals had taken place and spot checks of staff performance while undertaking care tasks were being carried out. Staff we spoke with confirmed they felt supported but that formal supervision sessions were not always regular. One staff member told us, "Supervision can be erratic, you can have a few then there be a gap until the next." The registered manager was aware of the gaps in staffing records, including supervision and competencies and were being supported by the management team to bring these up to date.

Staff knew how to deal with situations which may have challenged them, for example challenging behaviour or signs that people were dehydrated. One staff member commented on challenging behaviour and said, "I would try to calm any situation down or get out of that situation. I do support people who have dementia but any incidents have been of a verbal nature and never physical." Another staff member commented on possible signs of dehydration and said, "Not passing much urine, dry mouth, pale skin. If I had concerns I would contact the GP and report this to the office."

The provider used a number of ways to enhance the delivery of effective care and support. For example, we were told that one person receiving care received communication by text as they were hard of hearing. Another person used electronic devices to communicate with staff and staff were aware of how to support the person with the device.

People said they were not always informed when changes to the staff who were due to attend changed. One person told us, "Staff in the office never tell me if someone different is coming." However, another person told us, "Very good at communication" and, "This has improved as I now get the rota in advance to know who is coming in." One person told us they "dreaded" ringing the office as they felt messages did not get passed on. A relative told us, "I do feel that we should get a phone call to tell us about new carer's and that they are suitable for the role, but most of the people we have had have been really good." We discussed this with the provider and they said they would look into our comments.

One person told us that some care calls they had cancelled had not been actioned by office staff and care staff had still turned up at their home. We checked the provider's IT system and found that information had not been shared as it should have been. This all meant that communication within the office environment was not as good as it should have been. We discussed this with the provider and they said they would look into this.

Communication log recordings on the providers IT system had improved, although we did still see entries which were not fully completed or had missing outcomes. The management team were aware of this and were continuing to remind staff the importance of completing this information. Staff were made aware of any changes to best practice through meetings or via a newsletter or emails sent to them. One member of care staff said, "On our pay slips every month there is a newsletter which keeps us up to date with changes

and to encourage staff to get together at coffee mornings. We did get some information from the NHS on hydration week."

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. We observed that the service had assessed people's capacity upon initial referral and used local authority assessments to support this. The provider was in the process of ensuring that people they supported had an assessment in place when necessary.

We were not made aware of any person who was subject to a court of protection order from the records of people we viewed, although we were aware that two people were being referred. The Court of Protection advocates on behalf of people who are deemed to lack mental capacity and makes decisions on their behalf. Staff had a basic awareness of the MCA and we were told that further training was planned. The registered manager was aware of her responsibilities in line with the MCA.

People were asked for their consent. One person said, "They are very good and they seem to know what I want and need (but always ask)." Another said, "I don't think the girls would do anything without asking me first…they are a canny (nice) bunch." However, one person we spoke with told us that care staff had completed shadowing to their home as part of their general induction. They told us they had no problem with this but said that notice should be given to people to let them know and gain their consent for a stranger to come and shadow another member of staff in their home.

We recommend the provider follow best practice guidelines in gaining consent from people in relation to shadowing of staff.

People were involved in decisions and offered choices. Comments included, "Staff verbally offer choices"; "Yes, [person] is given choices about where [they] would like to go and what [they] would like to eat. Carer's know [their] routine and what [their] likes and dislikes are" and "They ask me what I want before they do my breakfast. They then help me get dressed after I have decided what to wear." Comments from staff about how they supported people with decisions and making choices included, "I will show people things or ask the question in a different way to try and help people understand" and "(Helping) deciding where they would like to go, on holidays. Sometimes contacting other agencies such as paying bills as some people can't cope with this."

We noted that on a small number of occasions we found the provider had not always recorded all best interest decisions made, for example, if medicines were locked away for the safety of the person. The provider said they would make sure they addressed this.

People and their relatives reported that care staff supported them with enough suitable food and fluids if this was part of their care package. This included any support to eat and drink the person might have required. One staff member told us, "There is training around how to support people with their nutritional needs. It was helpful to have this." Comments from people and relatives included, "Staff give me what I want to eat and always keep the kitchen clean and tidy" and "[Person] needs to have [their] food cut up and uses a straw to drink. Carer's are all aware of this and it is documented in [their] care plans."

Staff supported people to maintain their health and wellbeing. One person told us, "I'm sure they would contact the GP if they thought I was unwell or anything." From records we saw that health care

professionals, including support from the positive behaviour support team, GP's and hospital departments had been contacted when the need had arisen. One member of care staff told us, "I have contacted many a doctor for people. We sometimes ring the office and ask them to do it for us, but sometimes it's easier to ring from the home in case the GP wants to speak to the person. I report anything like that to the office though and it gets written in the notes."

