Safehands Homecare

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 and 19 March 2018 and is the first inspection of the service. The inspection was announced; we gave the registered provider two days' notice because the location provides a domiciliary care service and we wanted to make sure there was someone at the agency office to assist us with the inspection.

This service provides personal care and support to people living in their own houses and flats in the community. It provides a service to older people and younger adults. At the time of the inspection there were 20 people receiving a service and 12 care workers employed by the service, including a senior care worker who assisted with the management of the service.

The service has a manager in place who is registered with the Care Quality Commission (CQC). 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.

This is the first time the service has been rated Requires Improvement.

Staff received training on the management of medicines and care plans recorded that some people required prompting to take their prescribed medicines. Although people told us they received their medicines as prescribed, we noted that there were a small number of gaps on medication administration records (MARs). The registered manager assured us they would reiterate the importance of accurate recording with care workers.

The registered persons were aware of improvements that needed to be made to the recording of employment references and dates of staff shadowing. They had made good progress towards completing this task to ensure that only people considered to be suitable to work with vulnerable people had been employed.

People were protected from the risk of harm or abuse because the provider had effective systems in place to manage any safeguarding issues. Staff received training on safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. There had been one safeguarding incident and this had been managed appropriately by the registered manager. However, a notification had not been submitted to CQC in respect of this incident as required; we identified that this was an isolated event.

People had care plans in place that described their lifestyle choices and day to day needs. These were personalised and people told us they received support in a way that suited them. Care plans were reviewed and updated every three months to ensure they were a reflection of the person's current care wishes and

needs.

We saw there were sufficient numbers of care workers employed to meet people's individual needs, and that people received the level of support they required to meet their agreed support needs.

Staff understood their responsibilities under the Mental Capacity Act and people confirmed they were consulted about their care and gave consent to the support they received from staff. They told us they were encouraged to make decisions about their day to day lives. 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

We received positive feedback from everyone we spoke with about the support they received from care workers. Our discussions with people and their relatives confirmed that there were positive relationships between people who used the service, their family carers and staff. People felt care workers genuinely cared about them.

Care workers told us they were well supported by the registered provider and manager. They received an induction to their post that included shadowing experienced care workers, and had refresher training. This included training on supporting people to take their medicines. Staff told us they attended staff meetings and had supervision meetings with a manager; we saw evidence of these meetings during the inspection.

There had been a small number of accidents involving people who used the service and staff and these were recorded. The registered persons were aware that this information would need to be analysed if the level of incidents increased to monitor whether any patterns were emerging or if any improvements to staff practice were required.

There was a complaints policy and procedure and this had been made available to people who received a service and their relatives. Complaints records showed that only one complaint had been received; this had been investigated and the complainant had been satisfied with the outcome.

We saw evidence of satisfaction surveys and people confirmed they had been asked if they were satisfied with the service they received. We saw that most of this feedback was positive, and action was taken to address any suggestions for improvement.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were medicines procedures in place and staff had completed appropriate training, although there were some gaps in recording.

The records of staff recruitment required improvement to evidence that only people considered suitable to work with vulnerable people had been employed.

There were adequate numbers of staff employed to ensure people received the service they required.

Risks to people and staff had been identified and minimised, and any incidents that occurred were recorded.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training to enable them to carry out their roles and were supported through supervision and staff meetings.

Staff understood their responsibilities under the Mental Capacity Act and told us they supported people to make decisions about their care and support.

People were supported with meal preparation and to maintain good health.

Is the service caring?

Good

The service was caring.

People were treated in a kind and compassionate way by staff.

Staff knew people well and supported them to maintain their independence.

People told us that care workers respected their privacy and

dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People's needs had been assessed and care plans had been developed. These included information to assist staff in providing person-centred care.

People we spoke with were aware of how to make a complaint or raise a concern but told us they had not needed to raise any concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a registered manager in post and people told us the service was well managed, although we recommended that some areas required more robust recording to evidence good practice.

A small number of quality audits were being carried out to monitor that staff were following the service's policies and procedures.

Staff and people who used the service were given the opportunity to share their views about the service, and told us they were listened to.

