Midshires Care Limited

Helping Hands Leeds

Inspection report

First Floor Office 3 Beaconsfield Court
Garforth
Leeds
West Yorkshire
LS25 1QH

Tel: 01133229150
Website: www.helpinghands.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 and 30 August 2017 and was announced. The provider was given 48 hours' notice because the location provides domiciliary care services and we needed to be sure that someone would be in the office. We contacted people who used the service and staff by telephone on 31 August and 8 September 2017 to ask for their views.

Helping Hands Leeds is a domiciliary care service that provides personal care to people in their own homes within the Leeds area. Helping Hands Leeds was registered with CQC in August 2016 and this was the first inspection of the service. The service provides care for older people, younger adults and people living with dementia, mental health, physical disabilities, learning disabilities and sensory impairment. At the time of our inspection there were 39 people using this service.

The service had a registered manager and for the purpose of this report I will refer to the registered manager as 'The manager'. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and were protected from any harm. Staff were trained to recognise and report any form of abuse.

Accidents and incident processes were robust and actions taken to minimise risks. Risk assessments were in place for people that required them and we saw that these were updated when people's needs changed.

Staff were suitably recruited. Induction programmes completed at the start of employment and training was provided. Staffing levels were adequate to meet people's needs and ensure that visits were not missed.

Medicines were administered although we did see shortfalls in the recording on medicines records.

Supervisions and appraisals were not always completed in a timely manner in line with the provider's policy. Staff training on induction was in depth and this was followed by annual updates and new practices being discussed in team meetings with staff.

The provider did not always follow the guidance set out by the Mental Capacity Act. Care plans did not specifically state when a person lacked capacity and best interest decisions were not documented.

People were supported to maintain a balanced diet and were offered fluids when being visited. If people required support from health care professionals, this was arranged by staff and they were supported to attend hospital if needed.

Staff provided personalise care which facilitated peoples diverse needs and people told us staff were respectful.

Initial assessments were carried out to ensure the provider could meet people's needs and care plans were regularly updated to reflect people's personal needs.

The provider received complaints and compliments. The manager explained how complaints were managed and this was effective and considered actions, which may be required.

People spoke positively about the management and told us regular staff meetings took place.

Surveys for the service took place but these were usually at a national level or linked with other services making it difficult to determine the quality of the Leeds service alone.

Audits were completed in May 2017 but since this time, no further audits had been completed.

We found shortfalls in recordings of documentation, accuracy and quality assurance checks.

We identified one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014; you can see what action we told the provider to take at the end of the full version of this 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?

Good

The service was safe.

Medicines were administered to people as prescribed, even though we found shortfalls in the recordings on MAR's.

People told us they felt safe. Staff received training in how to protect people from abuse and how to respond if they suspected abuse was taking, or had taken place.

Risk assessments were in place for people who needed them and were specific to people's needs and their home environment.

Staffing numbers were adequate to meet people's needs and safe recruitment processes were followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to make decisions, care plans did not evidence compliance with the Mental Capacity Act 2005.

Not all staff had received supervision in line with the provider's policy.

There was an induction and training programme in place for staff.

People were supported to meet their nutritional needs and to maintain their health with access to professional, if needed.

Is the service caring?

Good

The service was caring.

People told us staff were caring. Positive and professional relationships had been built with people using the service and staff.

Staff treated people with dignity and respect and they were supported to be independent.

Staff involved people and their relatives in care planning and provided explanations.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. They and the people that mattered to them had been involved in identifying their needs, choices and preferences and how these should be met.

Initial assessments were carried out and regular reviews of care plans took place.

A complaints procedure was in place, which had been followed. People using the service knew who to contact if they wished to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found shortfalls in the lack of record keeping in the service and unsatisfactory documentation to monitor the quality of the service being delivered.

There were processes to monitor the quality of the services provided on a national scale but not specifically at Helping Hands Leeds to understand the experiences of people who used this service and plan on-going improvements.

People spoke positively about the management and felt they were supportive and approachable.

Helping Hands Leeds

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection, which took place on the 29 and 30 August 2017 and was announced. We contacted people who used the service and staff by telephone on 31 August and 8 September 2017 to ask for their views.

