Care at Hand Limited

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

Summary of findings

Overall summary

About the service
Care at Hand Limited is a domiciliary care agency. This service provides personal care to people living in their own houses and flats. At the time of this inspection 57 people were using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People's medicines were not always managed safely. People were cared for by staff who had an understanding of how to keep them safe, however not all individual risks had been identified or recorded to provide sufficient guidance to staff.

People reported they felt safe with staff and had developed positive relationships where they received a consistent service from regularly assigned staff. However, some people had experienced disruptions with the delivery of their care and support due to unforeseen changes to staff they were not advised about in advance, late visits, and changes to the timings of their calls.

We checked whether the service was working within the principles of the MCA. We found limited information regarding people's capacity to make decisions. Staff did not have all of their knowledge and skills refreshed regularly to provide people with support in line with national guidance.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Care records were not consistently personalised, nor did they contain all the knowledge from staff working with them at each care call.

The service's internal systems were not up to date and had failed to identify the issues we found on our visit. People and their relatives had not been regularly asked for feedback on the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 29 June 2017)

Why we inspected
This was a planned inspection based on the previous rating.

The overall rating for the service has changed from Good to Requires improvement. This is based on the findings at this inspection.

Enforcement
At this inspection we rated the service as requires improvement. We identified five breaches of regulations, in relation to safe care and treatment, staffing, person-centred care and good governance. Please refer to the end of the report for action we have told the provider to take

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Care at Hand Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience, who conducted telephone calls to obtain feedback from those who used the service and their relatives. An Expert by Experience is an independent person, who has experience of the type of service being provided.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing. It provides care to both older and younger people.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager and the provider were the same person.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. Inspection activity started on 25 June 2019 and ended on 04 July 2019. We visited the office location on 25 June 2019. We went back to the office on the 02 and 04 July 2019.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We reviewed information we held about the service, for example, statutory notifications. A notification is information about important

events which the provider is required to tell us about by law. We used all of this information to plan our inspection.

During the inspection
We spoke with 12 people and five relatives by telephone. We also spoke with five staff members and the registered manager. We looked at a variety of records. These included eight care files, four staff personnel records, policies and procedures and systems for assessing and monitoring the quality of service provided.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We also emailed six professionals.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely
• Risks to people were not assessed appropriately. We identified one person that did not have a risk assessment related to making sexual advances to staff. We found another person that did have a risk assessment in place for the same reason, but this did not provide any guidance for staff in relation to how they should respond if this occurred.
• Risk assessments were mainly tick sheets and did not provide any details or guidance for staff. We looked at one care plan that stated the door should be locked when staff left the property. The care plan did not explore any risks associated with this person being locked in their property. When we spoke to the registered manager they told us they did this because the family had requested this.
• The environmental risk assessment in place did not explore any risks related to people's environment in detail. This risk assessment was a tick sheets that just highlighted people were safe. We looked at one care plan where the person had a sight loss from a stroke. No information was recorded in relation to any environmental risks to this person due to their sight loss.
• There were insufficient systems in place to ensure the safe recording and administration of medicines. We were given a box of medicine administration records (MARS) that had been returned to the service after being in people's homes for checking. This box was labelled, "For analysis". We found numerous gaps on the MAR's and some of the records went back to 2018. When we asked for the audits to identify if the gaps had been investigated we were told there were no recent audits.
• On occasion, people had 'as required' (or 'PRN') medicines but were not always able to tell staff when they required them. PRN protocols were not in place to assist staff in assessing when to offer such medicines.
• In the care plans we looked at we only found one medicine risk assessment.

The failure to assess and take all reasonably practicable steps to mitigate risks to people and manage medicines processes safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• When we spoke with staff we found they had a good knowledge of the people they supported and potential risks. One staff member told us, "We know the clients quite well, risk assessments are in the care plan but quite basic. We do also get information sent to us about risk as well."