Safehands Homecare

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by one adult social care inspector. Inspection site visit activity started on 15 March 2018 and ended on 19 March 2018. On 15 March 2018 we visited the office location. We had a discussion with the registered provider, registered manager, senior care worker and two care staff. The registered manager also took us to the homes of two people who used the service so we could speak with them about the quality of the service they received. We also reviewed care records and other records relating to the management of the service.

On 19 March 2018 an Expert by Experience telephoned people who received a service and a relative to gain their views of the service provided. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. They spoke with six people who used the service and a relative.

Before the inspection we reviewed the information we held about the service, including information we had received from the local authority. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

Requires Improvement

Is the service safe?

Our findings

The local authority that commissioned a service from the agency had carried out an audit in January 2018 and had identified some concerns in respect of recruitment records and the safe management of medicines. While shortfalls had not had any adverse impact on people who used the service, the registered persons had not picked up on these issues themselves and taken appropriate action.

The local authority recommended that prospective employees completed an application form as well as submitting a CV and that two written references were also obtained. The registered manager told us that all care workers now had an application form and two written references in place, although some had been received in retrospect. We checked the recruitment records for two care workers and noted that for one person, a recruitment checklist had been used and that there was evidence of safe recruitment practices being followed. Checks had been made with the Disclosure and Barring Service (DBS) prior to both people being offered employment. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults.

However, one person's records lacked evidence to demonstrate that safe recruitment practices had been followed. We were assured by the registered persons that staff did not commence work until the agency had received evidence of the person's suitability for the post, and this was confirmed by care workers who we spoke with. We advised that staff personnel records should clearly record the person's start date, the date DBS checks and references were received, the date induction training was completed and the dates of shadowing shifts. In addition to this, any references addressed 'To whom it may concern' should be checked to confirm authenticity. This would provide more robust evidence that safe recruitment practices were being followed.

Staff supported people to take their medicines and had completed training on the safe management of medicines. Medication administration records (MARs) were returned to the office for storage with care plans and we noted there were a small number of gaps in recording on those we reviewed. However, people told us they received their medicines as prescribed and had never had any concerns, so this appears to have been a recording issue rather than gaps in administration. We saw in supervision records and in staff meeting minutes that the registered manager had stressed the importance of accurate recording, and they told us they would reiterate this again with staff. We advised that it was good practice for two staff to record handwritten entries on MARs and that care records should list the specific medicines the person had been prescribed, rather than recording that medicines were stored in the container provided by the pharmacy.

We recommend that the provider ensures the proper and safe use of medicines, and that recruitment practices evidence that only people considered suitable to work with vulnerable people are employed.

Training records showed that staff received training on safeguarding adults from abuse and staff meeting minutes recorded that safeguarding was discussed at every meeting. The care workers who we spoke with were able to describe different types of abuse. They told us that they would report any concerns to the

registered persons, and were certain the information would be shared with the relevant professionals. They added that they would contact the safeguarding adult's team themselves if they needed to. Staff also told us they would not hesitate to use the organisation's whistle blowing policy. A whistle-blower is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation. We checked the folder that contained copies of safeguarding alerts; one alert had been submitted to the safeguarding adult's team for consideration.

Care plans included risk assessments that were specific to the person whilst they were in receipt of support, such as mobility and mobility equipment, nutrition, medication, mental health and their home environment. For example, when a hoist was needed to help a person mobilise, the risk assessment recorded how many staff were required to carry out the task and that staff must have been trained in how to use the specific piece of equipment. Similarly, the risk assessment recorded any cutlery or crockery that people would need to help them to eat safely. Risk assessments were reviewed on a regular basis to ensure they remained up to date and relevant.

People told us they felt safe when care workers were in their home. Comments included, "Yes, four or five different ones come. I trust them" and "It is always someone I know who visits."

There were sufficient numbers of staff employed to ensure people received the level of support that had been agreed with them. Care workers told us they had enough time to carry out the tasks needed and that the registered persons would support them during periods of annual leave or sickness.

Staff received training on the prevention and control of infection and information about this topic was also included in their employment contract. Minutes of staff meetings recorded that the importance of staff using personal protective equipment (PPE) was discussed and that disinfecting hand gel had been distributed to staff.

