HH Community Care Limited

Stocksfield and Haltwhistle

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

We last inspected this service in February 2016 where we found the provider was not meeting regulations and these related to safe care and treatment, including medicines; complaints and governance at the service. We issued the provider with two warning notices for the failure to meet regulation 12 and 17.

This inspection took place on 1, 2, 3 and 4 November 2016 and was announced. This was so we could be sure that staff would be available in the office, as it is a domiciliary care service. The inspection included a follow up to the previous regulations which were not met.

Stocksfield and Haltwhistle provides personal care and support to people within their own homes or the community in Hexham, Haltwhistle and the surrounding areas. At the time of our inspection 247 people were active on the services register with over 155 staff members employed. There was a range of people using the service including older people and those with learning disabilities. Staff supported people with a variety of care packages, from shopping to 24 hour support which included personal care and administration of medicines. The service also offered an enablement service. This means staff support people to do tasks they would not normally be able to do without support. For example, going out to the shop or visiting the hairdresser.

The service had a registered manager in post. 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. The registered manager was also the nominated individual. A Nominated Individual has responsibility for supervising the way that the regulated activity is managed. They should be an employed director, manager or secretary of the organisation.

The practice around medicines had not improved since the last time we inspected and we found further concerns in the way that staff recorded people's medicines and the practices that were followed. Accidents and incidents were not always fully recorded and it was not clear whether they had been dealt with effectively by the provider.

People's records were not always up to date or relevant, including care plans and risk assessments. Reviews had taken place, but not always with the person or their relatives fully involved. There were no monitoring checks in place for care records, medicines or accidents for example. We also found policy and procedure documentation continued to be out of date.

People were encouraged to make their own decisions and where they could not, best interest decisions were made. Where it was considered that people did not have capacity to make decisions, records did not show how capacity was assessed, or detail how 'best interests' decisions had been made. The service did not routinely asked for details of lasting powers of attorney or if a person was under the court of protection. This meant that details may have been missing which were needed to make a best interest decisions and

ensure the correct people were involved.

People knew how to complain. However, the provider continued to not have suitable systems in place to evidence that complaints would be dealt with in a timely and effective manner.

People told us they felt safe with care staff. There were safeguarding policies and procedures in place. Staff could tell us what correct action they would take should they have any areas of concern around people's safety.

There was enough suitably recruited staff to provide quality care to people in their own homes. The provider had ensured the staff were trained to provide the care people needed. This included face to face and eLearning training. Supervision and appraisal systems were in place and staff meetings took place.

People were supported with their nutritional needs, including having enough food and drink and maintaining their choices around these.

People who required additional support from other healthcare professionals, for example GPs, were supported by staff to arrange this. People told us that the staff who supported them were friendly and caring and respected them and maintained their dignity.

Although the some changes had not been initially made, the provider has now made some improvements, although not enough to meet the breaches we found. We have asked the provider to send us weekly action plans and are closely monitoring this information to ensure that actions are taking place to address our concerns.

The provider had not sent us notifications which are a legal requirement of their registration regarding, for example, changes to their registration and had failed to display their latest rating on their website.

The provider was in breach of four regulations; 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?

Inadequate

The service was not safe.

Medicines were not managed safely.

Risk assessments and accident recording was not completed fully and correctly.

People said they felt safe and that staff supported them in a safe manner, however, this was not supported by what we found. Staff had received training in relation to safeguarding adults and said they would report any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

At the last inspection a recommendation was made in connection with the Mental Capacity Act to the provider. This had not been completed.

Staff had received training to meet the needs of the people in their care, although we were concerned about medicines training and whether it was suitable to address the issues we found with the safe management of medicines.

People received food and drink which met their nutritional needs and staff supported people with any additional healthcare needs, including appointments to hospitals or visits to the GP.

Is the service caring?

Good

The service was caring.

People told us that staff were on the whole caring and that many of the staff they had known for some time.

People told us that they felt their needs were supported and staff respected their privacy. They felt that their dignity was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records had all been reviewed since our last inspection but they still lacked detail and were not fully person centred.

