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Caring Hands

Inspection report

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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 comprehensive inspection took place on 13 and 14 December 2018 and was announced. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults.

Not everyone using Caring Hands received 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. At the time of this inspection the service provided personal care to 32 people.

The service was run by a single provider who was in day to day control of the service. It was therefore not required to have a registered manager. The provider is an individual 'registered person'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider was supported to run and lead the service by an office care manager and a community care manager.

At the last comprehensive inspection in April 2016 the service was rated Good for each key question. Was the service safe, effective, caring, responsive and well-led? This led to an overall rating of Good. At this inspection the provider had not maintained this standard and we have rated this service as Requires Improvement. This is the first time the service has been rated Requires Improvement.

We identified one breach of the Regulations of the Health and Social Care Act (2008). This related to the lack of governance and audits completed by the provider. The provider had no formal system to check if staff training equipped them for their role. There were no formal medicines or care record audits. This is discussed in more detail in the well-led section of the report.

We identified two breaches of the Care Quality Commission (Registration) Regulations 2009. The provider had not submitted statutory notifications to the CQC to notify us of the death of a person using the service or of an incident of alleged abuse as required. The provider acted to address these concerns during the inspection.

Staff supported some people with their medicines, as required. The provider gave assurances that they completed competency assessments to assess the ability of staff to deliver this care safely. However, these were not documented. This was not in line with the provider's policy. Without exception, people and their relatives told us, medicines were administered safely. The provider gave assurances at the time of our visit they would ensure they formalised this process in the future. We have made a recommendation about medicines management.

Staff received training to provide them with the knowledge and skills required for their role. However, the training was limited to what the provider considered to be mandatory. A review was required to determine

the appropriateness of the training and the potential impact this may have on staff and people using the service. We made a recommendation about the on-going management and recording of staff training and support.

People were protected from harm. Staff received training and understood how to recognise signs of abuse and who to report this to. Staffing levels were sufficient to provide safe care. The provider had an effective recruitment process to make sure the staff they employed were suitable to work in a care setting. When people were at risk, staff had access to assessments and understood the actions needed to minimise harm. The service was responsive when things went wrong, were open and reviewed practices and had a system in place to manage incidents. People were protected by the service's arrangements for the prevention and control of infection.

People were supported by staff, as needed, with meal preparation and the provision of drinks. People received appropriate healthcare support as and when needed from various professionals and services. There were good systems in place to ensure staff and the provider worked with health professionals to promote and monitor people's health needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People and their relatives described the staff as exceptionally caring, kind, and compassionate. People could express their views about their care and felt in control of their day to day lives. Staff and the provider showed very good knowledge of the people they supported and understood how to maintain people's privacy and dignity. It was clear they had developed positive relationships with people and encouraged their independence.

People were involved in developing their care plans which were detailed and personalised to ensure their individual preferences were known. If a person's needs changed, then their care plans were updated. Information about how to make a complaint was available and people told us they were confident to raise issues or concerns. The service actively encouraged feedback from people. No one was receiving end of life care at the time of the inspection.

The service had an open and positive culture. As well as the staff, the provider and community care manager also provided care to people in the community, which gave people the opportunity to highlight any issues through face to face contact. People, their relatives and staff all spoke very highly about the way the service was managed.

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?

Good

The service was safe.

Medicines competencies were not documented to demonstrate staff had been observed and assessed to support people with medicines. Medicines were not formally audited. We have covered this in well-led as we found no impact to people's safety.

People and their relatives told us that they felt safe with the staff that supported them.

Staff undertook training and procedures were in place to protect people from abuse. Staff had a clear understanding of what to do if safeguarding concerns were identified.

There were enough staff working to meet the needs of people who used the service. Staff pre-employment checks had been completed.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff told us they received good training and support to carry out their role. However, training was limited to what the provider considered as mandatory. We have made a recommendation in relation to this.

People consented to their care and the service operated within the principles of the Mental Capacity Act 2005 to protect people's rights.

People's nutritional needs were reviewed and they were supported to have enough to eat and drink.

Staff knew people well and recognised when they may need to be referred to an appropriate healthcare professional.

Is the service caring?

Good

The service was caring.

Staff treated people and their relatives with kindness and compassion.

People were treated with dignity and respect by staff who took the time to support their independence.