Accidents and incidents were recorded in an accident book and there was an accident and incident form available for staff to use if needed. There had been a very small number of accidents since the agency was first registered so no analysis had taken place. The registered persons were aware that this information would need to be analysed if the level of incidents increased so they could monitor whether any patterns were emerging or if any improvements to staff practice were required.

There was a business continuity plan in place that advised staff about the action to take in the event of an emergency, such as extreme weather conditions, IT failure or absence of the registered persons. The plan included a list of all users of the service and their level of risk, and how to prioritise their needs in the event of an emergency; this is good practice. The registered provider told us they had the use of a four wheel drive vehicle should there be difficulties in staff travelling to people in severe weather conditions, and that information about staff, people who used the service and their relatives could be obtained electronically even if they were not able to access the location office.

Staff told us that if there had been an incident or concerns had been received, these would be discussed with all staff to reduce the risk of reoccurrence. The safeguarding incident referred to previously was in respect of a person not being given their medicines at the correct time. The registered manager sent a letter to the person concerned informing them that staff would be attending further training on the management of medicines, and more time was to be allowed between calls so staff did not have to hurry. Minutes of staff meetings demonstrated that this incident was discussed with all staff and that all staff had also completed refresher training on safeguarding adults from abuse.

Good

Is the service effective?

Our findings

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection.

We checked whether the service was working within the principles of the MCA, and found that people using the service did not have any restrictions in place at the time of this inspection and that no applications had been made to the Court of Protection.

Care plans included a section to record whether people had capacity to make decisions and choices. For example, one care plan recorded, "I can make my own choices in regard to what foods I would like to eat and what clothes I would like to wear." This was signed by the person concerned. One care worker said, "We encourage people to make decisions in line with their best interests. It's their choice. I show them clothes and food to help them make a decision."

People signed consent forms in respect of information about them being held electronically, and sharing information with family and health and social care professionals when required.

Personnel records included evidence of staff induction to their role when they were new in post. Care workers told us they shadowed experienced care workers before they worked alone with people who used the service, and that they were introduced to people prior to working with them. Care workers completed on-line training soon after their start date, including moving and handling (theory and practical), infection control, MCA, Deprivation of Liberty Safeguards (DoLS), safe handling of medicines and safeguarding adults from abuse. The training database allowed the registered manager to access staff training records to monitor who had completed the required training so they could speak with staff who had fallen behind. Staff told us they shadowed experienced care workers before they worked alone with people who used the service, and that they were introduced to people prior to working with them. Care workers signed a document to record they had received a copy of the staff handbook and a job description and that they had read the service's medicines policy. This meant that staff were aware of what the service expected of them.

There were plans in place for care workers to undertake the Care Certificate. The Care Certificate is a set of standards that health and social care workers stick to in their daily working life, and is the training recommended for care workers. Training records showed that nine of the 12 care workers had commenced this award. The registered manager told us that care workers were paid for the time they spent working towards the Care Certificate, as a way of encouraging them to complete the training.

When the local authority audited the service in January 2018 they recommended that staff had regular

supervision meetings with their manager. The records we saw demonstrated that staff were now having supervision meetings. Managers visited people's homes to observe staff practice, including that safe handling techniques were used by staff, and that staff treated people with privacy and dignity and were empathetic in their approach. Care workers told us they felt well supported by the registered persons.

Some people we spoke with had support with the preparation of meals and drinks, and told us they were satisfied with the support they received. A relative told us, "Yes, mum couldn't do without them." We saw that care plans recorded the assistance people required with the preparation of meals and any special diets that were required. There was a form available for staff to record food and fluid intake if this was an area that required monitoring. One person told us, "[Name of care worker] has left me all of this water out as I need to drink plenty."

People's care plans included assessments that recorded information about their needs and choices. The person's medical history and general health, as well as any known allergies, were included and this information was readily available for staff. There was evidence that care workers liaised with health care professionals who were involved in people's care when this was appropriate. Care workers told us they would make sure people received medical attention if they were unwell, and that they would not hesitate to ring the emergency services if needed.