Good

Is the service caring?

Our findings

We received lots of positive comments from people and their relatives about the caring approach of staff. Comments included, "My carers are absolutely perfect and are usually spot on"; "They are very patient and kind"; "Carer will do anything for me; I wouldn't like to lose her"; "They put up with his sense of humour"; "Couldn't do without them, brilliant…lasses so friendly. Wind them up but they know it's fun. Couldn't be without them, can't fault them!"; "Very pleased to see them when they come"; "Wouldn't be without them"; "Quite happy with the care compared to another company"; "All the care I have had is excellent, they go out of their way for me and, the carer's are very, very good"; "When I have been upset due to the loss of my husband, they [carer's] have always been there to support me"; "I am very well looked after and the carer's sit and talk to me about life, we enjoy a chit chat" and "I'm very happy, I think they are great. It's lovely to see a face for the small times that they are here. The only thing is I have a job to remember everyone's names but they understand and are used to me forgetting."

One person explained how care staff had been "Genuinely interested" in their family members school report, and had asked questions, quoting back what was written on the report.

One relative told us that one of the members of care staff was leaving the organisation and said, "Take some replacing as she was more like a friend."

Where there had been issues with care staff it was addressed. For example, one person said, "One carer was not being very nice" and, "They were taken out and did not come back." Another person told us, "There was a carer who I didn't get on with but they don't come any more." People told us that staff were 'Great' but when a staff member had not provided care in an appropriate fashion, the provider had removed them from the care package.

People said they felt listened to by staff and staff had some time to talk to them during care calls. One person said, "Yes, they do this (talk to them) when they are writing in the book (daily records of care provided)." Another person told us, "Both carer's are happy and chatty and sit and have a cuppa and it's nice to have a bit of adult company without kids shouting."

Staff told us they provided care, which included taking time to talk with people and commented, "I always find time to have a chat…it's really important as at some calls we are the only people they see, so it's really important"; "Most of the time, there is occasional visits where there is not time to sit and chat. It depends on people's needs but we do have people who would chat to you all day as we are the only people that they see"; "I try and do the best I can, always friendly and chatty and making sure people have what they need" and "First class care, making sure, happy, clean, tidy, safe, comfortable. I always treat people how I would want my mother to be treated."

Staff gave us examples of how the provider 'cared' about them. One staff member said, "A good thing about the company is that they will let me work around my availability with my childcare needs." Another staff member said, "I know [registered manager name] and she cares about her staff. Sometimes others don't see

that, but I know what she has done in the past to help. I could go to her with anything."

When we asked staff what was good about the care provided, one staff member said, "We are a close nit set of carer's and we do help and support each other and we try to do everything we can for service users and their families. Relatives are very supportive of us as well."

The provider had set up a drop-in service in a local community venue and this had been available for over 10 years. One of the Helping Hands staff were paid to run this. This gave people the opportunity to attend groups and gain further friendships and make new acquaintances. We were told by senior staff that a garden seat had been commemorated when people had passed away. At a recent passing, they said, "We had a little service at the drop in and a poem was read. They [person] were friends and it was recognised."

Staff promoted people's dignity, respect and privacy, including knocking on front doors before entering people's homes. People's comments included, "They treat me with respect and always offer me choice" and "Yes (treated with dignity), and they give me privacy if I need it." One person explained about their close family member who had passed away and said, "Carer's are very respectful of this especially around anniversaries, i.e. birthday and day of passing away." One relative said, "Gets washed with dignity [person]."

One staff member told us, "We treat all of our clients with dignity and respect at all times. For example, if we are washing the top half of the body, would keep the bottom half covered over so that people are not all exposed. If people wanted to use the toilet we would give privacy."

We viewed compliments which the service had received. One included an email from one of the head injuries specialist team which said, 'Please forward on my profound thanks to [staff name] for the support she has provided to [person's name].' Another was a letter received from one of the team at the Specialist Speech and Language Therapist team. They had praised the team for supporting a person with specialist dietary needs with a holiday and commented, 'This outcome reflects the attention to detail, exceptional care and proactive planning that this team employ to look after him every day.'

Care plans were developed to ensure people's needs were met in a way which reflected their individuality. Staff attended equality and diversity training, and this was reflected in the observations we made during visits to people in the homes. Staff treated people as individuals and clearly knew the people they supported.