Staff understood the importance of confidentiality, so that people's privacy was protected.

Is the service responsive?

Good

The service was responsive.

People's care plans were personalised and contained information on the activities in which they preferred to engage.

People knew how to make a complaint and raised any concerns with the managers if they needed to.

People and relatives were involved in their care plan reviews and all were happy with this involvement.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems and processes were not in place to audit and analyse the safety and quality of the service provided.

Statutory notifications had not been submitted to the Care Quality Commission.

There was a clear vision and values for the service, which staff promoted.

The provider and staff worked in partnership with other services to help ensure people received effective care.

People's views were sought through regular reviews and annual questionnaires.

We received positive comments about the provider in relation to how supportive they were and their commitment to the service.

Caring Hands

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 inspection took place on the 13 and 14 December 2018 and was announced. The inspection activity started on 13 December which was allocated to completing telephone interviews with people who use the service and relatives. We visited the office location on 14 December to see the provider and staff and to review care records and policies and procedures.

One inspector carried out the inspection with the assistance of two experts by experience, who spoke with people that used the service or their relatives on the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older persons' care.

Before the inspection we reviewed all the information we held about the service. This included notifications the provider had sent us. A notification is how providers tell us important information that affects the running of the service and the care people receive. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before our inspection we contacted the GP practice accessed by people, who staff liaised with and Healthwatch to receive their feedback on the quality of care provided. Healthwatch are an independent organisation who work to make local services better by listening to people's views and sharing them with people who can influence change. Their feedback was used to inform the planning of our visit.

During the inspection we spoke with seven people who were supported by the Caring Hands and 13 relatives. During our site visit, we spoke with two healthcare assistants, the community care manager, the office care manager and the provider. We reviewed four people's care files, four medication administration records, policies, risk assessments, health and safety records, consent to care and quality audits. We looked

at four staff files, the recruitment process, complaints, training and supervision records.

Good

Is the service safe?

Our findings

At our last inspection in April 2016, the key question of safe was rated as Good. At this inspection we found this key question remained rated Good.

The provider had policies in relation to safeguarding and whistleblowing. These set out how to recognise abuse, staff's responsibility to report any concerns and the responsibility of the provider to contact the local authority who were the lead agency for safeguarding. Staff had received training in how to safeguard people. Staff demonstrated they knew people well and understood the importance of reporting any signs or symptoms of abuse, such as changes in a person's mood or behaviour. Staff felt confident that the provider would act on any concerns they raised.

Information held by the Care Quality Commission (CQC) demonstrated there had been no safeguarding concerns relating to the service following our last inspection in April 2016. However, where a concern of alleged abuse had been raised, this had not been notified to CQC as required. The provider had raised the alleged abuse with the Local Authority for review and investigation. Therefore, people's safety had not been compromised. We have reported on this in the well-led section of this report.

Accident and incident forms showed where issues had occurred and how staff had responded. Staff recalled incidents where they had called the GP following a person having a skin tear. This information matched with details recorded on the person's incident form and showed staff had responded appropriately. No overall log was being kept by the service to help track any accidents/incidents and to consider any wider learning or improvements required. We have reported on this in the well-led section of this report.

Staff received annual medicines training and the provider and community care manager shadowed staff to help them understand how to manage medicines correctly and safely when supporting people. However, there was no formal process for assessing the competency of staff. People's safety had not been compromised and, without exception, people and their relatives told us they felt medicines were managed safely. We have reported on this in the effective section of this report.

The provider had a medicines policy which was available to staff and set out guidance for the safe storage, disposal and administration of medicines in people's homes. Each person's ability to manage their medicines had been assessed. A record was made of what type of support people required to take their medicines, the application of topical creams and who was responsible for ordering people's medicines. Clear directions were in place to guide staff to which part of a person's body each cream should be applied. One relative said, "When the instructions on new medication was not clear, they [staff] would not administer until they received clarification." When people were given 'when required' medicines, such as for pain relief, staff recorded the reason that these medicines had been given.

The provider told us medication administration records (MAR) were audited to check that staff were signing them when they gave people their medicines; and to make sure people were receiving their medicines as prescribed. When shortfalls had been identified, these were investigated and the appropriate action taken. If

staff had not signed the MAR when they had given a person their medicine, clear protocols were followed to help minimise the occurrence. If a person had not received a medicine, staff knew to seek medical advice. However, the audits were not documented and therefore could not be evidenced. We have reported on this in the well-led section of this report.

