HH Community Care Limited

Helping Hands - West Northumberland

Inspection report

St Matthews House
Haugh Lane Industrial Estate
Hexham
Northumberland
NE46 3PU

Date of inspection visit:
09 January 2018
10 January 2018
11 January 2018
12 January 2018
23 January 2018

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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 9, 10, 11, 12 and 23 January 2018 and was announced. This was the first inspection of the service since changing the service name, re-branding and moving into new premises in Hexham under a new registration. As the service was previously in special measures under its old registration, we returned to check improvements had been made.

This service is a domiciliary care agency based in Hexham, Northumberland. It provides personal care and other additional support to people living in their own homes throughout the west 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 244 people receiving a service.

Not everyone using Helping Hands – West Northumberland receives 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 they do we also take into account any wider social care provided.

The service had a registered manager in post. The registered manager has been in post since the service first registered on 13 November 2017. 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 but we found further issues that needed to be addressed, including, for example, completion of medicine records and ordering procedures. The provider needed to fully embed best practice from the National Institute for Health and Care Excellence (NICE) guidelines.

People told us they felt safe and comfortable with the staff who visited them in their homes. They felt cared for by kind, compassionate and respectful staff. People were safeguarded from abuse as staff knew what to do if such an instance arose. Safeguarding incidents had been fully investigated and recorded with lessons learnt and shared.

Care staff supported people to maintain their health and welfare. Risk assessments had been carried out where risks had been identified. We saw these were regularly reviewed. Accidents and incidents were recorded and monitored for any trends and further discussed at senior management meetings for any future learning opportunities.

There were enough staff employed at the service, however further improvement needed to be made on rota systems, timings and continuity of staff to fully meet the needs of people who used the service.

There was still not a fully robust system to monitor missed calls as the provider relied upon staff or people to report these. However, the provider was in the process of introducing a new addition to their IT system to address this and this would be implemented by the end of June 2018.

There had been improvements in support provided to staff and this needed to be maintained. Staff told us they worked as a good team and felt able to speak up about issues that were important to them. We saw evidence of this in minutes viewed. Training had been provided but there were some gaps in staff records. A new internal trainer was about to be employed and plans for a robust package of training would be implemented immediately.

Recruitment of care staff was continuous to the needs of the business. Applications were requested, interviews held and successful applicants provided evidence so that employment checks could be undertaken appropriately.

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.

Care staff supported people with their food and refreshment needs. People were content with the level of support received in this area with staff offering choice at meal times and monitoring intake, when necessary, to avoid malnutrition and dehydration. Healthcare professionals were involved when this was required, including GP's and community nursing staff to maintain people's health and wellbeing.

The people and relatives we spoke with told us that care workers were kind and friendly. Staff respected people's homes and belongings. People said staff maintained their independence, privacy and dignity. The staff we spoke with all displayed a very caring approach and were extremely considerate when working with the people they cared for.

The care planning process had been reviewed with new paperwork implemented. We saw improvements had been made to the quality of people's care records to ensure they were more person centred, although this still needed to be completed for everyone.

We saw all formal complaints had been logged and investigated in a timely manner. Less formal complaints had been logged but the provider needed to ensure that they were fully completed with outcomes. There was a complaints policy in place which was due to be approved by the board of directors.

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. Additional staff had been employed in key roles and staff worked more together as a team.

We saw audits and checks of the service had been reviewed; existing procedures had been improved and new checks had been implemented. These were being embedded into practice and we have made a recommendation in connection with this area.

People had been given opportunities to feedback to the provider. A survey had been recently sent out to people and their families. This was in the process of being analysed. Feedback was also sought through care plan review meetings. Management had taken action where this was required, although needed to ensure actions were fully recorded.

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. We also made three recommendations, one in relation to scheduling systems, on in relation to audits and the other in relation to the accident and incident policy. 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.

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

Risks to people had been minimised with risk assessments in place. We recommended a review of the scheduling system to ensure people received care calls as required.

The recruitment process for staff was robust and staffing levels were appropriate.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Training was provided to staff but there were gaps found, however a new trainer was in the process of being appointed. The support for care staff had improved.

Consent was sought in relation to people's care and treatment. People and their relatives were involved in care planning.

People were supported to eat and drink. General healthcare needs were met including involvement with external health professionals, as necessary.

Is the service caring?

Good

The service was caring.

People told us all staff were kind and caring. Staff understood people's needs and responded to these.

People were treated with dignity and respect.

People made decisions and were offered choices. Staff encouraged independence where possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

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

Staff had responded appropriately to people's changing needs.

People told us they felt comfortable raising any issues with staff. A complaints policy was in place and people were aware of how to complain.

Is the service well-led?

Requires Improvement

The service was not well-led.

The overall rating for a service cannot be better than 'requires improvement' if there is a breach of regulations.