This inspection was carried out by one adult social care inspector.

Before this inspection, we reviewed information we held about the service. This included statutory notifications received from the provider and the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make. Statutory notifications are notifications of certain events and incidents that the provider has to inform the CQC by law. We used this information to help plan the inspection. We also contacted the local authority, local safeguarding team and Healthwatch.

During the inspection, we spoke with three people who used the service, two relatives, the registered manager, the quality assurance manager and three care workers. We looked at a range of records including five staff files relating to recruitment, supervisions, appraisals and training. We also looked at four people's care records, which included care planning documentation, risk assessments and daily records. We viewed records relating to the management of the service, surveys, audits and a wide variety of policies and procedures.

Good

Is the service safe?

Our findings

People using the service all told us they felt safe and replied "Yes" when asked the question 'Do you feel safe?' One relative said, "[Name] feels safe, they take the trouble to get to know us, they take an interest and build up a personal bond."

Safeguarding procedures and policies were robust and staff demonstrated their understanding of safeguarding procedures to ensure people were protected from any harm. One staff member told us, "If we suspected any abuse we would report it to the manager and the local safeguarding team. It could be anything such as financial, physical or even the safety of someone living alone." The staff member gave an example of a person who was at risk due to leaving there gas on; this was reported and resolved on the same day. In the past 12 months, the manager had accordingly dealt with one safeguarding incident with actions taken to avoid any future concerns.

Staff had a clear understanding of their duty to whistle blow should they suspect or witness poor practice. One staff member said, "If it was about another carer I would speak to the manager but if it was about management I would ring the head office."

Accidents and incidents were managed appropriately by the manager and staff were provided with a policy on how to report these. We found one accident had been reported over the past 12 months and action was taken by the manager to reduce the risk of re-occurrence. For example, a person fell and following this a falls assessment was completed to manage the potential risks to prevent it from happening in the future.

Risk assessments were relevant to meet people's individual needs. Some risk assessments included moving and handling, medication, falls and challenging behaviour. For example, one risk assessment identified the need for a person to be supported to stand and to get out of bed, with the use of a mobility aid, due to their risk of falls and not being able to weight bare. The risk assessment instructed staff on how the person wished to be assisted. It stated 'Attach each strap to the stand aid hooking the 5th green loop onto the hooks on the stand aid. Place my feet on the foot plate. I will use the control independently and whilst doing so, carers are to introduce my chosen chair behind me to lower me onto.' Another assessment outlined when staff should avoid providing personal care to a person who may become aggressive for example, 'I live with vascular dementia. I can be verbally aggressive and physically aggressive. Carers must not attempt to deliver personal care when I am distressed or angry as this will put carers at risk of injury.' This showed the provider assessed people's individual needs in relation to risk to minimise any potential incidents and to keep people safe.

Staffing levels were adequate to meet people's needs who currently used the service however; the manager told us they were not currently taking any new referrals as they wouldn't be able to provide quality care as there would not be sufficient staffing levels. The manager told us, recruitment for new employees was ongoing and until new staff had been trained they did not want to compromise care for other people currently using the service. This showed the provider had an overview of staffing levels required to support people and to ensure care was not compromised.

People using the service and the manager told us that no visits had been missed in the past 12 months. One person using the service told us "We've never had a missed visit" and a staff member said "They bend over backwards, they would never see anyone without care." The manager told us if staff were off sick or unable to attend a visit they would make sure the person was informed and another member of staff would attend.

We looked at staff recruitment records which showed that appropriate processes and checks were undertaken before staff began work. This included staff submitting application forms, being interviewed, their identity being confirmed and two references and a Disclosure and Barring Service (DBS) check being obtained. These checks identify if prospective staff have a criminal record or are barred from working with vulnerable children or adults. We looked at five staff files and found all the necessary processes were followed.

A 24 hour 'on call' system was available for people using the service when the office closed. For people who required additional support throughout the night, when the 'on call' was not in operation, they had access to an alarm pendant. which if triggered notified a care line who then responded and provided support.