Staff supported and encouraged people to remain independent. One person said, "The carers do encourage me to be independent and I think it's good that the carers encourage you to get dressed, as I think people do feel better when they get up and dressed." One member of care staff told us, "I have encouraged people before to attend to personal care to maintain cleanliness and change clothes. Sometimes people will say they can't be bothered to go to the day centre so I would talk to them about the benefits of going out." Staff told us of people who used electronic 'Possums' to maintain their independence. One care and support officer said, "We have one lady who uses this machine to tell staff what they want or how they want things done. It means they still have a full say and can maintain their independence." Possums are portable electronic devices used for people who are no longer able to verbally communicate.

Most people and relatives told us they had been involved with the planning of their care. Although some people we spoke with could not fully remember and this may have been because of their cognition. People told us, "I think I have one but I am not sure"; "I am involved in the care I receive" and "I haven't had to sign anything but I have seen my care plan and I do agree with it" One relative said, "[Person] is aware of [their] care plan and knows that [their] carer's write in the book when they have been and what they have done.

[Person's] care manager came and visited last week to discuss [person's] care plan." Another relative said, "There is a file in the house where staff document when they have been out with [person] and this gets reviewed at times" and "When [person] has a review, we get asked if there is anything we want to discuss or raise at the time." People had been given a service guide which contained information about the provider and what to expect from the service. We were told that one family supported by the provider, did not speak English. Staff texted one of the family who then converted the message into their own language. We were told this had worked well and helped them to be fully involved in the care provided.

Surveys had been sent out to people at the end of 2017 and they had recently received the results of this. One person said, "Yes, I did (get a survey) and I wrote on the front of it that I was very happy with all the carer's. I didn't fill in another section as I don't like filling in forms and I didn't know what to say." Findings of the survey were based on 228 respondents, from questionnaires issued to 767 people (a response rate of approximately 30%). The provider had sent out the finding to people which were mostly excellent, very good or good. The provider had, however, noted they were not complacent and had highlighted for example, some issues with care planning and communication needed to improve. Included in the letter which went out to people with the survey results was actions on what they had done to address these issues so far and what they were continuing to do.

We saw information in some people's records which indicated they had previously been supported by advocates. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights. Senior staff were aware of how to refer a person to an advocate if this was required. One member of care staff said, "Relatives act as advocates (in the main) for the person receiving care and I know some people have a power of attorney."

Records held in the provider's office were stored in filing cabinets and confidentiality was maintained with no unauthorised staff members having access to them. Passwords were used on any electronic systems in use which also maintained compliance with the data protection act. Staff knew how to maintain confidentiality as one member of care staff said, "Social chat would remain between the person and staff and we would not discuss any client outside of the company."

Requires Improvement

Is the service responsive?

Our findings

One person told us that in their original care plan they could cook with some supervision. They said they were now dependent on care staff to do this task, however, their care plan had not been updated. One person we visited had no care plan in place at all and although older paperwork was held at the office, there was nothing in the persons home to support staff. We discussed this with the provider who said they would address these issues.

New paperwork had been introduced by the provider which was intended to gather much more information about people and be far more person centred than previously. We saw this paperwork in place for some people and found it to be a marked improvement on previous care planning processes used. Each record detailed the person's area of need, such as personal care, medicine support or nutritional care required. Records included medical histories, what the person liked to do and how they preferred care delivered. Much more information was held which mean that staff had better tools to assist people in an individual way.

The provider was aware that further work was needed to ensure that all care records were on the new paperwork. The registered manager held summaries of which records had been updated and which was still to do.
Staff told us that personalised information about people they supported was held within care records in their home. One member of care staff told us, "This is documented in the care plans in the files and if it is a new care service and we don't know the person we can get a phone call giving us information as well." The provider was also in the process of implementing a new IT system which would mean that people would be supported to receive timely care and support.

People and their relatives felt the service generally provided responsive care. One person said, "Really chuffed with them." Another person said, "Very happy and wouldn't change a thing".

One person told us their 'usual' care team looked after them well and went the "Extra mile", by looking in their fridge for example, and telling them what was going out of date and "It needs eating". However, they also said that when different care staff attended the response was not the same as care staff took little notice of them and just got on with what they had to do. We passed these comments to the management team.

A relative said, "Very good, ladies very friendly, no issues and couldn't get a better service…happy, as it's true." Another relative explained that a couple of times when their smoke alarm had gone off, "They [office staff] are straight on the blower checking everything is okay." A third relative said, "To be honest on the occasions when they have been needed, they have been there…spot on!"