There had been no complaints since the last inspection and people confirmed they knew how to complain, however, the system had not been improved and paperwork was stored with other different processes.

People told us they were involved in their care initially, but were not always able to confirm involvement after that.

The provider had groups in the local community to help people avoid social isolation.

Is the service well-led?

Requires Improvement

The service was not well led.

The registered manager at the service, who was also the nominated individual, wanted to provide "Good old fashioned care" to the people using the service. However, we found they had not been proactive in ensuring the correct processes and procedures were in place and monitored.

The registered manager had not sent in notifications as legally required or displayed performance ratings on their website.

Quality assurance checks were not in place.

Policies and procedures were in place but needed to be updated to provide staff with accurate information and guidance to help them support people appropriately.

Stocksfield and Haltwhistle

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, and to follow up on a warning notice issued at the last inspection.

This inspection took place on 1, 2, 3 and 4 November 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office when we called and also to give prior warning and arrange visits to people using the service. The inspection was carried out by one inspector, one pharmacist inspector, one expert by experience and one specialist advisor. 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 specialist advisor had a background in nursing.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service, including the notifications we had received from the provider about safeguarding concerns and deaths. We also contacted the local authority commissioners for the service, the local authority safeguarding team and the local Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. We used their comments to support our planning of the inspection.

We visited eight people and spoke with 11 others who used the service. We also spoke with seven family members/carers of these people. We briefly spoke with the registered manager (who is also the nominated individual), a director, the clinical lead, the training officer, one team manager, five administration staff (which included two scheduling officers) and six care staff. We observed how staff interacted with people and looked at a range of records which included the care and medicines records for seven people who used the service. We looked at six staff personnel files. We also looked at other documents relating to the

management of the service, including policies and procedures.

We contacted four district nurses during the inspection process and three local GP's. Where we received responses, we used these to support our judgement of the service.

We have asked the provider to send us weekly action plans and are closely monitoring this information to ensure that actions are taking place to address our concerns. We will follow this up with a further inspection to ensure that all concerns have been addressed and will report on our findings.

Inadequate

Is the service safe?

Our findings

At the last inspection the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to safe care and treatment. People were not fully protected because the provider had not always accessed and mitigated against risk. Accidents had not always been recorded or monitored fully. Risk assessments were not always completed or reviewed. Medicines had not been managed safely and in line with good practice.

A review of people's care had taken place, however, there continued to be shortfalls in relation to risk assessments, management of medicines and accidents were not always recorded fully or monitored.

People's medicines records were not completed accurately. Staff had not been provided with full details of the medicines that people were prescribed. Staff had not followed a specific method to record medicines, and instead, we saw a range of comments had been used, including, "Prompted medicines"; "X tablets prompted"; "Given tablets from dosette box"; "Eye drops" and "Legs creamed". Dosette boxes are monitored dosage systems used by pharmacists to dispense medicines so that people can keep track of what to take at particular times of day. They are usually in some form of tray with medicines boxed into individual pods which are labelled by day and time. We found there were cases where the actual medicine was recorded and not always the quantity given. From the records we looked at, it was impossible to ascertain if medicines had been administered as prescribed as no clear detail had been logged. This meant that people were at risk of not receiving their medicines as prescribed.

Staff had not been supplied with information about how to administer medicines safely and we saw medicines had not been administered as prescribed. Some medicines that needed to be administered at a particular time of day and before food, had not been. Staff had given these medicines with other medication approximately an hour after food. We also found that this particular medicine for one person had been given at the incorrect times on two occasions. The person told us, "I sometimes have to remind the staff to give it to me."

We found another medicine had not been administered for two weeks. This meant that the particular person was placed at higher risk of harm due to the medicine not being administered as prescribed.

Staff had no record of what medicines people should have been taking and relied on the correct medicines being sent by the pharmacist. This included medicines in dosette boxes and those in separate boxes. In some cases, when staff had written on people's medicines records, for example, seven tablets taken; we could not be sure if this was from the dosette box or the individual boxes prescribed. This placed people at risk of not receiving their prescribed medicines and could have impacted on the effectiveness of the medicine in question.