Medications were ordered by people's general practitioners and delivered by local pharmacies. These were usually delivered in blister packs but individual prescriptions were also provided in separate boxes. Blister packs contain designated sealed compartments, or spaces for medicines to be taken at particular times of the day. They can help people to keep track of their medicines.

The service used Medicine Administration Records (MARs) to document the medicines people had been prescribed and recorded when medications were administered to them. We found shortfalls in the recording on MARs and gaps where staff had not signed these records. However, when we explored this further we found when we looked at people's daily notes and found where we had identified gaps in recording on people's MARs, staff had made entries in their corresponding daily notes and these confirmed that medicines had been administered, or alternatively where they had not been taken, a specific reason for non-administration was documented for example, hospital admission.

We discussed these recording shortfalls with the manager who told us the matter had already been raised with staff in team meetings and confirmed they would address this again.

Requires Improvement

Is the service effective?

Our findings

Staff were provided with the skills and knowledge to work with people using the service. A 12 week induction programme was completed by new employees'. This included, three days in the classroom, online training exercises, a minimum of six hours shadowing an experienced member of staff and one day working in the office. The manager told us all new staff completed the care certificate that was introduced on 1st April 2015 and staff were provided with a work book which included information about the providers policies and procedures. The online and classroom training included, personal development, equality and diversity, duty of care, person centred, communication, privacy and dignity, fluids and nutrition, moving and handling, MCA, Safeguarding, basic life support, health and safety, handling information, infection control and falls.

Training updates were required to be completed by staff on an annual basis via an online system. The updates included moving and handling, safeguarding and health and safety. However, not all of the training courses completed in the induction were updated annually. We discussed this with the manager as to how they ensured staffs knowledge and skills remained relevant. For example, MCA training was only completed on induction and therefore meant staff were not regularly updating their practice. This could result in them not being up to date with current practices or changes in legislation. The manager confirmed that regular updates were provided to staff in team meetings. We saw evidence from the last team meeting that MCA processes were discussed.

Staff were encouraged to partake in specialist training to enhance their learning. One staff member told us, "We have a dementia champion based in head office, they did some training for the staff and it was really interesting. We got to experience how it would be in their shoes with practical experiments." The staff member said this helped them to provide support to people with dementia and have awareness of how a person maybe feeling when receiving care.

Supervision and appraisals were carried out by the manager, however we saw not all supervisions and appraisals had been completed in line with the provider's policy. The policy stated formal supervisions should be completed every three months and annual appraisals. Out of the five staff files we looked at, two files did not contain an appraisal. We also saw that three out of the five staff did not have supervisions in accordance with the provider's policy. For example, one staff member had a supervision in November 2016 and the next one was documented in July 2017. This was over the three month period set out in the provider's policy and showed staff were not being monitored on a regular basis. In addition, we saw on the PIR information received in June 2017 that only two out of 30 staff had received an appraisal. We discussed this with the manager and they agreed to review and update staffs supervisions and appraisals to reflect their policy.

Not all of the people who used the service had the mental capacity to make informed choices and decisions about all aspects of their lives. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best

interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We discussed whether anyone in receipt of care from the service had a granted authorisation in place from the Court of Protection, to lawfully deprive them of their liberty in a community setting. The manager told us that to their knowledge none of the people they supported had such authorisations in place but should such authorisations be necessary in the future, they would pursue this with the relevant parties.

We checked whether the provider was working within the principles of the MCA and found that staff and management understood their responsibilities under the Act. The manager told us they did not currently assess people's capacity as they were not trained to do so however, if a person required an assessment they would contact the relevant professionals such as the persons GP to carry out an assessment.

Care plans did not specifically record when a person lacked capacity. The provider did record if a person had difficulties understanding information, for example, 'I live with dementia, my understanding is variable'. This information was vague and care plans did not document specifically what the person could or could not understand. We also noted that when best interest decisions had been made, these were not documented in the care plans. This meant it was not clear what decisions had been made in the persons best interests and who had been involved in such decisions. The provider's policy stated; any actions taken must be documented in daily log books and further documented in the person's records on their computer systems however, we found no evidence of this. We discussed this with the manager and recommended they reviewed this to ensure they were working within the principles of the MCA.