The service had tailored care to the needs of people in a person-centred way. For example, one person told us they preferred flexible calls twice per day as they liked to get out of bed when they wanted. Another person said, "I'm not a person who likes to get up early and I like to go to bed late so the times they visit suit

me." A relative told us, "I think they are all quite good, it's an all-male support team and this is his preference so he can talk about things they have in common" and "Does have communication difficulties but carer's are able to understand him due to them being very familiar with each other." A member of care staff said, "There is flexibility for choice to be recognised for people's preferences."

A relative explained that one member of care staff, when preparing certain meals containing cardamom seeds, would go through the dish and pick out the seeds as their family member did not like them. They said, "They did this without being asked."

The service had supported people well at the end of their life and staff confirmed they provided on-going palliative care to people with the support of GP's, district nurses and other relevant health care professionals. We were not made aware of any person at end of life at the time of the inspection. People's records included information about advanced decisions. For example, people who had authorised 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)' forms in place. A DNACPR form is a document issued and signed by a doctor, which informs healthcare professionals not to attempt cardiopulmonary resuscitation. One member of care staff told us, "If anything happens and people don't want to be resuscitated there would be paperwork in the file, it's usually in a yellow envelope"

Most people we spoke knew how to complain, although some were not sure but said they would ring the office or ask care staff. We were told that every new person receiving care now received a business card directly with management details on it as well as the normal complaints policy. One member of care staff said, "It is recorded in the back of peoples care plans how to complain but people can also do this verbally. If someone complained to me about another carer I would pass this information on to the office." Staff told us that complaints are dealt with. One member of care staff said, "If someone complained about me I would get a phone call to discuss this with me and if necessary the carer for that call may be changed." We viewed complaints received and found letters had been sent to complainants to acknowledge their concerns and the provider had followed their own policies appropriately.

One person told us, "I get two calls per day and I have no complaints." Another person said, "If I have any complaints I would tell the carer's themselves or ring the office." A third person said, "I have never had to complain once." One person said they did not know how to complain, but when we spoke with them again, they said information was "probably in my file". The provider monitored complaints through their governance procedures and any actions were addressed.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was an established registered manager in place who was very supportive throughout the inspection process.

Management were working hard to make changes in the areas which needed to be improved and recognised there were not quite there yet. Key staff in strategic positions had been employed, for example, the head of HR (human resources), head of the specialist team and new care and support officers. The provider had also employed a project manager to take the lead of specific pieces of work. The managing director told us that their next piece of work would be taken up with the smooth implementation of the new IT system. The provider had a clear vision for the future, which included being "The best care service" to people in their own homes.

Audits and checks had been made on medicines and daily notes returned to the providers offices after completion by staff. These checks had not always uncovered the issues we had. However, the provider was aware the checks had not always been completed as often as they should have due to staff changes in the office and other staffing issues. As key staff were now all in post, the provider told us, this would change and be more robust.

The provider completed action plans for the service to monitor progress in particular areas. For example, they recognised last year that surveys had not been sent out to people and rated themselves as 'red'. In January they were rated as 'amber' and at the inspection they were 'green' as the surveys had been sent, analysed and results also sent out to people and their families. The red rating meant action had not been taken, amber rating meant some action had been taken and green rating meant the provider felt they had achieved their goal and actions were fully met.

The organisation had policies in place, however there was a need for further development of some corporate policies. HR policies were in the process of being updated by an outside source to ensure they included all relevant and best practice legislation and guidance. The service did not have a formal Accident and Incident Policy in place; accidents and incidents were covered briefly in the Health and Safety Policy. We discussed this with the provider and confirmed this needed to be addressed.

We recommend that the provider review accident and incident procedures and ensure a robust separate policy is in place.

We asked for a copy of the provider's policy which incorporated receiving gifts from people who used the service. The policy and the statement of purpose we also received was clear, in that staff should not accept gifts from the people they cared for, unless express permission was given.
One person told us they were happy to give staff money at Christmas and sweets to thank them for the work they had done as a token of appreciation. We had no proof of this and we found nothing documented in the providers IT system or staffing records we checked.

We recommend the provider follow best practice regarding receiving gifts and reiterate this with all staff.

'Care and Clinical Governance' meetings took place and were attended by the providers registered managers (from all services) and the clinical nurse lead who was also the nominated individual. The agenda included, safeguarding, incident and accidents and quality assurance. It was clear that sharing and learning from events occurred. For example, registered managers shared concerns about staff not following the providers sickness policy in one meeting and how this would be addressed.

A monthly operation report was produced which gave an overview of the service and included for example, new referrals, ceased care packages, safeguarding incidents, compliments and accidents and incidents. This was a further way the provider kept oversight of the quality and governance of the service.