One person we visited had a number of out of date medicines on display, and although they only took one particular medicine, we found no record to show that staff had taken any action to discuss the need to dispose of these medicines with the person or with the provider, which potentially put the person at risk of

harm.

We found staff were administering medicines to people when they should have been prompting. For example, one relative told us, "Staff remind [relative] to take their tablets and they do it themselves." However, we saw a staff member administer medicines to this particular person which was not in accordance with the care plan or risk assessment in place.

Staff used the word 'prompt' when records and observations showed they were administering medicines to people. People confirmed that staff administered their medicines to them. One person told us, "The staff sort it out and give me the tablets in a pot, it's hard for me to get the tablets out of the container." Another person told us, "The staff put the meds in the pot and watch me take it." A third person was seen being administered medicines from a shop bought dosette box and staff waited until they had taken it. A fourth person told us, "I know not to touch my medication or take it, I take it when the care worker gives me it." In all these cases, the staff had recorded they had 'prompted' the person to take their medicines. There is a difference in best working practices between 'prompting' and 'administering' and these practices were not being followed by staff or monitored by the provider.

We asked a senior member of staff how many people who used the service had their medicines administered to them and they told us, "None." We found this particularly concerning as they told us that all staff, "Prompted" people to take their medicines and we were aware from the last time we inspected that many people had their medicines administered to them.

Where care staff had been trained in medicines administration, we saw documentary evidence that a senior member of staff had completed supervision and a competency observation. However, from conversations with senior staff, we could not be confident that they were aware of best practices in relation to administering and prompting medicines, or were able to distinguish between the two. From the practices that we saw, we were concerned that supervisions and competency observations were in need of review.

People care notes showed that in some cases, medicines were regularly left out for people to take unobserved. The related care plans did not indicate if medicines had to be taken at specific times and were not always clear on actions staff should take. This meant there was a risk of taking the medicines at the incorrect time and not in the correct way.

Care plans did not always include the details how staff should fully support people and relevant medicines risk assessments were not always fully completed. One person took a particular medicine which needed to be taken at specific times every day. There was no record in the risk assessment of what staff should do in the event of a missed dose. This meant staff may not have been fully aware of the risks or what to do if the person took an overdose for example or missed a dose by accident.

Accidents were recorded on the providers IT system and staff telephoned the office to log any events. We found that when staff had called in to report events, that these were not always followed up with details about what had happened after the event. Copies of accident forms were not kept separately at the provider's office and were archived with people's other care information when they were returned to the office periodically.

Accidents continued not be monitored and analysed for any trends forming, even though the provider confirmed they could review and analyse information by printing off the electronic entries for each individual. This meant that people may have not been fully protected from further accidents occurring.

We found there were risk assessments in place for care staff to be able to work in people's homes safely. Risk assessments had also been completed for example, in relation to supporting people with personal care, dressing or emptying commodes, but had not been put in place for all issues. For example, one person who required creams to be applied to a particular area of their skin. We also found risk assessments continued to be basic and did not include particular action for staff to take in case of an accident, for example, risks relating to medicines had not been addressed. They also contained detail about risks that did not apply, for example, in relation to the use of a commode when the person did not use one. We found a number of people who needed particular medicines at certain times of the day and required them to be taken before food; however we could not be assured that this had occurred and risk assessments were not in place to mitigate against this eventuality. We found that risk assessments had all been reviewed recently, however, the assessments continued to be inadequate in places. The provider had not ensured that all risk assessments were detailed to protect people and the staff working with them from possible avoidable harm.

There had been a number of recent incidents which had left the provider short of care staff, including the cover arrangements to over 60 people the week before the inspection. The provider had contacted the local authority and they had worked together to ensure that all the calls were covered by utilising other providers in the local area. We asked the director for a copy of the organisations emergency contingency plan and they told us, "We work together with the local authority and use theirs [local authority contingency plan] to make sure everyone is covered." This meant that the provider did not have a contingency plan in place for such events and relied on the local authority to support them with cover arrangements.

These were a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to safe care and treatment.