Staffing and recruitment
• We received mixed feedback from people that care calls were not timely to meet their needs. Some people

we asked told us staff turned up on time and said, "I can only really go at one pace and that's very slow these days, the carers I see, never rush me and they are very patient and make sure everything is done how I like it to be done. Sometimes this means they can be a bit late leaving me, but they never complain or tell me it's my fault they're running late",
• Fifty percent of people we spoke with had experienced changes to the timings of their visits. Comments included, "We have had to speak to [named provider] a couple of times in the last few weeks concerning the moving round of [family members] visit times without us being told about it beforehand","[Family member] has been looked after by the agency for many years and until just recently everything was fine with regular carers coming at the times that had always been suitable to her. Unfortunately, [family member] has recently lost their two regular carers and now to make matters worse, the timings of her calls have started being irregular" and, "They never have enough staff and those they do have, don't stay very long these days unfortunately."
• The registered manager had informed us at the beginning of the inspection they were experiencing a staffing crisis. They had completed a route cause analysis to identify how they could move forward. However, we did note they continued to accept some care packages.
• Staff views were also mixed in relation to staffing and some staff told us they felt under pressure to cover additional care calls. One staff member told us, "There is definitely not enough staff, we do not rush people or cut their care calls, but we are under constant pressure to do extra hours. It has been the last four to five months." Another staff member said, "Very short staffed at the moment all staff feel really under pressure to cover clients care calls. The clients are aware, and some are very understanding when we are late. I have never missed a call, but I am aware people have had missed calls. A third staff member told us, "We are pretty short staffed at the moment, and that means we are getting extra calls, but we are getting by. We do not cut people's calls or their time."
• Whilst initially we could not find any incident forms related to missed calls eventually the registered manager shared with us his notes which had recorded three recent missed calls. We looked at all the care files related to these missed calls and found the impact on people was fortunately quite low and they remained safe as they or their family members had been able to provide support.
• The registered manager told us the usual process for missed calls would be to complete an incident form, but this had not happened. We were given Information called event sheets, but these had only looked at eight people in relation to late calls. This meant there was not a robust system in place to monitor missed and late visits effectively. We were unable to find a missed visits policy or procedure.

The provider had failed to ensure sufficient staff were deployed to meet people's needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager had ensured pre-employment checks were undertaken to ensure people's safety.

Systems and processes to safeguard people from the risk of abuse
• People using the service told us they felt safe and protected from harm by the staff working with them. One person told us," Yes I do feel relatively safe when the carers are here because without them I wouldn't be able to get up or downstairs on my own. I have a stairlift, and I know I could use it on my own, but I feel better when the carer is here to use the controls, so I can just concentrate on sitting and keep my balance. "
• Staff we spoke with knew how to recognise abuse and protect people from harm. However, staff training in this area was inconsistent.

Preventing and controlling infection
• People were protected from the spread of infection. Staff wore uniforms and used personal protective equipment to minimise the risk of cross-contamination.

Learning lessons when things go wrong

• Systems were not being kept up to date for the effective monitoring of late and missed calls to ensure people received safe care and support.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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.

Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty

- The registered manager was not working within the principles of the MCA. Where people did not have the capacity to consent, the registered manager had not considered what decisions people could make for themselves and had asked family to consent. For example, we found staff were locking one person in their property. The person's care plan did not contain any information about their capacity or whether this decision had been made in their best interests. We spoke with the registered manager who confirmed the person did not have capacity to consent to this, they had not escalated this to the person's social worker to identify if this was a deprivation of the person's liberty. We raised this concern with the local authority.
- There were no assessment processes to identify people's capacity to make informed decisions or when best interests' decisions were needed to be made on people's behalf.
- Care plans we looked at were unsigned.

The failure to act in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Initial assessments of people's needs were brief and consisted of an overview of daily living activities. A copy of the local authority's assessment was also within care files.
- Staff were not provided with current or sufficient guidance to inform their practice. We found one care file where guidance for a specific health condition was included within the care files. However, when we looked at the local authorities' assessment we found the guidance printed was for the wrong health condition.