Where people did not require support with their medicines, staff did not assist. However, if concerns were identified about people's ability to safely self-administer, this was then raised with the provider, and the relevant discussions were had to ensure people remained safe. One person said, "I don't need any help with my medication, but they often check to see if I have taken it." One relative said, "Every day the carer checks the blister pack to see if [person] has taken the tablets. If they haven't taken them, the carer will let me know."

Without exception people and their relatives felt the service they received was safe. One relative said us, "They [staff] are marvellous and friendly. [Named person] is completely at ease with them. I am absolutely delighted with them."

Before a person received a service an assessment of risks in their environment was undertaken. This was to identify potential hazards in the person's home, such as uneven floors and with electrical appliances, and to look at ways to minimise them. Individual risks to people were assessed with regard to people's health and wellbeing such as when moving around their home, not having sufficient to eat or drink and of developing pressure areas. Where a risk had been identified, control measures and guidance for staff were in place detailing how to minimise the risk. For people who were at risk of falling, guidance was available about the type of equipment they required and the number of staff to support them safely. Detailed guidance was in place for people who used a hoist including what movements people could do for themselves, the type of sling and hoist and which coloured strap should be applied to a specific part of the body. One relative said, "A hoist is required to move [named person]. The hoist and sling is regularly reviewed and two carers operate it."

Risks to health and welfare were assessed for each person, reviewed and actions were taken to reduce those risks. Risk assessments sought to minimise the risk whilst allowing people to maintain independence within their own homes. These areas included moving and handling, showering or bathing, and for the risk of developing pressure areas. Information was available to guide staff if people had a health condition, such as diabetes, and included details of what staff should do in certain situations, what to look for and where to get further advice.

The provider had a recruitment system to ensure suitable staff were selected to support vulnerable people. This included obtaining pre-employment checks prior to staff commencing employment. These included references from previous employers, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS check helps employers make safer recruitment decisions in preventing unsuitable potential staff from working with vulnerable people. We looked at four staff recruitment files and found they contained all the relevant checks.

There were suitable numbers of staff to meet people's needs. The service was run by the provider, who was supported by two care managers. One being office based and the other being community based. An on-call service was available should people experience any emergencies or staff required support. People and their relatives told us staff were reliable and visits were always covered with staff attending at the expected time. People knew which staff member was coming and the time of the visit. This was recorded within schedules sent to people a week in advance. One person said, "I am very happy with the carers. I have different carers and they are all very nice. When you get to know the carers, they are like friends and they seem to enjoy their

work." Another person said, "One of the things I like about Caring Hands is that they are on time or within a couple of minutes. If they are held up somewhere, they always ring and tell me. They keep in touch with you so that you know where you are." One relative said, "We only have the one carer and she is the highlight of our week. She is very good, she is a happy soul."

People were protected from the risk of infection. Staff told us they were issued with personal protective equipment and correctly identified when they would wear this and change it. Staff demonstrated a good understanding of how to prevent the spread of infection. For example, staff washed their hands before preparing food and before and after supporting people with their personal care.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in April 2016, the key question of effective was rated as Good. At this inspection the service continued to demonstrate people received support to access healthcare services and staff delivered effective care and support. However, improvements were required to ensure staff received further training to underpin their current skills and knowledge. The rating has therefore changed to Requires Improvement.

The provider explained staff were expected to complete three mandatory training courses, which were medicines, safeguarding and moving and handling. Staff training records showed staff had not completed training courses such as first aid awareness, infection control and prevention, health and safety, food hygiene and the Mental Capacity Act 2005. There was no evidence of people having experienced harm because of this.

The provider used the medicines policy written by the Local Authority which states: 'Care providers should have a formal system to assess care staff competency when administering medication. This should be recorded in the care staff training file. It is expected that competency is checked annually as a minimum.' At the time of inspection, the provider confirmed there was no formal system for carrying out medicines competencies to observe and assess the knowledge and skill of staff when providing medicines support. The provider agreed to change this and showed us an example of a competency form that would be used to assess staff's competencies in the future.

The provider and community care manager told us they worked alongside staff until they were satisfied staff were competent in their role. Staff, people and their relatives who used the service confirmed this.