People told us they felt safe with the care staff from Helping Hands and their relatives confirmed these feelings. Comments from people included, "I trust the girls with my life, and I know my things are safe when they visit"; "I always feel safe with the carers and trust them"; "I feel very safe with the carers always"; "I feel safe" and "Yes I feel safe here…the staff make me feel safe."

One person had two care staff attend on each visit and said they always felt very safe when being hoisted. Relatives comments included, "I am confident when the carers are with my husband he is safe"; "Nice to have local carers"; "Staff are absolutely great" and "I think [relative] is safe with the care staff, they seem sensible in that respect." However, one relative told us, "Have regular staff… I get nervous when they are off and feel standards slip."

Staff were able to explain the process they would follow to report any concerns. We were satisfied from the conversations we had with staff and people, that people were safe and that staff would report any concerns they had. However, when we asked the provider to give us a copy of their safeguarding policies they sent us an out of date working protocol from the local authority dated 2008. The provider had safeguarding procedures in place although these needed to be reviewed and updated in line with current process and best practice.

These were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to good governance.

People we spoke with told us that there was generally enough staff and they were mostly on time, with the odd occasion of being late. Comments included, "Staff more or less on time"; "Regular team of care staff"; "I have a set time, and the office will call me if they [staff] are late"; "I mainly have one carer which is nice" and "I see the same group of carers." One relative told us, "We tend to get the same care staff which is good, we

understand that staff need holidays." People told us that they received weekly rota's which informed them of which staff would be attending. One relative told us, "The usual care staff are wonderful, it's when you get stand-ins where some problems can occur. I don't want to make a fuss, but it could be better."

We were made aware that the provider subcontracts to other organisations in the area when they did not have enough staff to support people. As the service is the local authorities preferred provider this means that the organisation is the first point of call for the local authority if a person is in need of a care package. When the service does not have enough of its own staff to support a new person's care package, they rely on other local organisations to fill the gap. We were made aware of an issue in the week before the inspection of a large number of staff being ill. The provider had contacted the local authority to inform them and they had worked together to ensure that every person was covered.

Staff were provided with work mobiles to keep in touch with the office and to ring people if they were delayed. We were also informed that these phones were used as a safety measure in case of emergency and the need to contact emergency services was required. We noted that the provider had issued staff with personal safety alarms and they had on call emergency numbers for staff to call should they need additional help. This meant processes were in place to support staff when they were lone working.

Safe recruitment procedures were followed. We found appropriate checks had been undertaken to ensure staff were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Staff had completed application forms and identity checks had also been carried out. References had been provided and approved. We noted that copies of actual CRB (which was the system used prior to DBS) forms were still kept on staff members files. These were no longer required to be kept in line with best practice guidelines.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we made a recommendation to the provider that they use best practice guidelines to follow the Mental Capacity Act, including in the recording within people's care records of relevant information. We found that the provider had not followed our recommendations.

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. Staff had been provided with an overview of the Mental Capacity Act 2005 (MCA) during their induction. We also saw that a small number of staff had completed Deprivation of Liberty Safeguards training (DoLS). DoLS is not applicable in this type of service. The provider would refer to the Court of Protection with any concerns relating to a person's capacity in order to keep them safe from harm. Management confirmed that no person had been referred to the Court of Protection.

We saw examples recorded in daily care records where staff had conferred with relatives or health care professionals when a decision needed to be made for people who lacked capacity. A member of care staff told us that one person had a Lasting Power of Attorney (LPA), although we found no information on the person's records in their home. A 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. It was not always clear from the person's records how staff had established the person lacked capacity or how the best interest decision had been made and by whom, although we saw in some cases that information had been provided by the local authority.

We discussed this with the provider and they confirmed that no mental capacity assessment had been completed by them and no best interest decisions had been recorded separately. We were not able to establish if people had a LPA or if they were subject to a Court of Protection order because the provider had not routinely asked this question during the assessment process or recorded these details as a matter of course in people's records. One relative told us they were the LPA for their relative, but we found no detail in their relative's records to confirm this was the case. Although we saw no evidence to show staff were, it meant they may not have acted in the best interests of the person because the provider had not followed our recommendations and placed relevant paperwork in place to record this.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In relation to good governance.