Audits took place to ensure good practice was followed, but had not always identified the issues we had during our inspection.

The provider had made good improvements since we last visited and had clear visions for the future which included a recent rebranding. New staff had been employed and continued to be, to ensure key staff were in the correct positions.

Paperwork had been reviewed and kept confidential and in good order.

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

Helping Hands - West 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 service had previously been registered as, Stocksfield and Haltwhistle and we had rated this service as inadequate overall. The provider sent us an action plan to show what they would do and by when to improve the key questions, safe, effective, responsive and well-led. Following our previous inspection the service moved address and this is therefore a new registration for the provider at their new location, however we did review the improvement plan the provided had submitted as part of this inspection.

The inspection visit commenced on 9 January 2018 and ended on 23 January 2018. The inspection was announced. We gave the provider short notice of the inspection because we needed to ensure the registered manager and other key staff would be available at the office when we visited. One lead inspector and one specialist advisor visited the office location on 9 January to see the registered manager and staff and to review care records and other documentation in connection with governance. A specialist advisor is a member of the team with specialist knowledge in a particular area. In this case the advisor specialised in quality assurance and governance procedures.

We visited people in their homes on the 10 and 12 January 2018 and this was completed by the lead inspector and a pharmacist inspector. An expert by experience conducted telephone interviews with people who were receiving care in their own homes and their relatives on 11 January. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The lead inspector returned to the provider's offices on 23 January to complete the inspection.

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 care managers and district nurse staff involved with the people who received care from the provider. All of this information helped to inform our planning of the inspection.

We spoke with 23 people and eight relatives to gather their views about the service. We also contacted 14 care staff, including one 'roaming warden', through attendance at a team meeting, face to face during visits to people in their homes or over the telephone. We also spoke with the senior care and support officer, a senior scheduling officer, a scheduling officer, a care and support officer, a human resource officer, the registered manager, the nominated individual (also the clinical lead) and the managing director.

We visited one of the drop-in centres which Helping Hands set up in Bellingham and spoke with two people who used the service and others from the local area who attended the group.

We contacted with two occupational therapists, four care managers and social workers from the local authority, two community nurses and two GP's. From those who responded, we used their comments to support the inspection process and judgements made.

We reviewed a range of 20 care records, including medicines records. We looked at seven 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 lead inspector and pharmacy inspector visited people in their own homes and checked medicine procedures followed by care staff. The provider had implemented changes and updates to procedures.

We found complete medicine records were not always in place, particularly for those who were supported with reminders to take them. One person had only recently been prescribed warfarin, which they appeared capable of taking independently. However, staff supported them by reminding them to take their medicines. Without information in place to ensure staff knew what medicines to support them with, there was a risk medicines may be missed. We spoke with the provider about this. At the end of the inspection they confirmed that all people who were supported in any way would have a MAR chart put in place immediately, including for topical medicines. Topical medication refers to, for example, applications to the body surfaces of a selection of creams, foams, gels, lotions, and ointments. They confirmed they would follow best practice via the National Institute for Health and Care Excellence (NICE).

Topical medicine application charts were mostly in place but staff had not always used them to record applications they had supported people with. One person required support with a particular medicine four times daily but only had three care visits. It was not clear in care plans how this person would be supported with the additional dose and the risk assessment was not up to date regarding this. We also found that the times between support with this person's medicines was not sufficient, which meant there was a potential for an overdose situation to occur.

When staff supported people with their medicines, and medicines were not taken by the person, there was not always a reason recorded. Some of the people we visited in their own homes had families who also supported them at different times with their medicines. We were able to confirm with the family members that all medicines had been given at the correct times. However, the MAR charts which staff completed had numerous gaps at the times support was provided by family. We spoke with the provider about this. They confirmed they needed to review the procedures in connection with family involvement to ensure staff captured this information on the MAR charts, as records currently portrayed missed medicines when this was not the case. It was also not always recorded on people's care plans the level of support families would give and how or reflected on medicines risk assessments.

One person had eye drops with a prescription label dated 11 December 2017. This medicine should be discarded 28 days after opening, and we could not be certain if this was out of date as it was not dated when it was opened. The same person's care plan stated that staff supported them with four different eye drops. There was no information recorded to explain to staff how this should be done, particularly at a certain time of day when all four were due.

Medication risk assessment and consent forms stated whether the provider had responsibility for ordering medicines. However, there was not always information on how this would be done, who was responsible or what records would be kept; in line with NICE guidance.

People did not always have correct lists of medicines in place for staff to monitor. For example, one person had two separate lists of medicines in place dated the same date but with different medicines listed. Therefore we could not be certain as to which medicines list was accurate.