We recommend that the provider identifies key areas of training they expect staff to undertake to support the knowledge and skills required for their role. We also recommend that the provider reviews their training policy and keeps accurate and up to date records of training to ensure effective systems are maintained and staff are competent in their role.

Following our visit, the provider gave us sufficient evidence to demonstrate they had made initial efforts to improve their training programme. We will review the progress at the next inspection of the service.

New members of staff received an induction and shadowed the provider or community care manager for a minimum of one week. People understood the reason for this. One person remarked, "Staff are all well trained and there is always someone with them when they first start. They are all different ages and I can talk to all of them. They are all very nice." One relative said, "Any new staff member is always introduced during a shadowing visit before they come alone." This ensured staff knew people well, their individual needs and promoted continuity of care.

People told us they felt safe with staff as they had met them and knew they understood their care needs. One relative said, "Any new carers are always put on shifts with senior staff at first." New staff went to the office each week to help familiarise themselves with the needs of the people they would be supporting,

talking through their rotas with the office care manager. All new staff had a spot check to observe their practice. Further spot checks were undertaken if issues were identified. This showed new staff were supported to familiarise themselves with the service and expectations of their role.

New staff were required to complete the Care Certificate within 12 weeks of starting employment. The Care Certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. It was important to the provider that all staff were inducted on the values and ethos of the service. The provider told us it was important to them that each staff member represented the provider and worked the same way as the provider to deliver a high good quality service. Without exception people and their relatives confirmed this is what they received.

Staff had supervision twice a year. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed as well as considering any areas of practice or performance issues. Staff told us that they found these meetings useful. The provider said that as well as formal supervision staff had at least one observed visit annually where their performance and competence were assessed. They said that if there were concerns about any aspect of staff performance they would increase the level of support. Staff told us that they could get any support they needed by telephone or visiting the office, they described an open-door policy where support was readily available to them.

People received the support they needed to manage their dietary requirements. People's likes and dislikes were recorded in their care plans. People and their relatives told us staff responded to their individual dietary needs and choices. One relative said, "The carer buys individual puddings and fruit that [named person] likes. I buy the frozen meals and the carers cook a frozen meal in the microwave and [named person] is able to choose which meal they have. [Named person] will prepare their own breakfast." Another relative said, "They help with cooking by chopping the vegetables for [named person]." People's needs in relation to food and fluids were assessed and the support they required was detailed in their care plan. A record was made of what people were offered and how much they ate to monitor if people were eating enough.

Communication between care staff and staff in the office was good. Staff were sent some messages by text and there was a system in place to monitor this. Other changes were communicated by telephone or through a weekly update that was sent out with timesheets. The community care manager told us that each person had a communication sheet in their home which was used by staff, relatives and other health and care professionals to exchange information and ensure any changes to care were communicated. We were shown examples of these records. One relative said, "They [staff] keep a log book and I read it each time I visit. I can write in the log book if there are any issues, to let the carers know the next day what's happened." The provider said that district nurses and GPs had commented on how useful this system was in maintaining clear communication between all parties involved in a person's care.

Information about people's health and medical history were included in people's care plans. This set out the person's health condition, how it affected them and the support and assistance they needed from staff. One person's mobility had weakened, the provider worked in partnership with other health care professionals such as occupational therapists and district nurses, and acted on their advice. Staff knew to contact the district nurse if a person's skin integrity had deteriorated. Body charts were used to identify and monitor which part of a person's skin was affected. Relatives told us that they were informed of any changes in their family member's health. One relative said, "They [staff] went above and beyond when [named person] went into hospital and they had to wait for an ambulance. The carer waited and stayed with them until an ambulance came. I felt more at ease because someone was there with them."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. The application process for this is via the Court of Protection.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. No one was deprived of their liberty under an Order from the Court of Protection at the time of our inspection.

Staff followed the principles of the MCA and people's consent was sought in advance of care being provided. All staff we spoke with explained that they had received training in the MCA through their previous employment and always presumed people were able to make their own decisions. Staff told us they would always obtain a person's consent before carrying out any care. Staff knew to offer people choice and what to do in the event they refused care.

Good

Is the service caring?

Our findings

At our last inspection in April 2016, the key question of caring was rated Good. At this inspection we found caring remained Good.