Good

Is the service caring?

Our findings

People told us they felt care workers genuinely cared about them. Comments included, "When you are talking to a person you can tell when they are sincere. I have never had a problem with the ones who come now", "This carer will stay a bit longer if we are nattering. We just gel – she is lovely" and "The electric went off. I rang the care worker and she came down in her own time. I said to another care worker that I fancied some cheese and they went to the shop especially to get it for me." A relative told us, "Mum is really happy with everything they do. She is quite confident with them."

One care plan we saw recorded, "[Name] is to be treated with empathy and patience. For example, if they do not remember a staff member's name, they are to be gently reminded, not told they know it. As [Name's] long-term memory is good, staff are encouraged to engage them in conversations about their life." The care plan described the type of music the person enjoyed and that staff should play this during their visit. This demonstrates a caring attitude from both managers and staff.

People told us that care workers respected their privacy and dignity. One person said, "They give me as much time as I need to sort myself out. Then they discreetly help me to put my clothes on." People also told us they could choose whether to have a male or female care worker. One person said, "I can choose a female because I wouldn't feel comfortable with a male. I have also chosen someone around my age. They [Safehands Homecare] accommodated that wish."

Staff told us they encouraged people to be independent. They said, "Some of our service users are quite independent. We only do what they can't do." We saw that assessments and risk assessments recorded any cutlery or crockery that people would need to help them to eat safely and independently.

Satisfaction surveys were distributed to people who used the service to gain their feedback. People were asked about privacy and dignity, making choices, respect, confidentiality, independence and consistency of the service. We saw the responses were mainly positive and included comments such as, "I receive an excellent service." The responses had been analysed and the report included comments from the registered provider to record the actions that had been taken to address any shortfalls or suggestions for improvement. We advised that it would be good practice to record how the outcome of the surveys and the action taken had been shared with people who used the service and staff.

Staff employment contracts included information about the importance of confidentiality. We saw that written and electronic information about people who lived at the home and staff was stored securely. Minutes of meetings included the initials of people who used the service rather than their names. This protected people's confidentiality.

Everyone who we spoke with told us they received a service from the same group of staff. Comments included, "Yes, always the same" and "I have a regular one." We saw that people were sent a list each week of the times staff would visit them each day. People told us they were not always told who would be visiting them, but it was always someone they knew, as they were supported by the same group of staff.

We saw that there was information in the agency office about advocacy services in the area. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Good

Is the service responsive?

Our findings

People had a care plan in place that reflected their individual care needs, and people had a copy of the care plan in their own home. Information about the person's life history, their family relationships and their hobbies and interests was included, along with specific information about the persons prescribed medicines, nutritional needs, keeping safe and personal care needs. Specific details of the tasks staff needed to carry out to support people and ensure they were safe each time of day they visited were also included, such as instructions about the use of bed rails. People had signed their care plans to acknowledge their agreement.

Care workers said they would receive information from the office about any new service users and would be introduced to them, so they knew a little bit about the person before they first visited them. Care workers told us the information in care plans helped them get to know people and their individual support needs and lifestyles. They told us that, because they visited the same people on a regular basis, they also got to know their family members. People told us that care workers knew them well and were aware of their likes and dislikes. One person told us, "Yes, they ask me questions and engage in conversation. I do think they know my likes and dislikes."

The senior care worker continued to support one person who had expressed a wish to receive support from them. Because it was known a change of staff member would cause this person distress, this was agreed to. This demonstrated that people's individual needs were considered and acted on.

We observed that care plans were reviewed and re-written every three months to ensure staff were following up to date information. One person told us, "Yes, I have one [a care plan]. It suits my needs at the moment" and another said, "Yes, they review it every so often. [Registered manager] comes and chats and asks us if we are satisfied with things."

People told us that care workers made notes in the care plan at the end of their visit so that the next care worker was aware of how the person had been during their visit and the current situation. These records were signed and dated appropriately by one or two staff. One person said, "Yes, they record. The staff come and read the notes." We saw that one person also had a diary in their home where their relatives recorded information for the care worker, such as medical appointments and meal requirements.