One person we visited received a particular medicine which should have been taken 30-60 minutes before food. We observed staff supporting this person to take their medicine five minutes after having breakfast. The same person was prescribed Warfarin and Paracetamol but these medicines were not on their MAR charts.

We passed all the information of concern over to the registered manager and they said they would address them immediately.

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

We reviewed five care staff rotas in different areas in the county for the previous three weeks. Calls overlapped in places. By overlapping, people did not get their allocated time to receive care and support.

The provider used an IT system called 'Carefree' to allocate shifts to care staff and monitor missed calls. However, not everyone we spoke with, including people, relatives and staff were always happy with the way this worked or was communicated. For example, we received mixed views on the consistency of care staff and the timing of calls.

Comments from people and their relatives included, "I have 24 hour care…everyone is absolutely brilliant. The senior carer always makes sure there is cover. I have no complaints everything is champion (good)"; "I have had missed calls and recently had to speak to the manager. Every other weekend I never know who is coming and I have to telephone the office to find out. Also the office doesn't seem to grasp how long it takes between calls…I am about 10 to 15 minutes away from the previous call and no time is given"; "No problem in missed calls however they are supposed to call between 9.30am and 10am. Sometimes it is lunch time or after. The carers who come are very helpful"; "Some [care staff] record they have stayed for 30 minutes when they only stay for 10 minutes"; "I have carers four times a day. No missed calls…the carers are absolutely brilliant. There are various carers' depending on the rota but no complaints" and "We recently introduced a bed time call and receive two carers at different times for my parents. Cannot understand why they don't just send one carer and that person does one at a time. The different carers came at the same time once and could not both use the bathroom."

One relative told us, "My [family member] has carers three times a day. They are spot on with times. My [family member] is down as time critical. If any problems I always receive a phone call. The office is aware my [family member] needs to know the voice of the carer so can't send anyone who has not been introduced properly."

Some of the people who had made negative comments, we further contacted to ask if they wanted to have their details passed to the provider so that they could look into the issues they were having. They declined and said they would address any further problems directly themselves.

A number of staff we spoke with told us that they did not understand how the rotas were calculated on occasions and felt more planning was needed around distances. One staff member said, "They [office] don't listen to us. We know the area. We know it's not easy working rotas out, but if they would just listen." The registered manager told us that staff have had the opportunity to visit the provider's offices and support

schedulers with rotas, but very few staff had taken up this offer. We were aware that new staff have been employed in scheduling roles and were steadily becoming more familiar with the area.

We looked at continuity of care staff on rotas produced. We could see on the three people we checked that there had been continuity of staff with one staff member visiting one person over 300 occasions while another had visited the same person over 350 occasions but another had only been placed on the rota 20 times.

We discussed comments and concerns regarding the scheduling system, timings of calls, travel times and consistency of care staff with the registered manager, nominated individual and managing director. They were aware of the difficulties and were trying to resolve them.

Based on the feedback and our findings we recommend the provider review their scheduling system to ensure that people receive allocated care calls in a timely manner.

The provider told us they were investing in a new upgrade to their current IT system which would better monitor calls and ensure that people had received them, which would include some form of logging in/out for care staff. They said this system would be installed by end of June 2018 as they had already received the new mobile phones which would be compatible. In the meantime, we saw that monitoring of missed calls was completed by the registered manager but was still difficult as the provider would only know this had occurred if care staff informed them or the person themselves contacted the provider. From 29 December 2017 to the 9 January 2018 there were six missed calls recorded.

People told us they felt safe with the care and support staff provided them. Comments included, "Safe, yes, of course"; "The girls have been coming ages, I feel very safe" and "I know all the staff, have no worries at all." Relatives told us, "[Person] feels safe…well he knows them anyway doesn't he"; "No worries at all with the staff that come out. All trusted by the family" and "It's not easy letting unknown people into your house, but I have confidence and trust in the staff that come out to look after [relative]. No issues at all with safety of any description."

One community nurse we spoke with said they thought that people who used the service were safe in the hands of care staff.

We reviewed the 'safeguarding' file. As part of the updated governance procedures a 'governance quality report and dashboard' had been produced. These tracked safeguarding incidents which helped the registered manager to monitor any trends which may form. The registered manager had processes in place to investigate all safeguarding incidents we viewed, which had included statements from staff and medicine error reports, for example. Actions taken after outcomes to safeguarding incidents were seen, including for example sharing lessons learned through staff team meetings. Staff had received safeguarding adults training and we were confident through conversations with staff that they understood their responsibilities to report any areas of concern through the appropriate channels.

Risks people were susceptible to in their everyday lives, such as mobility and moving and handling had been assessed. Daily notes made by care staff showed they were recognising risks and reporting these to office staff. For example, one person had begun to have problems swallowing medicines and this had been reported and the person was in the process of seeing healthcare professionals in connection with this. The registered manager was in the process of ensuring that the person also had an updated care plan and risk assessments put in place.