People and relatives were complimentary about the staff providing the service and the way they delivered care and support. Feedback from people and their relatives indicated that staff were very friendly, but maintained a professional approach. Staff addressed people and their relatives by their preferred names.

One person said, "They [staff] are so caring. The way they speak to you is so comforting, they are very friendly. I can't fault them at all." Another person said, "The care we receive is beyond reproach. The carer is very efficient, kind and very pleasant." One relative said, "[Named person] has one carer who is regular and [person] is very close to them. I can tell that they are good friends and the carer will go the extra mile. For example, yesterday the heating wasn't working and I arranged for the plumber to come. I asked the carer to contact the plumber about the situation and they also rang [person] to make sure [person] was available."

People were involved with the development of their care plans. One person said, "I was involved in writing the care plan. It was reviewed earlier this year. The lead carer came to see me at home. She made an appointment to come. I would say that the whole thing is designed around the person and what they require. I have a telephone number for them and if I ring up and ask them to sort something out they do. They are very friendly." Where this was not possible the person would choose an appropriate person to support them, for example a family member. One relative said, "Originally [person] and I were involved in setting up the care plan. I have been through the care plan with the owners when they reviewed the plan." Another relative said, "The managers came to the house and we discussed the care plan together." Information on how people wished to be supported, their likes, dislikes and information that could enable general communication was sought.

People reported that the staff were, "Polite and respectful." The service ensured that people were visited by a consistent staff team, who had been selected based on their knowledge of the person's needs. In addition, as far as possible, staff were paired based on people's general likes and dislikes. This would allow them to provide personalised care. One relative said, "The staff understand what the [person] does and doesn't like."

People told us that staff respected their privacy and dignity when they attended to them. Staff could clearly describe how they maintained this. They told us they addressed people how they wished and always took note of what people wanted. People told us that staff respected their privacy when they attended their homes. When we asked one person if staff respected their privacy and dignity, they told us, "They [staff] knock and call out when they open the door." A relative confirmed, "They always knock and call [person's name] before they come in". Another person said, "When I am in the bath they pull the door to so that I have privacy."

Staff had a good understanding of equality and diversity. They discussed how they ensured people were not discriminated against and were treated equally. The service made certain that every person was cared for in

line with the Equality Act 2010 and the Human Rights Act 1998. People were provided with care and support that ensured they were not discriminated against. For example, people with protected characteristics such as a age, disability, gender reassignment, race, religion or belief, sex and sexual orientation. People with a physical disability had plans to ensure they were supported appropriately. This meant that equipment to maintain their safety was in place and used according to need.

People were encouraged to be independent and their individuality was respected. A staff member told us it was important to help people stay in their own homes and to work with people rather than do everything for them. For one person they had a walk-in shower to enable them to wash more independently. The person said, "I am 100 per cent comfortable with the care staff. They are absolutely wonderful. I am over the moon about being able to shower in the walk-in shower. They are kind, they are a laugh. I wouldn't change things." Another person said, "When I am showered, they make sure I am dry, I do try and do things myself to be independent and they encourage me. They are the first set of people I have had that are caring. I look forward to seeing them."

Confidential information was handled appropriately by staff and this included the use of any information held electronically. There was a policy and procedure on confidentiality and confidential records were held in the office and locked in cabinets. The staff induction programme included handling information, and staff had a good understanding of how they maintained confidentiality.

Good

Is the service responsive?

Our findings

At our last inspection in April 2016, the key question of responsive was rated Good. At this inspection we found responsive remained Good.

People told us that they received the care they needed, in the way they wanted. One person said, "They [provider] are very adaptable. When I was in hospital, they provided extra care for when I came out of hospital. They are very adaptable to your needs." One relative said, "I am not quite happy, I am really happy. I am over the moon with what they do for [person]. They are so efficient."

An assessment of people's needs was completed before a service was offered or agreed upon. These assessments were completed with information from the person and/or their families and health or social care professionals, where available. The provider told us that staff worked with health care professionals, such as GPs and district nurses, to ensure they had advice about working within current guidance. They told us how they had incorporated information about one person's health condition into the person's care plan. This gave them information about how the condition affected the person and current good practice guidance about how to care for them.

Care plans were developed from the full assessment process. Care plans were recorded on a computer system which could be accessed by the care managers to ensure the most up to date information was recorded. This was then printed and copies given to people. Relatives could access these records with the permission of the person.