People felt that staff provided them with an effective service. Comments included, "The service works well because they work hard to match people [staff] to my needs"; "I feel my carers are matched well, if I'm not happy they have changed my staff"; "The staff know what they are doing…very happy" and "Cannot fault the staff." Family members told us, "Staff are well matched and always offer [relative] choice"; "Staff are trained

to [relative] specific needs"; "They [staff] understand my [relatives] needs, they communicate well with [relative]" and "Happier now we have these wonderful carers."

Staff had received support sessions with their line manager and also as part of a group in team meetings. We noted by looking at staff personnel records that the number of support session's staff received varied. However, staff told us they felt fully supported, one member of care staff said, "I can go for support whenever I need it, they are good like that." Annual reviews (appraisals) were carried out and the provider was in the process of working through these.

At the last inspection we found the organisation had an induction programme which included the review of operational policies and procedures such as, the care of pressure care, confidentiality, and record keeping. Staff had told us the induction they completed was good and staff assured us they were following the Care Certificate standards. The Care Certificate was introduced on 1 April 2015 as a framework of good practice and is a set of standards that social care and health workers stick to in their daily working life. We therefore did not recheck this information.

The staff that we spoke with felt that they had received training appropriate to meet the needs of the people they supported. They also confirmed that they had completed NVQ training in health and social care and we saw evidence of this which the provider showed us. NVQ training has been replaced by a diploma and relates to training (including observations) completed while working within a particular type of related service. The service had a clinical support manager who had responsibility for providing advice and support to staff in regard to people's specific health needs. Staff had received a range of training, including, emergency aid, safe moving and handling and care planning and these had been via eLearning or face to face. We saw that staff had undergone competency spot checks which had been completed by the management team. However, these checks and training had not addressed some of the issues that we found during our inspection, particularly in regards to medicines.

From people's records we saw that when they needed support from healthcare professionals, for example, GP's; staff had supported them. One person told us, "If I need to see a doctor they [staff] will call one for me." Another person told us, "I normally call for an appointment myself, but I do remember a time when I was not well and [staff name] called the doctor for me because I could not." Relatives confirmed that if their family member had ever needed support with making any appointments or liaising with health professionals, that staff would provide this level of support or help to them. One relative told us, "I usually do all the arrangements like that, but I have confidence that staff would if I asked."

People told us they were satisfied with the level of support the service provided them in respect of their needs regarding nutrition and hydration. Relatives confirmed that care staff provided the level of support their family member required. People's comments included, I'm always asked what I would like to eat or drink" ; "I like all my carers and they always ask me what I would like to eat and drink" and "They [staff] make me my breakfast, something at lunch time and then my tea later in the day. I don't know what I would do without them……...starve probably." One relative confirmed that staff ensured that their family member had something to eat which they had left for them. They said, "They make sure [relative] has eaten something, otherwise they may forget." Another relative told us, "I rely on the staff for that. They make sure a sandwich or something along those lines is left at lunch time." This meant that people received food and drink of their choice at the times they needed.

Good

Is the service caring?

Our findings

People and their relatives were generally very complimentary about the care staff who supported them. Comments from people included, "The two care workers always include me in the conversation, I am never ignored….always involved with everything"; "They [staff] always listen to any suggestions and implement it if they can"; "They [staff] are lovely and so helpful, I could not cope without them"; "I trust the carers, they are always nice and pleasant"; "Very Happy"; "Happier than I've ever been"; "All the staff are very kind" and "Very caring staff, can't do enough for me." One particular person said that the care staff were, "Like extra daughters to me…I love them all." One district nurse we spoke with told us, "Whenever I have been involved with staff, they have always been as caring as they should be in this sort of service. No problems there."

Comments from relatives included, "Overall I am happy"; "Care staff and office staff are lovely"; "I don't know what I would do without the care staff"; "Staff are great" and "Trust the carers." One relative said, "The carers are all lovely, very caring and including [relative] in everything…..they always make time to check if I am ok too…we have only used the service for about five weeks and I didn't know what to expect and I am so impressed already, they are brilliant."