Staff support: induction, training, skills and experience
• Care staff received induction training in line with the Care Certificate. The Care Certificate is the nationally recognised benchmark set as the induction standard for staff.
• Whilst induction training was comprehensive, refresher training provided to staff was limited and some staff who had worked at the service for a long time had not had their training refreshed for a number of subjects. For example, 24 staff out of 30 staff had not received a safeguarding refresher in the last three years. Other subjects such as MCA and DoLS and dementia had not been refreshed for staff since their start date.
• Staff did receive medicine refresher training however we were not assured their competencies had been assessed as this was part of a general competency assessment. For two staff members the medicine part of the competency had not been completed. We discussed this with the registered manager who told us a questionnaire was used as part of the training which they considered sufficient. They did not have an overview in place to ensure staff were regularly assessed administering medicines competently.
• Despite our findings people told us they thought staff were well trained. One person told us, "I suppose the only thing my [family member] needs specific help with, is the hoisting and the care of [family member] catheter bag system. Although I'm here if they need to query anything with me, I have to say they've all got on very well and [family member] has been pleased with how their knowledge is translated into how they look after [family member]. No problems whatsoever so far." Another person said, "I'm very fortunate because I've still got just my few regular carers who have been looking after me for a while, although every few weeks they tell me they feel like packing it all in. I like having them because they are very experienced in knowing exactly how I like to be looked after. "
• Staff we spoke with were positive about the training they received. One staff member said, "We had three full days training at the beginning and [registered manager] calls up in from time to time and goes through it."
• Staff were provided with support through individual supervision and checks were made in people's homes to ensure the staff were working safely.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us staff supported them well at meal times. One person said, "My carers help sort all of my food for me. They'll tell me what I've got available in the freezer or the fridge and then they'll cook or prepare whatever it is I fancy eating. No one ever minds whether I just feel like a snack or I want them to put me a complete meal in the oven. "
• Staff we spoke with had a good understanding of people's dietary needs and how to support people to eat safely.
• There was limited information in people's care plans surrounding specific dietary requirements such as diabetes or being on a soft diet. This meant people may be at risk if staff did not know their needs well. A staff member told us, "I do not do a lot of food, we do have people with diabetes and because I know people I would know if they were not well but there is no guidance in the care plan to refer to."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Staff supported people to access healthcare services when needed and liaised with these and relatives to ensure people received healthcare treatment when they were unwell. One person said, "My [family member] had a stroke some years ago, but we were managing on our own until they had a series of falls within a few weeks of each other. Having got their care sorted out, I have to say [family member] hasn't had any falls or any admissions to hospital since it started. "

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• Recent staff shortage meant planning and deploying staff did not always consider people's preferences. One person told us, "It sometimes feels a bit hit and miss from one day to the next, I must admit!". Another person said, "Not always, because like recently when I phoned to ask them why they had just changed my visit times without asking me, and I wanted my evening one reinstated because I didn't want to go to bed that early, they listened to me, but nothing happened as a result of it." A relative said, "I can't fault the carers, who I think do a very difficult job, for very little reward. However, the organisation in the office leaves a lot to be desired. I'm a retired logistics manager and I can't for the life of me understand why they allocate their rounds to the carers as they do, because the ones that come to me seem to end up criss-crossing such a large patch, they must spend the majority of their day on the road, rather than looking after clients."
• People were very positive about the staff supporting them. One person told us, "I cannot fault the carers at all. They are all very friendly, professional, caring and never mind doing anything I need to make sure I'm comfortable." A relative said, "For my [family member], it's just the little things like remembering [family member] needs a glass of water and their glasses leaving on the right hand side of them rather than the left hand side of their easy chair where they won't be able to reach them all morning. Little things like that can make all the difference."
• All the staff we spoke with were committed to providing a good service for people. One staff member told us, "I think people are getting a good service, we have some good carers."

Supporting people to express their views and be involved in making decisions about their care
• People were not always involved in the development and reviewing of their care. A relative told us, "My [family member] started being cared for by the agency back in June 2016. I don't remember anybody coming out to do a review or up-date the care plan since, even though [family member] overall condition has changed during that time. Looking at the care plan in the folder now, it is the same one as was completed when we first started with them in 2016 and although it's signed by somebody from the office, there is no signature from my [family member] or myself." Another person said, "As far as I can recall, we last had a visit from one of the ladies at the agency well over 12 months ago and their care plan hasn't been updated for a while."

Respecting and promoting people's privacy, dignity and independence
• People were supported to maintain their independence. One person said, "The carers are good and know I like to do as much as I can for myself, so for example, I can load and unload the top basket in my dishwasher, but it's too much of a struggle to bend down to do the bottom basket. They do this for me and

then they'll switch it on and then that should mean that it's done for just before they come back later on. That then allows me to empty the top basket and put things away, and they just do the bottom basket again for me."

• People and their relatives told us their privacy and dignity was respected. People and their relatives told us staff never rushed them during visits. One person said, "All of the carers I see now are lovely and very patient with me in my old-age."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People's care plans did not give information to staff about their personalised care needs such as dementia, diabetes or mental health. Care plans we reviewed had limited information about these personalised needs.
• One person living with dementia did not have any information about how this may affect their life or what staff could do to support this person. This person had Visuoperceptual episodes, there was no information recorded about how staff might support this person. Visuoperceptual ability enables the recognition of objects based on their form, pattern and colour. This can be affected by some types of dementia causing the misidentification of objects and hallucinations.
• Another person's care plan identified they had epilepsy. However, there was no further information about how staff should respond if the person had a seizure.
• People's care plans held either little or no information about people's likes, dislikes and preferences. There was no information in people's care plans about their life history and things which were important to them.
• People did not always receive person centred care because staff were not always deployed at a time they preferred. One person told us, "What I've found is when you start with the agency they are very happy to agree to deliver everything at a time and in a way you want it to be delivered, but as time progresses and circumstances change in the way the organisation is either run or how it's operated, you can find things start to change without you really having any input into whether it's suitable for you or not.