None of the people currently using the service were in receipt of end of life care.

People were given a leaflet when they started to use the service that advised them how they could complain. The service had received a complaint from one relative, who had used the leaflet to record their complaint. The records we reviewed showed that they had received an apology from the agency and that appropriate corrective action had been taken. People were also informed that they could speak to CQC if they were dissatisfied with the service they received.

People told us they would be happy to speak with any of the care workers or managers if they had a

concern. One person told us, "[Name of registered provider] is very keen to get things right." Care workers told us they would encourage people or their relatives to make a complaint if they were dissatisfied with any aspect of the service, and would pass on the information to their line manager.

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post who had been registered with CQC since the service was first registered on 25 August 2016.

People told us they thought the service was well managed. Comments included, "Yes, it's well managed. Anytime we have wanted them, they are there" and "[Name of registered provider] told me, if I had a problem, I could always speak to them." A relative said, "Yes, if the carers have a concern they get in touch with the line manager and it's acted on. We had problems with the key safe. It was sorted the same day." People told us they could contact the agency office or a member of staff if they needed to speak to someone, even out of hours. One person said, "We have a number to ring 24/7." Comments from care workers included, "They both [provider and registered manager] put everything into it" and "They are good guys. They listen to staff."

One alert had been submitted to the safeguarding adult's team for consideration in February 2017. However, the registered manager had not submitted a notification to CQC as required. The registered manager told us they would ensure they submitted a notification in future and we were satisfied that this was an isolated occurrence. During our inspection we did not become aware of any other incidents that required the submission of a notification.

The local authority that commissioned a service from the agency carried out a monitoring visit in January 2018. They made some recommendations about improvements that were required to the recording of staff recruitment and medicines management, and some improvements that were required to care plans. The registered persons carried out audits of care plans, staff personnel records and medicines records. We saw that good progress had been made towards meeting the local authority recommendations, although we identified that the recording of recruitment and selection needed to be more robust and the auditing of MAR charts needed to be more thorough to ensure any gaps in recording were addressed with care workers.

We recommend that quality monitoring systems ensure responsibilities are clear and that quality performance and regulatory requirements are understood and managed.

The registered persons attended a provider forum organised by the local authority. They also subscribed to a care journal. They said that this helped them to keep up to date with current good practice guidelines and any changes in legislation. We saw that the service's policies and procedures referred to NICE guidelines and CQC standards, which indicated that good practice guidance was being taken into consideration.

Care workers told us they attended staff meetings and that they felt their suggestions and views were listened to. One care worker said, "It's a safe environment for us to share information." The minutes recorded that business updates were shared with staff, and that the topics of record keeping, policies and procedures, PPE, safeguarding adults from abuse and whistle blowing were discussed.

The minutes of staff meetings also recorded liaison that had taken place with other professionals such as

occupational therapists, physiotherapists and care managers. We witnessed a conversation between the senior care worker and a local authority care manager when we were at the location office, when concerns about a person who received support from the service were shared.

The registered manager told us they planned to start a 'Client Committee' to provide another way for people to be able to give feedback. However, they felt this should wait until more people were using the service. There were also plans to introduce a newsletter for people who used the service and staff. Completed time sheets were collected from the person's home each week by a manager. This provided an opportunity for people to give feedback about the service, and for managers to keep in touch with people who received a service and care workers.

The registered persons told us that they paid particular attention to the topic of equality and diversity during the interview process and they only employed people who they felt shared the values of the service. We saw that the updated service user questionnaire included questions such as, "Do you have any particular care needs relating to your race, culture, religion or sexual orientation that are not being met?" which demonstrated that people's diverse needs were being considered. One care worker told us, "We are a diverse, mixed team who understand the principles of equality and diversity."

We asked staff to describe the culture of the service. Comments included, "We are a close team", "Everyone, including the bosses, really care about the people we support" and "Super friendly and caring – dignity is paramount." The registered persons described the culture and values of the service as, "Sharing, caring and promoting dignity and respect" and "The door is always open – we have a culture of openness."

The service operated an 'Above and Beyond' award for staff to recognise good practice and performance from the staff team.