People we spoke with thought that staff respected them and helped them to retain their dignity. One person told us, "They respect me and my dignity….when I had a little accident, they were great, and did not embarrass me anymore then I already was." Other comments included, "They show me respect"; "Carers listen to me, very nice people" and "Staff are a credit to the company."

We heard a number of conversations taking place with staff in the offices of the service. In general the conversations showed a caring manner and a wish to resolve the situation the person calling the office found themselves in. One staff member was heard speaking with one person about a forthcoming appointment they had and that they wished to cancel a visit. The staff member clearly knew them and asked them about issues that were personal to them and a pleasant conversation took place. Staff were heard speaking with people in a kind and cheerful manner. Through conversations we had with the provider's representative (director) and other staff within the management team, we saw that a caring environment continued to be displayed throughout the organisation. However, we did find one staff member who was curt. After the staff member had left the person told us, "I don't like the way she talks to me, it's like I am a child, but I don't want any fuss." We brought this to the attention of the new general manager who made a note and said he would look into the matter. Overall, we found that this was an isolated case and that the overwhelming majority of staff were respectful of people from what we saw and from what people and their relatives told us.

People were supported to remain independent. One person told us that staff encouraged them to get up and move about. Another told us, "[Staff name] helps me to get out, which I was not good at doing before." One person said, "The staff encourage me to make choices." Another person said, "The staff encourage me to make decisions about what I want to do and help me to do it."

The provider tried to make sure that people received continuity in the support provided by sending the

same staff. We saw from records that the provider had tried to ensure that this was the case and only in emergencies would this be different. A number of people that we spoke with told us that staff had been visiting them for many years, and were still the same. One person thought so highly of one particular member of their caring team that they told them they were not allowed to retire and said, "She will have to come up the drive using her Zimmer."

All of the people and their relatives we spoke with were aware of their care plans and said that it was reviewed regularly. Although one person was not aware that it had been recently reviewed and another relative who was normally fully involved with reviews was unaware that a review had taken place. Reviews had been completed at times, without people or relatives involved in the process. Overall, however, we found that the provider did carry out reviews with the full involvement of people or their relatives.

We did not see any evidence of people using advocates. All of the people that we viewed had family support of some description. Staff at the service were aware of how to access advocates if the need ever arose. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. This meant that if people needed the support from this type of service, staff would be able to support them to find an appropriate service.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the provider had not always maintained up to date care records and found that they were in breach of regulations 17. When we returned we found that although reviews had taken place, issues remained and the provider continued to breach regulation 17.

The provider had also been in breach of regulation 16 in relation to complaints at our last inspection. Although no complaints were recorded since we last visited, we could not confirm if the correct procedures would have been followed, as the file in which complaints were held appeared unchanged. We will review this at our next inspection.

Staff completed referral forms for people who intended to start using the service. The referral form collected key information about the person and this was used as the starting point in building a care plan tailored around the person and to ensure it met the needs of individuals. People's records included information on their care preferences, likes and dislikes. People had parts of their background documented to help staff provide suitable care. This information had been usually completed with people and their relatives. For example, one person told us they had been fully involved when they first started to use the service and said, "The staff visited and we went through what I wanted them to do. They have been very good and if I need to change anything….it happens with no problem." A relative told us, "Staff prompt medicines and help with meals." However, when we looked at this person's care plan it stated that staff supported them in other ways that was not required, including emptying a commode and helping them to get dressed. The person confirmed they used the toilet themselves. This meant that care plans were not tailored to people's individual needs.

People's care records continued to be inaccurate or not fully completed. For example, one person's care plan stated that they were prompted medicines and we saw staff administer medicines to them. We were also told by people that staff administered medicines to them, however their care records did not state this. One person had no care plan in place, only the one provided by the local authority which was lengthy and not tailored to the person's specific needs which the staff would be addressing. Overall, it was still not clear from the records we saw that the provider had fully assessed or planned people's care and support needs to meet each individual's needs.