Care plans provided clear written guidance for staff members. Information included why people needed the care and support they received, the difficulties the person experienced, what they needed help with and how staff should do this. Information was set out for different types of care needs, such as washing and dressing, continence and medicines management.

Care plans were written in a person-centred way, meaning that people's wishes were put at the centre of the care process. Care plans contained information such as the person's history, how they liked things done and how they communicated their everyday care needs. One relative said, "[Person] lets them know which way they want their care. They do take [persons] preferences into account." Another relative said, "I was involved in the care plan when they came to the house. They gave us general ideas on what we needed and how often they should come. They came to the house to review the care plan about three months ago and I was involved in that."

Care plans for those who had additional health conditions were available. These provided guidance regarding what staff should do if the person became unwell and described the effect this would have on the person. Staff had a very good understanding of people's needs in this area. They told us that there was enough information in care plans to guide them in supporting each person. We saw the care plans had all recently been reviewed and if new areas of support were identified, changes had been made. Daily records provided evidence to show people had received care and support in line with their care plan.

Without exception people and their relatives told us that they knew how to make a complaint and who to contact for this. There were copies of the complaints procedures in each person's care records. Records showed there had been no complaints in the past 12 months. People and relatives confirmed they had no need to make a complaint.

The provider was proactive in ensuring that they complied with Accessible Information Standards. These are standards introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. The service adapted to meet people's needs. For example, a person's care plan showed that staff were encouraged to check a person's hearing aids, support them to change their batteries and to keep their glasses clean.

There was no one at the time of this visit who was receiving end of life care. The provider had a policy and procedure for end of life care in place to support staff in meeting people's needs.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in April 2016, the key question of well-led was rated Good. At this inspection the rating has changed to Requires Improvement.

We reviewed the service's quality assurance and governance procedures. There was no formal audit of medicines, accidents and incidents, safeguarding referrals or care plans. Accidents and incidents were appropriately responded to but the lack of auditing meant that the provider did not have an oversight of what was happening. This meant they were unable to identify trends or recognise any potential issues. The provider had an insufficient training plan in place, relating to medicines, safeguarding, and moving and handling. The provider agreed they needed a plan as this would help identify training requirements to support staff to gain and develop their knowledge and skills relevant to their roles. The provider had policies and procedures in place to guide staff. However, there were no systems in place to check and review the policies and update them if required, to ensure staff were following current best practice guidance. The provider's safeguarding policy did not contain the safeguarding team contact details for all the local authority areas in which the provider worked, nor the Care Quality Commission's (CQC) details. They also did not contain the new legislation relating to the General Data Protection Regulation (GDPR) and relevant data protection law which came into force in May 2018. Systems and processes were not robust in relation to governance and records and were not effective in measuring and monitoring the quality of care provided and the service overall.

The provider's failure to implement effective quality assurance systems and processes to monitor and improve the safety and quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. This is necessary so that we can check that appropriate action has been taken. Notifications are changes, events or incidents the provider is legally obliged to tell us about within required timescales. The provider had failed to submit notifications for the death of one person that had been receiving a service and of an incident of alleged abuse. The provider was unaware of what their responsibilities were regarding this. The provider did not have an effective system to prompt them to send notifications to CQC of significant events in line with requirements. In response to our feedback the provider submitted these notifications at the time of the inspection. During the inspection we showed the provider the CQC website which gave guidance about notifications.

Failure to submit statutory notifications was a breach of regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009.

We discussed the failures in relation to governance with the provider, who acknowledged improvements in the monitoring of safety and quality were required. They gave us examples of measures they had begun to ensure these improvements were made without delay and to ensure the service benefited from good quality leadership in the future. Following the inspection, the office care manager sent us evidence of a new

monthly audit tool which meant incident records will be audited by a manager monthly to ensure incidents are analysed for patterns and trends. The tool checked that incidents requiring referral to the local safeguarding team had been made and if CQC had been notified as required. The provider offered assurances they would audit the service monthly to ensure all safety and quality monitoring aspects of the service improves. At our next inspection, we will assess how changes to their quality assurances processes have been embedded to ensure improvements are made and sustained.