People were supported to maintain a healthy and balanced diet. Some people using the service were supported with their nutritional intake for example, one staff member told us, "We had a lady that used to hide her food and she was losing a lot of weight. We decided in her best interest to monitor her food intake and stay with her whilst she ate to make sure she was getting the right food intake." People using the service told us they were always offered food and a drink upon visits. People said, "They make me a coffee and some toast" and "Yes, they offer me something to eat and drink." We saw care plans identified if a person required support with their diet for example, 'I have lost weight recently and my appetite is poor, I should be encouraged to eat foods which are high in calories – cream could be added to my cereal or my bedtime milk.'

Any health concerns were reported to the manager and staff told us should a person require further assistance from other health care professionals that the manager would arrange this.

Good

Is the service caring?

Our findings

People using the service and their relatives told us they were well cared for by the staff and were positive about the support they received. One person told us "All the staff talk to me and understand their job" and "I'm very satisfied with them; the [staff] are very nice." One relative said "[Staff name] usually comes every day to see my mum and she's really good, professional and comes on time."

Care plans identified people's diverse needs. For example, care plans asked 'what is important to me' and included information about people's nationality, religious and marital status. This showed staff were able to support people with diverse needs and had an awareness of their preferences.

People told us they felt respected by staff when receiving personal care. One person told us, "I have no qualms getting undressed in front of them; they make me feel comfortable and are very respectful." Staff provided examples of how they ensure people's privacy was maintained. One staff member said, "I often support people into the bath and then leave them to wash themselves. I will take people to the toilet to assist onto the seat and then leave the room for a few minutes to have privacy."

Staff and people using the service told us they were encouraged to remain as independent as possible. One person told us, "I get dressed by myself, I like to do things for myself while I can but if I needed any help I would ask the staff." One staff member said, "It's a case of letting people do things for themselves and that's why it's important to have consistency with the carers going in because they know them and know if they are capable of doing things. I always encourage people to make their beds etcetera." Another staff member told us "One lady that we see needs some prompting with washing but is quite independent. I give her the flannel to wash and then leave her to do this herself."

People and their relatives were involved in the care planning stages and explanations were provided by staff. One relative stated, "The manager calls me to check I'm happy with everything going on." One staff member told us, "The customer and family are fully involved when we write the plans and we write it how they want. If a person was lacking capacity we ask the family what they liked doing before and try new ideas. I did a pamper session with one person and she loved it, I did her nails and gave her a face mask."

The manager told us that no person using the service had an advocate but should this be required the manager said they would contact the relevant professionals.

Information about people was kept securely in the office at all times and documentation was also kept in people's own homes. Staff told us they were aware of keeping personal information confidential and knew how to access this information.

Good

Is the service responsive?

Our findings

People received personalised care which responded to their specific needs and preferences. For example, one care plan asked, 'What is important to me?' and the answer stated 'I live with Alzheimer's disease, it is important for me to have regular carers so that I can become familiar with them.' Care plans also documented peoples preferred methods of communication, one care plan stated 'I like to communicate verbally or use gestures.' This showed the provider had collaborated with people using the service to gather personalised information to form part of their care.

Staff and people using the service told us they were always offered a choice, whether this was deciding on food they wanted to eat or picking what to wear for the day. One relative said, "They always ask mum and give her a choice all of the time. Mum likes to do things herself and they respect that."

Initial assessments were completed by the provider to make sure they could meet people's needs and this was often reviewed. One person using the service said, "[The manager] came out at the beginning to see me and often rings me to see how I'm doing." One relative told us "Yes there was initial contact; the site was good and the only one in the area. The woman in the office was very helpful and [The manager] came out to see me and I had confidence in her and she was friendly."

Care plans were reviewed on a regular basis and the manager told us they regularly contacted people using the service to ensure they were happy with the care provided. People using the service told us they had their care plans at home to review if they wished. One person said, "Yes I have my care plan at home."

People using the service did not comment on any activities provided as this was not part of their care package. We did hear from staff and people using the service that activities sometimes took place in people's homes but this was not routinely something the provider offered.