We saw accidents and other incidents were recorded and monitored. Accidents involving staff were documented and investigated. Where necessary actions had been taken or recommendations had been made to correct working practice or prevent further accidents occurring. Where necessary people's individual risk assessments and care plans were updated following accidents or incidents. Trends were monitored via the governance quality report. We saw a range of three different types of accident reports used. However, we were shown the newly branded accident and incident recording form which all staff should now be using.

Office staff managed an 'on-call' service which operated outside of normal business opening hours. A log was kept of any calls made during these times and information passed over as necessary during normal working hours. Any emergency action was taken in a timely manner.

Care workers used personal protective equipment such as disposable gloves, aprons and hand sanitising gel to reduce the possibility of cross contamination. The people we spoke with confirmed this and we saw it in practice during our visits to people in their homes. However, one healthcare professional we spoke with had raised some concerns that staff were not always following safe working practices. We saw this had been previously discussed at team meetings. The provider said they would reiterate the importance of good infection control procedures with the staff team.

We considered the service had enough staff to operate, although more staff were continually being recruited. One healthcare professional we spoke with said, "There is a turnover of staff and I think it is the same across this area, I think it is because of the rural location."

We looked at the staff files of eight staff, including care staff and office staff, some of whom were newly appointed. Application forms were in place, interview documentation, two references had been obtained and an enhanced check with the Disclosure and Barring Service (DBS) had been undertaken. DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role.

Requires Improvement

Is the service effective?

Our findings

People and their relatives thought that the staff team were trained well enough to complete the care tasks they were employed to undertake.

Comments included, "They manage all the things I need them to do and do it well"; "I have regulars, they know me and I know them. It's not quite as good as when the less known staff come, but they are ok. My usual's are better though" and "The staff need to be trained in specific areas. There have been some gaps, but overall on the whole good."

We reviewed the staff training matrix which was maintained to monitor staff training and ensure it was kept up to date. We saw staff had received training in a range of subjects, including medicines, equality and diversity, infection control, safeguarding adult and food hygiene. However we found gaps in some of the staff training records.

The provider was in the process of recruiting their own internal trainer as had previously outsourced training. Interviews were taking place in the very near future. The aim being to establish tailored, individual training to the whole staff team and have consistency throughout. A new training room was available within the new building at Hexham and this was in the process of being fitted with equipment, including electronic whiteboards to support this.

The provider was aware of the gaps in training, including refresher training; and assured us that as soon as the trainer was secured, a robust programme would be set up and continued. The provider also used on line training to support the staff team. One staff member told us, "Training has been very good. I learnt a lot, but then it stopped. I think they are looking for a different trainer to take over." Another member of staff confirmed they felt up to date with their training and said, "I may be due some refresher training, but know what I am doing…been doing it a long time."

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 behaviours that are required by people to provide safe, effective and compassionate care. We found this to be part of the training staff had undertaken and we were told this would be reinforced by the new trainer they were about to employ.

Care and support officers conducted medicine competency checks on care workers as part of their checks on the service received by people and where staff fell short of expectations, additional training or support was given. This demonstrated that people received effective care from staff who had the skills and knowledge to suitably perform their role.

Staff records showed that formal one to one supervision meetings and annual appraisals had taken place and spot checks of staff performance while undertaking care tasks were being carried out. The care staff we spoke with confirmed they had received supervision and appraisal, been spot checked and that their performance at work had been competency assessed by senior staff. Although supervision had improved, it

needed continued monitoring to ensure this remained the case.

Since the last inspection under the previous registration, new office staff had been employed and were still working to embed themselves into their roles. We overheard the office staff making and receiving telephone calls. Communication was very good. We heard people were informed about disruption to their usual visits, office staff resolving queries and questions and people being informed that one care worker was running late. People and staff told us that on the whole communication was good and had improved. One person said, "I have never had any problems with communication, the staff seem to be more involved now." Another person said, "Good communication." A relative told us, "Staff will contact me if ever there is anything wrong. No concerns with communication at all."

Communication logs were entered onto the provider IT system, although the majority of entries were recorded fully, we saw some entries which had no final outcome entered. For example, one person had been prescribed a change to their medicines. We saw staff had contacted the clinic to confirm this information, but it was not recorded if the information was passed to staff. However, we were able to confirm that the information had been transmitted to staff.

A small number of people and their relatives told us that communication needed to be further improved. For example, one person told us, "Communication and travel time are the two things which need to be addressed." Another person told us, "The caring is very good. The difference is in the office… poor understanding of office procedure. When you call you don't know who you are speaking to and they don't know you… this needs improved. Just recently I have been given a contact. This hopefully is an improvement."

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 all people who they supported had an assessment in place.