These were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three people showed us where the office telephone number was in their records held at their homes and said they would call the office if needed. One person said, "I would ring them if anything was wrong". People and their relatives knew how to complain. We saw that people had a copy of the complaints procedure in their homes. The people we spoke with seemed to understand how they would complain and comments included, "Had Helping Hands many years…. no reason to complain"; "I Would call the office to complain"; "Any complaints, I'll call the office and they will listen and always try and help"; "If I complain action will take place"; "I've had no complaints, but if I did, I am confident the office would help me" and "I asked for a

different carer once and they changed them, this put my mind at rest." One relative we spoke with did not know what would happen if they did complain. Relatives held mostly the same views as people, although one said, "I would call the office to complain, but not confident they will take action." We tried to find out more information about this comment but were not able to. Another relative said, "I would speak to staff generally, but if I could not get the issue addressed, I would take it up with the office."

When we viewed the complaints policy we found that changes had been made, however the policy was not robust and did not include all the information it should have. For example, details of local government ombudsman who local authority funded people could contact if they were not satisfied. Although there had been no complaints since the last inspection, we found record keeping still needed improvement with complaints, safeguarding information and incidents all in the same file. We found no clear order and it was difficult to match records together. The way complaints were recorded was raised as a concern at the last inspection and from what we found, nothing had changed.

These were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt that staff were responsive to their needs. One person told us, "They [care staff] always try and do any little jobs that I ask them to do." Another person told us, "All my needs are met." We saw from one person's care records that after a recent review, their care package had been increased. Another person was in the process of having their care increased after a further review had taken place.

One member of care staff told us about a person who used the service, "The care package works well and we enable the client to stay in their own home and enable them to go out in the local community a few times each week… it works well as long as there is continuity with care staff. Managers have always tried to make sure it is always the same staff, because the client gets upset and this has an impact on their mental health."

One member of care staff informed us that they had reported to the provider an occasion where a person had been influenced by cold callers to sign up to charity. The member of staff stated this had been dealt with by her line manager immediately with the person receiving an apology from charity concerned. Other measures were taken to stop this happening again and the "person was happy with the outcome".

The provider had set up support groups within local communities for people to attend in recognition that people enjoyed this type of social event. A director of the service told us groups were set up using various fundraising and other activities within the local communities. They said, "People come along and join in a number of activities….it's important for them to meet others and keep in contact with people from where they live. It's terrible when people have nothing to go to or don't have an opportunity to have a chat with other people. We have done this for some time now."

Two people we spoke with were taken out by staff as part of their care package. They told us they went to a range of places, including for tea, to garden centres and local community venues where they were able to meet friends. One person told us, "I always bump into people I have known for years and it's nice to see them and have a chat when I go out."

People were given a choice. They told us, "Staff always give me choice" and "Staff give me choice and leave me snacks and drinks". Another person told us, "The girls [care staff] never force me to do or have anything I don't want…..they ask me what I want to eat and help make it. They are very good." A relative told us, "We choose what is going to happen and the staff follow what has been asked of them."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection people and staff were not fully protected because the provider had no quality assurance systems in place to monitor the service provided to the people receiving it. This included monitoring risk and ensuring policies and procedures were up to date. The provider did not always maintain up to date records for people or keep them secure at all times and failed to check that records were completed appropriately by staff. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had made some improvements but had not addressed all of the concerns we had raised. Archived records were now stored appropriately and other records were kept secure in locked filing cabinets. However, the registered manager confirmed that other issues had been left for the newly employed general manager to address when they started their employment. As the new general manager started their employment on 1 November 2016, the registered manager had not actioned the warning notice which should have been addressed in July, meaning that people and staff were not fully protected as quality monitoring systems remained poor.

The service had a registered manager, who was also the nominated individual. They had worked for the organisation since 1993. We saw very little of this person during the inspection as we were told they had retired, although they did send us information we required prior to the inspection and kept in touch via emails throughout.