Not providing staff with information about peoples personalised care meant people may not receive individualised care. This is a breach of Regulation 9 HSCA RA Regulations 2014; Person Centred Care.

• When we asked one person if staff knew them and treated them as an individual they told us, "The carers definitely do, and the office staff try their best when they are standing in as carers as well."
• Staff we spoke with knew the people they looked after well. One staff member told us, "Some people are getting a good service and we know people well. We speak to clients as we usually see the same clients every day."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's care plans contained minimal information about their communication needs.
• The provider was able to produce documents in other formats if required.

Improving care quality in response to complaints or concerns
• The provider had a complaints policy and procedure in place. No formal complaints had been received. However, not everyone felt confident their complaint was taken seriously. One person said, "There is a leaflet in my folder that tells me how to make a complaint. I've made what I call informal complaints and spoken to the registered manager about certain things. Some of these have been sorted satisfactorily, like requesting certain carers not to come again, whilst others, particularly about the timings of my visits, whilst getting an apology, have not been resolved at all."

End of life care and support
• No one was receiving end of life care at the time of our visit.
• People's wishes about the care they would like to receive at the end of their life was not included in care plans.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

• The checks of the safety and quality of the service had not highlighted all the issues we found during this inspection.
• The registered manager did not have a robust oversight of missed or late visits
• People's care plans and risk assessments had limited details about how to support them with their care needs.
• The provider's medication management systems were ineffective. Medication administration records were not being completed or checked to ensure people received their medication as prescribed. The registered manager could not, therefore, be assured people had not suffered any impact to their health as a result.
• The registered manager did not have an effective system in place to ensure care staff had the correct skills and competencies to support people's needs.
• A review of policies was required to ensure they all remained up to date and reflective of current legislation.
• Not all people or relatives spoken with believed the service was well-led or managed effectively. People had mixed views about the quality of the service provided. This meant there were variations in people's overall experience of using the service. One person told us, "Sadly, certainly during the last six months, they seem to have been getting worse unfortunately, not better." Another person said, "From what I've seen, the carers just struggle on doing what they do best, which is looking after their clients to the best of their ability." A third person said, "I've been with them for such a long time, but it's unfortunate at the minute to see them in the state they are because they used to be so good and there was never anything that was a problem."

Effective arrangements were not in place to assess and monitor the quality of the service provided to ensure compliance with regulatory requirements. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• Staff meetings were held which was an opportunity to share information about changes and updates to the service.
• The provider used an impartial feedback service to gather feedback from people, relatives and staff. The

last one had been completed in February 2018 and whilst overall the feedback was positive we noted several recommendations in the report. When we asked the registered manager for their action plan in relation to these recommendations they said they did not have one. One person told us, "They ask for our views in a survey that's done probably at least once a year. Not that I recall hearing anything about it afterwards though."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• We received mixed views from staff about the support they received. One staff member told us, "I have just returned to work and they have been very helpful. [Named registered manager] always helps out if we need him. Another staff member said, "Staff morale is quite low at the moment as staff feeling under pressure to cover extra shifts. [Named registered manager] is quite hands on and will deliver care if needed." A third member said, "I do feel supported by some managers but not all, I have noticed an issue with the management team at the moment."

Working in partnership with others

• The registered manager and office coordinators worked with social care professionals, health care professionals and the local authority to improve people's quality of care. A professional told us, "We feel that Care at Hand communicate with our team well and demonstrate a professional attitude when they liaise with us regarding the referrals we source with them."

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 9 HSCA RA Regulations 2014 Person-centred care Not providing staff with information about peoples personalised care meant people may not receive individualised care. This is a breach of Regulation 9 HSCA RA Regulations 2014; Person Centred Care.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The failure to act in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured the safe and proper management of medicines. Risk assessments were not in place for each identified risk or detailed enough to guide staff. This meant the provider was not doing all they could to minimise risks to people.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Effective arrangements were not in place to assess and monitor the quality of the service provided to ensure compliance with regulatory requirements. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient staff were deployed to meet people's needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.