We were not made aware of any person who was subject to a court of protection order from the records of people we viewed. 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 in this area within the next month. The registered manager was aware of her responsibilities in line with the MCA.

The registered manager told us that should they have any concerns or issues in the future regarding a person's capacity level, they would liaise with a social worker to ensure that a capacity assessment was undertaken and the best interests' decision making process was followed.

We observed staff ensuring that people were involved in decision making. Staff comments included, "Would you like tea or something else to drink [person's name]"; "What would you like for breakfast [person's name]?"; "Would you like me to do that (piece of meat shown) for you?" and "What would you like me to make you for lunch? (the staff member then recited what was available for them to choose from)." People confirmed that staff asked them their opinions and gained their consent before carrying out any tasks. People also told us care workers knocked on their door before entering and always shouted through before fully entering the property if access was via a key pad. The provider was continuing to review people's care

records to confirm that where possible people had been involved in their assessments and had consented to their care and treatment. Where appropriate, relatives had been asked to sign on people's behalf where they had lasting power of attorney (LPA) to do so. LPA is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related. The provider ensured they asked for copies of any legal documentation before people started to use the service.

People reported that care staff supported them with enough suitable food and fluids of their choice and to suit their diverse needs, if this was part of their care package. Comments included, "The staff ask me what I want to eat and then make it…all very nice" and "They [care staff] make my breakfast. Sometimes I have toast and sometimes porridge. They come at dinner time and tea time as well and make sure I have had something to eat. Not sure what I would do without them." Daily records confirmed that staff had provided people with their nutritional needs. Some people were more closely monitored with food and fluid charts in place. This recording was an aid to quickly highlight if a concern was arising and supported staff to act quickly to make referrals to relevant health care professionals. We saw while checking people's records that one person had been referred to their GP due to concerns in connection with their diet, noted by care staff.

Staff at the service supported people to maintain their health and wellbeing and ensured their needs were met. Records showed care staff had reported issues and concerns to office staff and this had been investigated with referrals made with health care professionals if necessary; for example, GP's or community nurse teams. We could also see records of contact with care management from the local authority and other relevant healthcare professionals involved in people's care, for example occupational therapists and speech and language therapists (when people had difficulty swallowing).

Good

Is the service caring?

Our findings

At the previous inspection we deemed the provider had not taken action swiftly to promote a caring approach; we found this had vastly improved.

Without exception, we received positive comments about current care staff. People who were spoken with said care staff were caring, kind and went that extra mile in many cases. People and their relatives felt that the care staff were the organisation's greatest asset.

Where a member of care staff fell short of expectations, the provider had dealt with the situation appropriately and people and their relatives were satisfied.

Comments from people receiving care included, "I have to say though the carers themselves are very good and pleasant"; "The usual carer and others who have come are very good. Really helpful"; "I find the care excellent. No trouble or problems. No complaint of any kind"; "They are angels, every one of them"; "They [care staff] are a God send…could not do without them"; "I know many of their families coming from a local area. They are like friends not staff" and "They are a good bunch."

One relative told us, "I have no problems, lovely bunch of local girls. I have known some of them for years." Another relative told us, "Very good and caring from what I have seen."

People and their relatives we spoke with had mixed views about office staff and were not as generous in their comments. However, the comments were in connection with scheduling of care calls and consistency of care staff allocation and not with the way they had been treated in any communication or interaction. People who had made contact with the new registered manager said they had made a difference and had seen some improvements. They believed they were trying hard to 'put things right'.

Staff demonstrated values that promoted people's dignity and privacy. People we spoke with told us, "The staff always look after my dignity especially during personal care," and "I feel comfortable with staff, that's because they are considerate and kind. They wouldn't do anything that would make me feel uncomfortable." We spoke with staff who told us how they always supported people's dignity. One staff member told us, "We try our best to keep things dignified. I treat people like I would want treated." Relatives had no qualms in praising staff for the dignity they showed to their relative and one said, "Very dignified. I get chased away (in a nice way), and only right too." We saw staff close doors when they were about to support people with personal care tasks and when one staff member was seen leaving a bathroom to get an additional towel, they knocked on re-entry. We heard people talking in a relaxed way with staff behind closed doors as personal care was carried out. People's records were stored confidentially and maintained in secure settings in the office environment.

People and their relatives felt that care workers spoke to them with respect and we confirmed this through observations. One person told us, "The girls look after my belongings and respect my property and being in my home." A relative told us, "They are very respectful. No worries there at all."

People were provided with emotional support from the staff who supported them. One relative told us, "A little while ago my [relative] was upset and [member of care staff] gave her a hug and stayed a bit longer to talk things over. I will not forget that, it made a big difference to them."