The provider had a complaints policy in place. During our inspection, the manager had received their first complaint over a 12 month period. The manager explained how she planned to manage this for example, speaking to the complainant, documenting the concerns and planning outcomes. This was in line with the provider's policy. Staff and people using the service felt confident to complain and knew who to contact. One person told us, "In the first place I would contact the manager." A relative said "They are always just a phone call away and I would feel confident to complain."

The provider had also received compliments from people using the service; we saw three compliments were received over the past 12 months. One person wrote, 'A huge thank you goes to you [Name], all the staff in the office and those who have provided such excellent care, the service has been very efficient and so much appreciated.'

Requires Improvement

Is the service well-led?

Our findings

We found shortfalls in a number of areas relating to the lack of record keeping in the service and unsatisfactory documentation to monitor the quality of the service being delivered.

We saw medicine and daily log audits had last been completed in May 2017 but any more recent records had not been checked to identify any errors or concerns. We found shortfalls in audits that had been completed as they did not always highlight where action would be required. For example, one daily log audit did not identify missed signatures. Another example included gaps in recordings on MARs. Although we could see these medicines had been administered, staff had not completed the MARs. The MARs audit completed had not identified these shortfalls.

We also found shortfalls with recordings in care plans. The provider had not stated specifically if a person lacked capacity and the reasons for this. The documentation was vague making it difficult for anyone person to determine if a person lacked full capacity or whether they were able to make some decision's such as financial or care choices.

The provider had also failed to follow their internal policy in regards to supervision and appraisal of staff.

The manager informed us at the time of our inspection that no audits had taken place since the beginning of June 2017. The manager told us monthly medicine audits should be completed and two monthly personal care files and daily note audits. This showed that the provider was not auditing their care records in a timely manner.

There were no customer forums nor did the provider complete internal questionnaires to receive feedback about the service however, the manager did state that they regularly contacted people to check they were satisfied with their care. People and their relatives we spoke to also confirmed this however, there was no documented evidence to analysis the information for quality assurance purposes. One relative said, "[The manager] gives me calls to check I'm happy with everything going on."

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 entitled Good governance.

The quality assurance manager told us annual audits were completed; the last one in April 2017 for the Leeds and York branches. The audit focused on care files, care worker files, complaints, standards of care provided and customer quality assurance. The quality manager said they made approximately 10 percent of calls to customers from the Leeds and York branch to gather feedback on their experiences with the services. Overall, the feedback was positive with 80% of people rating the overall service as excellent and 20% as average. However, it made it difficult to determine the quality of service being provided solely in the Leeds service alone as this was a joint survey.

Nationwide surveys were also provided to people using the service and their relatives on an annual basis but

again this was not specific to the Leeds branch making it difficult to determine if any improvements to the service were required.

We discussed our concerns with the manager and quality assurance manager about the lack of evidence to show that people were satisfied with their care at a local level and that this should be implemented. The manager agreed and told us they would look to improve this by introducing their own questionnaires and surveys for the Leeds service.

Team meetings were held quarterly by the manager and we saw the last meeting took place in June 2017. Discussions included the importance of MAR's being brought to the office once completed, code of conduct, medication documentation and MCA policy topics. Staff told us they found the meetings useful and provided them with opportunities to give feedback about the service.

At the time of our inspection, there was a registered manager recently in post who received their registration in June 2017. People using the service, their relatives and staff told us the management were approachable and supportive. One relative told us "They are very good. Previously with another company that let us down but Helping Hands haven't. The people are good, friendly and helpful, we are very pleased." Staff members commented, "It's better since the manager has started, the communication has improved and I can go to anyone to talk if I need advice." Other comments from staff included, "The area manager is good, if you ask a question they get back to you with an answer" and "They are all very nice and pleasant, very supportive and offer help where they can."

The manager was compliant in notifying the CQC of incidents which had occurred. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service in the form of a 'notification'. This allows the CQC to check that appropriate action had been taken at the time of the event.

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 17 HSCA RA Regulations 2014 Good governance There were not established and effective systems or processes in place to assess, monitor and improve the quality and safety of the service being provided. In addition records throughout the service were not always well maintained.