We asked the provider what their knowledge was of 'The Duty of Candour', Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. The provider told us, they had not heard of this and therefore had no system in place to ensure its compliance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given and on a provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The provider had failed to display their rating on their website. When we notified the provider of our visit, we also notified them their rating was not displayed. We provided them with the guidance to initiate this without further delay. At the time of our visit to the office, the rating was displayed on the provider's website and at the location. The provider informed us they were unaware of their legal obligation to display their rating, despite being given the guidance to do this at the time they received their final report in 2016.

We discussed with the provider, the concerns we had regarding their lack of knowledge around their legal registration obligations. The provider acknowledged there was a 'knowledge' shortfall that could potentially impact the quality of care people experienced and how staff were supported. The provider told us they had recognised this before our inspection visit which is why they had appointed an office care manager. The provider told us it was their intention to support the office care manager to make an application to CQC to become the registered manager for Caring Hands. 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.

It was clear the provider was fully committed to ensuring people were well cared for and supported. This was confirmed by what we were told by staff, people and relatives. The provider told us this is where they spent their time, delivering care to people, supporting and shadowing staff. We spoke with the office care manager who told us, the provider had encouraged them and was supporting them to complete a Diploma, level 5 in 'Health and Social care management.' This is a work based award that is achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The office care manager demonstrated they were enthusiastic about the opportunity to apply for registration with CQC.

Without exception people and relatives we spoke with, were extremely positive about Caring Hands, highlighting both the high standard of care and the professionalism of the management.

Comments from four people included:
"I do feel that Caring Hands is well-led. As far as I know, it works very well.", "I need the confidence that somebody is here and they provide that. I am very happy with them, I am pleased with what they do and how they help me.", "I think Caring Hands is very good. It comes from the top and permeates through. The owner is very business-like, they know what they are doing. The service is efficient, prompt and very

pleasant.", "I would recommend the service to a friend. I would say that they give us what you need, which is what you want."

Comments from four relatives included:
"I do feel the service is well managed.", "I have found them to be polite and if I have had to leave a message, they do ring back.", "You tend to forget all the good stuff because it just happens naturally with Caring Hands. Their telephone manner is always excellent. They are caring, reliable and not too expensive, so they are value for money.", "I would say that they are well organised, always helpful and they are usually pretty well on time, kind and caring."

The culture of the service was open, transparent and supportive with honest leadership in place. Staff told us they worked within a caring and supportive team where they were valued and trusted. Staff morale and a team spirit throughout the work force were good and staff were committed to their work with their colleagues. Staff told us they felt supported and valued by the provider and that any suggestions made were listened to. Communication was achieved through a range of meetings. Staff memos were sent to keep staff up to date with best practice, polices and introduce new staff members each Friday. All staff were provided with a handbook which set their expected standard of contact and key policies such as safeguarding and whistleblowing.

Spot checks were carried out twice a year on each staff member to assess the quality of care provided. These checks included if they arrived on time, treated people respectfully, communicated effectively and carried out all expected tasks. This included how staff moved people, medicine management and the correct use of infection control procedures such as using gloves and aprons appropriately. The checks included looking at the persons care records to ensure they were fully completed and meeting people's current needs. When any shortfalls had been identified, action had been taken to address them. At the time of our visit, the provider had identified that it would be beneficial for spot checks to be carried out monthly in the future to monitor the quality of care people received.

Disciplinary procedures were set out in the staff handbook and included the expected standards of staff performance and behaviours. The provider demonstrated they understood how to follow these procedures to make sure staff working at the service were of good character and had the necessary skills and knowledge to carry out their duties.

Feedback from people and their relatives about the quality of the service was sought through survey questionnaires. The results of the survey in 2018 had only recently been received, so had not yet been shared with people and staff. People responded that overall the service met their needs, choices and wishes and that they would recommend it to others. People said they were treated with dignity, staff arrived at the right time, staff were polite and helpful, had enough time to spend with them and talk to them.

The provider worked in partnership with other health care professionals such as occupational therapists and district nurses to meet people's health care needs. Feedback from the GP practice informed us communications with Caring Hands had always been positive.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The registered person had failed to notify the Commission without delay of the death of a service user. (1)(a)

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the CQC of an incident where a service user suffered abuse or an allegation of abuse had occurred. (1)(2)(e)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not established systems and processes to audit and monitor the safety and quality of the service provided. The arrangements in place were not as effective as they should be to ensure compliance with the fundamental standards. (1)(2)(a)(b)