We viewed many compliments which the service had received in the last few months which reflected the provider's beliefs and values. One community nurse had passed over a compliment from one person regarding how well they had been supported with their medicines. Another person had commented how kind, caring and respectful staff were and that they were a credit to the organisation. Another compliment received thanked staff for the bouquet of flowers sent for the birthday of one person.

We spoke with staff about the people they cared for. They showed a good understanding of people's needs and were able to demonstrate a good knowledge of people's likes, preferences and routines. One person was very hard of hearing and preferred staff to write on a pad to communicate with them. We saw this in action. The staff member was aware of how the person also liked to have their TV put on once they had completed care tasks and were about to leave. The person was asked, "Do you want your TV on with the subtitles?" We saw recorded in their care records which TV channel they preferred and this was discussed too.

Care plans were developed to ensure people's needs were met in a way which reflected their individuality. Some staff told us they had attended equality and diversity training which encouraged them to promote individuality and ensure people's personal preferences, wishes and choices were respected. However, it was evident that all staff we observed treated people as individuals and met their needs in this way.

People told us staff supported them to be as independent as possible. One person told us, "They help where I struggle, but when they know I can do it, they encourage me to get on with it." Another person said, "They encourage me to do things myself. When I get stuck, they will step in." A third person said, "It's probably easier for them sometimes to do it (care tasks) themselves, quicker I mean, but they take time and help me to do it for myself."

People and relatives told us they had been involved with the planning of their care. They told us that a representative from the office visited their home to carry out either an assessment of their needs when they started using the service or a review of care already received. One person told us, "I have told the staff what needs to be done and that is what happens. They are coming out soon to see how things are going, but everything is fine at the moment." We saw from records viewed that relatives had been actively involved helping their family member with decisions about their care. One relative told us, "The whole family has been involved. If we are not happy, we contact the office and [name of scheduler] will sort it out." Records had been signed when participation had occurred and the provider was working their way through documentation to ensure this was the case where possible.

People had been given a service guide which contained information about the provider and what to expect from the service. They were also provided with opportunities to give feedback during care plan reviews. The provider had also recently sent out surveys to the people they supported and were in the process of analysing the data. This all offered people the opportunity to express their opinions on the service provided.

We were not made aware of any person who used an advocate as many had relatives or friends who acted on their behalf. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights. Staff were aware of how to refer a person to an independent advocate from the local authority if people needed that level of support.

Requires Improvement

Is the service responsive?

Our findings

On referral to the service, through either the local authority or via private arrangements, an initial assessment was carried out. Care and support officers usually completed these assessments and undertook reviews of the care provided to people to ensure that when their needs changed, their care plans were changed to reflect their current requirements.

New care planning paperwork had been implemented and the provider was currently working their way through people's files to update them. Care plans were detailed and person centred. They included information about the people's preferences, full medical history, routines and hobbies. They covered areas of need such as nutrition and hydration, communication and continence care. However, some further work was needed to ensure all detail was available. In one person's care records, it had recorded that their hobby was going out with staff, but it did not explain what 'activity' would occur when the person was out. We also noticed on a couple of occasions actions were not always recorded after issues had been raised during reviews. For example, one person and their family had raised concerns about some staff being less experienced. There was then no record made against the entry of the agreed action staff would take. We spoke with the provider and commended them on the improvements made. They agreed that further work was required and assured us this would continue.

We found a number of care records which did not always accurately reflect the changed needs of that person. For example, one person used a particular leg support and this had not been updated in their care plan to provide staff with appropriate information on actions they needed to take. However, staff were following correct procedures without the records in place.

During people's reviews, care and support officers or one of the management team checked that people's desired outcomes were met and still applicable, however, some people's outcomes and goals were not completed. Comments from people when asked about their care needs included, "I have been visited recently. They [care and support officers] normally ring and arrange a good time to call. My daughter normally comes along too. They are checking I am happy with everything, which I am"; "The office people have been out to speak to me and check everything is okay. They went through my paperwork. I am happy with what the girls do [care staff]."

The service had responded quickly when staff had failed in their responsibilities. One relative explained their family member had received care from one particular member of care staff which had fallen short of expectations and they had found them not to be completing all of the tasks they should have. They said, "I telephoned the office to say I did not want this particular carer visiting my [family member] in the future. They have assured me this carer will not be back. All the other carers are absolutely brilliant and I am quite happy with everything else."

Another relative gave us an example of a quick response from the provider after their relative had fallen. They said, "I live quite a way from my [relative] who has carers twice a day. They are wonderful. [Relative] fell down last week and they phoned me straight away."

One person who had been placed on end of life care after being in hospital had made such improvements in their health after returning home, that they were now not under that status. We spoke with staff and saw they were responding well to the person's changing needs and this was reflected in improvements made. One staff member said, "Didn't think she would make it, but she's pulled through. We do really care about people you know."