We noted in a newsletter sent to staff in April 2016 that the registered manager had announced their pending retirement in September of the same year. The provider had failed to send us a notification of change to the service in respect of the retirement of the registered manager/nominated individual.

This is a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

Training needs analysis had not been completed and we found that the medicines training that staff received had not been reviewed in light of the issues we found at the last inspection. Training was not checked to ensure it was robust to meet the needs of people who used the service. We saw in records that the provider aimed to look at staff development and wanted to complete a training analysis of the staff team, however this had not occurred to date. We found a number of staff had out of date training and because the provider had not monitored this effectively, people were at risk of harm because staff may not have been following best practice procedures.

People received an initial review after staff had worked with them for a number of weeks into their care package and then six monthly checks thereafter. Notes from records held in people's homes continued to be removed in an ad hoc manner and returned to the office. The provider had no written guidance detailing when staff should return completed care records back to the office, or set out the timeframe which this was expected to occur in. This meant that some people's archived notes were at the office and some were not.

One entry on the providers IT system included information about a person being found after a fall, but we could find no further entries about what happened to that person after they were found, in either hard copy care records or on the providers IT system. We showed a member of staff what we had found and they agreed that information was not fully recorded and should have been. The member of staff was able to confirm that the person had, in fact, gone into hospital but was only able to do this by looking at the person's rota where a member of staff had marked the person as 'in hospital'. We noted that at the last inspection we had found a similar case, where a person had gone into hospital and no further entries had been made. Therefore, the provider continued to keep inaccurate records. It also meant there was a risk the provider may have missed providing care visits to people by means of inaccurate record keeping.

We asked the provider to send us copies of some of the main policies prior to the inspection. Some of the wording continued to be out of date and therefore potentially incorrect. Many of the policies, such as manual handling, should be regularly updated to comply with legislation. We saw that the document continued to be dated 2005. The medicines policy was also found not to be robust. There was also a safeguarding policy available and this continued to require updating as there was a suggestion that staff would review the evidence within the company delaying handing it over to the appropriate authority. When we looked at the provider's website, we found the same 'service user guide' dated 'Feb 04' which we had found at the last inspection and which contained out of date information. For example, the name, address and details of the Care Quality Commission.

Since the last inspection no surveys had been completed or analysed to gather the views of people or their relatives using the service. Staff could not tell us when the next survey would be carried out.

We asked what quality monitoring checks were carried out by the provider and we were told that apart from 6 monthly reviews of people's records, that none were completed. We therefore found no audits on care records, medicine administration or monitoring of health and safety issues at the service.

Overall, this meant the provider had no systems in place to assess, monitor and improve the quality and safety of the service to ensure that people remained safe.

These were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt that the service was well led from the contact they had with mostly team managers. People's comments included, "I would recommend Helping Hands to anyone"; "Very genuine carers"; "Credit to the company [care staff]"; "Brilliant service"; "So, so helpful"; "Excellent service" and "Really happy with my carers."

Care staff spoke positively about their direct line managers, who were team managers based at the providers main office. We saw that staff had opportunities to discuss items that were important to them through team meetings held in the community with members of the care staff team. One care worker said, "We have meetings from time to time. We can discuss any issues we are having and it's a good way to catch up with what's going on with everyone."

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 15 Registration Regulations 2009 Notifications – notices of change The provider had not sent us all notifications which they are legally obliged to do as part of their registration and not informed us of the intended retirement of the registered manager/nominated individual. 15 (1) (a)(b)(e)(iii)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not fully protected because the provider had not always accessed and mitigated against risk. Accidents were not always recorded or monitored fully and risk assessments were not always completed or reviewed. Medicines were not always managed safely and in line with good practice. 12 (1) (2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had no quality assurance system in place to monitor the service provided to the people receiving it, including monitoring risk. The provider did always maintain up to date records for people. The provider had policies and procedures in place, however the majority of these were out of date. Complaints

	procedures were not kept in order to ensure they were followed appropriately. 17 (1) (2)(a)(b)(c)(d)
Regulated activity	**Regulation**
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not published their most recent inspection report from February 2016 as required. 20A (1) (2) (a)(b)(c)