'Patch' staff meeting had taken place across various areas, including Cramlington and Seaton. Staff told us that these were meetings where they could collect gloves and aprons and ask any questions or raise any concerns in general. One member of care staff told us, "There is a weekly meeting but it is not compulsory for people to attend but you can also collect any equipment at these times also such as gloves and aprons. If there is any feedback that is to do with us we would get a phone call from a manager. This would mainly be if there was a change to a care plan such as the person away into hospital, respite or permanent care." Another staff member confirmed, "We did have staff meetings now and again when all the changes were happening and we do get news letters in with our pay slips to tell us what is happening." The provider was looking to continue to make these meetings more meaningful and encourage staff to attend.

Staff told us they did not always feel listened to, Comments included, "That's divided. I think we are sometimes listened to but nothing really gets done about it" and "We do get a say at meeting or through to management, but it feels like we are given lip service and no one really listens. I can understand that sometimes ideas cannot always be put in place but you never hear why. If they could explain why, that might help us understand." We however, saw evidence that the provider had listened to staff. For example, by making changes to the way salaries were paid from monthly to a four-weekly cycle.

The managing director produced monthly team briefs to update staff on changes within the organisation, we noted that recent ones had discussed changes to the specialist team, staff retirements and call monitoring. These were sent to staff via email or usually with their pay slips. The provider had recently implemented and launched a 'Helping Hands' App. An App is software used on, for example, mobile phones. The providers App would eventually allow staff to log in and view, for example, policies and procedures and have access to team briefs.

Senior staff meetings regularly took place which discussed a range of issues. These included, staffing levels, new documentation, the new IT system planned and health and safety. Agendas were set and minutes produced with actions. A separate action plan was produced with details of who was responsible. We noted from one meeting that most of actions had been completed with outstanding issues being carried forward to the next meeting. For example, in relation to the implementation of the new IT system.

The provider had a clear vision for the service and had introduced as part of this; rebranding, including new uniforms, new office environment, new website, new paperwork and a range of new processes. The more complex people who were cared for, were managed by the specialist team. This team now had newly appointed manager's which included the head of the team and a manager for its day to day operation. The provider had moved to new offices in the Cramlington area. The new office was a very different environment to the last and much more suited to the needs of the business. Any visitor to the service was welcomed by a staff member who manned reception. Any staff attending could speak to senior staff should they need to

and although office meeting space was limited, a staff relaxation area was available which could have been utilised. The managing director told us, "We have confidential paperwork in offices, we cannot have anyone wondering around. Staff are always welcome though." The registered manager told us, "Staff do come and use the reception to have a drink and fill time sheets in. Staff are welcome, it's just different and some staff will take time settling in."

We asked people what they thought the service did well. Comments included, "I think that they do everything to the best of their ability"; "They must train their staff well" and "They are very efficient and quick (care staff)."

The majority of staff thought that the management team and office staff were approachable. Comments included, "The office staff who have worked as carer's before have more compassion for us as they understand the job role and what we have to do" and "I have never had a problem with management or anyone in the office at all. Mind, think others might say something different, but things have changed and some don't like change."

We did receive some negative comments in relation to changes of contractual arrangements with staff. We noted, that although staff had not been overall happy with the changes made to the pay structure; we found the process had been completed in an appropriate manner and fully communicated to all staff as part of the consultation process.

People and relatives reported that generally staff were happy in their work and the atmosphere was good. Comments included, "They seem to be (happy), they never moan about work to me" and "They seem to be (happy)." However, staff comments about morale were mixed and included, "Yeah, I like my job and have worked for them for 14 years and I wouldn't have done it this long if I didn't like it" and "I love my job. Some of the office staff are lovely and we have had some good team leaders. Staff morale has been very low with all the changes"

At Christmas staff had received a gift voucher with a message from the managing director. Each of the 12 days before Christmas a raffle was drawn with some high value prizes, including TV's and cash prizes. Staff told us they appreciated these gestures. The provider told us they were in the process of looking at new incentives for staff.

The provider sought feedback from people and their relatives to continually evaluate and improve the service. One relative told us, "I haven't had one recently but they do seek views as part of review meetings." A staff member said, "From my personal experience of having a family member supported by Helping Hands I do think service users and their families are listened to." Another staff member confirmed, "Managers do spot checks and they go out and they ask clients if they are happy with the service they receive."

We saw evidence that the provider had good links with the local community and other healthcare professionals. For example, the drop-in service operated by the provider had regular visits by the police service and had integrated with allotment gardens ran separately as part of a community partnership.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that robust medicines management procedures were in place. Not all risk assessments were in place or up to date. Regulation 12 (1)(2) (b)(g)