We viewed records of one person whom staff had supported to go on holiday. Compliments had been received as it had been a great success. The registered manager told us, "We had to take everything into account for safety." We confirmed that the provider had reacted positively to the holiday request and tailored a suitable package in response.

The service had previously supported people 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. At the time of the inspection, the registered manager reported that no person was receiving end of life support. Some people's records included information about advanced decisions they had made about treatment in the case of an emergency. For example, the provider had recorded information about 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.

Some people told us that the service was flexible and they had been able to re-arrange visits at short notice or cancel visits to accommodate appointments and family visits or other occasions.

Everyone we spoke with said they knew how to complain and would complain if they felt they needed to. One person told us that they had recently complained about the timing of calls and confirmed office staff had been out to visit them to get the matter resolved. Another person told us they had complained some time ago and said, "Things were sorted out straightaway." Other comments included, "I have no complaints to make, but if I did, I would tell the staff and I know they would work it out"; "Those girls are great…no complaints what so ever"; "Won't have a word said about the staff, they are very good" and "I have complained before and the manager was very good. I am quite happy now thank you." One person contacted us during the inspection regarding a concern they had with the care calls received. We looked into their concerns with the care manager and the provider and found that professionals were working together to have their concerns resolved.

The service had a complaints policy in place which was due approval by the board of directors. We found one formal complaint had been received since the service registered in November 2017. However, less formal complaints had been recorded on the providers IT system, 'Carefree'. The provider had followed the organisations policy in response to formal complaints from the information we viewed. We saw a timely response had been given at all stages of the complaints process. We noted that informal complaints had not always been fully completed with outcomes, although we recognised that this had improved since our last inspection. The registered manager told us, they would ensure this was addressed. The registered manager had implemented a dashboard and governance quality report to monitor complaints and all senior management had overview also through the updated governance procedures in place.

Requires Improvement

Is the service well-led?

Our findings

Prior to the service moving address and being registered at a new location we had identified some areas in which the service needed to improve. At this inspection we found the provider had worked hard to implement improvements although there were still some areas which required further work.

One healthcare professional told us, "There has been a big effort to put things right – they are not just quite there yet. Most staff have their heart in the right place."

The provider had a vision for the service and had moved premises to a more suitable location for staff in particular. The provider had rebranded and now had a new logo. New uniforms, new website, new paperwork and a range of new processes was part of this redesign. Additional staff had been employed in key roles, including new schedulers, new care and support officers and a new HR officer. New staff were still getting used to the business and the area in which they worked, but we saw a more positive atmosphere within the office environment.

There was a registered manager who had been in post for less than a year. The registered manager was present during the inspection and greatly assisted us by liaising with people who used the service and staff on our behalf. They were knowledgeable and able to tell us about individual people's needs when asked. Not all of the people we spoke with knew who the registered manager was, although most were aware that there had been some changes in the management team and also in the office environment. One person said, "[The registered manager] has acted quickly, everything they said they would do, they have done. I can't fault them for that."

We overheard the registered manager giving feedback to a recently interviewed individual. They were very professional and transparent and offered the person the opportunity to attend the office for feedback on their interview which is very good practice.

Regular audits and checks had been undertaken, including those in connection with medicines and daily records. However, these had not always found the issues we had, during our inspection. Audits and checks had been completed with actions noted. For example, on one daily record audit care staff had been noted as 'crossing out' items with the action that the care and support officer would speak to the staff members in question. We did not see this recorded on the individual staff member's records. We did however see that it had been discussed in team meetings regarding recording techniques.

The provider had only just implemented a 'MAR (medicine administration record) chart collection and audit checklist'. This form was used to monitor the return of completed MAR charts and would be used to record when and by whom they had been checked. This meant the provider would be able to check all MAR charts had been returned and had been checked.

We recommend the provider further review their medicine audit procedures in light of feedback during the inspection process.

We reviewed minutes of board meetings, which we considered needed improvement. They did not demonstrate how decisions were reached and if there had been any challenges during the meeting. We were informed by the managing director during discussions that board minutes were "brief and needed to demonstrate a challenge." This was corroborated by the minutes of the last board meeting which stated the same.

The service did not appear to have a consistent approach to policy approval and ratification. Some policies were approved by the senior management team and some not. Overall the organisation had policies in place, however there was a need for further development of corporate policies. The HR department had carried out some initial analysis of what policies and procedures were required and had plans in place to address these gaps.

We saw recorded in senior management records that the provider planned to have all polices in place by the end of March 2018. The service did not have formal Accident and Incident Policy in place; accidents and incidents are covered briefly in The Health and Safety Policy.

We recommend the provider review their accident and incident policy and ensure there are clear and transparent processes for staff to account for their decisions, actions, behaviours and performance.

Care and Clinical Governance meetings took place and were attended by the providers two location registered managers and the clinical nurse lead who was also the nominated individual. Over time it was evident that this meeting had become more effective. The agenda had expanded and included, safeguarding, incident and accidents, HR issues, supervision, appraisals, spot checks, quality of care audits and people's case reviews. Trends and policies are also discussed.

The registered manager kept a list of hospital admissions and discharges on the office wall. This was to ensure that office staff were fully aware of people who were in hospital and could better monitor this for discharge to ensure care staff were in place when required. The registered manager told us, "It's a fairly new system, but has helped us monitor better."

We also reviewed the 'Senior Management Team' file. Originally meetings were held every two months and these meetings appeared less formal and structured. The information now demonstrated that improvement had taken place in terms of the depth and breadth of information received and reviewed. A performance dashboard was now produced which gave an overview of the service and included for example, new referrals received, how many 'service users' active, concerns (including safeguarding and complaints), audits completed and support provided to staff. This showed the provider had a good oversight of the service.

We were told by all staff we met that they felt they had a good team of staff around them and that included, care staff and management. Staff told us that they worked together as a team if issues arose. For example, one staff member told us of a person who they had found unwell. They said, "I contacted the office and they phoned their GP who came out straight away." Another staff member told us of an instance where one person was poorly but did not want to have their GP called. The staff member explained they were concerned about them so contacted the office who then contacted the family; who came and persuaded the person to seek help.

Office staff we spoke with told us about improvements within all aspects of the service. Comments included, "There's been a lot of work done since you were last here", "Communication has improved" and "There has been lots of changes made, they [management team] keep improving things." There had been a number of new staff had joined the service, particularly in the office environment and were settling into their new roles.

In the new premises the registered manager was located within the same area as schedulers and care and support officers and this had led to better exchange of communication between the staff team. Every morning a meeting took place between the office team and registered manager to discuss any issues arising. The registered manager said that these meetings had provided invaluable.

Monthly staff meeting had taken place over different geographical areas. Including Haltwhistle, Hexham and Bellingham. The agendas of these meetings covered, for example; confidentiality, updates on policies, rebranding, uniforms, office relocation, health and safety concerns, safeguarding concerns and training needs. We attended a team meeting and gained feedback from a range of staff. They confirmed they discussed a range of topics and said they had an opportunity to openly discuss any areas important to them. This was reflected in minutes we viewed.

We reviewed care records, staff records and records related to the management of the service. These were stored securely and were accessible to authorised personnel only and meant confidential documents were protected. Storage and record keeping at the service had vastly improved. All of the records we asked for were made available to us and were stored in an organised manner.

We noted that some management records had no date entered, we reminded the provider of the importance of dating all documentation, including for example, statement of purpose, versions of documents (e.g. medicine risk assessment) and all policy documentation.

On occasions we found records, including care plans, risk assessments; electronic logs and audits did not always have recorded the outcome or action taken when issues had arose. Although we found improvements had been made in this area with recording much better than at the previous inspection, there was still room for further improvements.

The provider sought feedback from people in order to continually evaluate and improve the service. A 'Quality Assurance Feedback Service Users Survey' had been undertaken with 86 completed responses to the survey received. At a senior management meeting on the 5 January it was confirmed that analysis of the survey would be completed by the end of January 2018. Meaningful analysis will allow the provider to highlight issues, concerns and areas of good practice.

The provider worked with other healthcare professionals. We saw regular contact was recorded on people's records with a range of outside agencies. This included, care management, community nurse team, and GP's. We came across a number of instances where the registered manager or other office staff had worked with care management to try and secure a better care package for people, including increased hours. One care manager said, "Overall, little complaint about them. They have been very open and transparent. I have good communication with [senior care and support officer] and they bring items to my attention; for example if a double up call is needed." The same care manager said, "I have a particular client and they have dealt with all concerns in a timely manner and I have found them very accommodating with an increasingly difficult case."

At Christmas the provider had updated their reward scheme. 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. The majority of staff spoken with appreciated these gestures.

The provider had a number of 'pool' cars which were used to support staff to visit people when needed. This included, for example, use by the travelling wardens to visit people in their homes for care calls and also by

care and support officers when needed. The cars could also be used when care staff travel arrangements had broken down and they needed support to get to their care call.

The providers understood their responsibilities to ensure that the rating for the service was clearly displayed once published using the CQC widget. A widget is an IT tool which can be used by anyone to enable quick access to a particular area of the internet (in the CQC's case, directly to our website and the services latest report). The provider had publicised the new website to ensure people using the service and other interested parties were aware of its existence. The registered manager was aware of their responsibilities and had submitted notifications as and when required.

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 fully managed medicines in line with best practice or with the National Institute for Health and Care Excellence. Regulation 12(G)