Midshires Care Limited

Helping Hands Live in National

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 28 June 2018 and 29 June 2018. On both days, the inspection was announced due to the amount of people this agency supported. The provider was given five days' notice of our inspection visit to ensure senior management, registered managers, care staff and associated records were available when we visited the office.

Helping Hands Live-in National is a domiciliary care agency which provides personal care and support to people in their own homes nationwide as a 'live in' service, which supports people who may have complex care needs. Care staff would usually be on site in the person's home up to 24 hours per day.

At the time of our inspection visit, the agency supported more than 750 people. This was the first time the service had been inspected under its current registration. However, the service was inspected previously in June 2016 under a different registration, when we found the provider was compliant with the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We rated the service as 'Good' in all areas.

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. Helping Hands employed several registered managers at this location. There were three registered managers in post, and two registered manager posts were being filled at the time of our visit, both of these registered manager posts had been recruited to. Both new appointees were progressing their registration with CQC, and one was due to commence their employment. Each regional area, North, South, East and Central had a manager (or registered manager) responsible for the staff and the delivery of care to people using the service, within those regions. In addition, there was a registered manager appointed to manage clinical support and clinical training for staff.

People felt safe using the service and staff understood how to protect people from abuse and keep people safe. There were procedures to manage identified risks with people's care and for managing people's medicines safely. Checks were carried out on staff during the recruitment process to make sure they were suitable to work with people who used the service.

There were enough staff to deliver the care and support people required and people usually received care from a consistent staff team. People told us staff were friendly, respectful and caring and had the right care skills to provide the care and support they required. Staff received an induction when they started working for the service and completed training to support them in meeting people's needs. Staff felt the training provided them with the right skills and knowledge to support people safely and effectively.

The provider understood the principles of the Mental Capacity Act (MCA), and staff respected people's decisions and gained people's consent before they provided personal care. People were protected from the

spread of infection, as staff were trained in how to use preventative measures such as protective gloves and clothing to prevent cross contamination.

Care plans contained relevant information for staff to help them provide the personalised care people required. People knew how to complain and information about making a complaint was available to them. Staff said they could raise any concerns or issues with the provider, registered managers, and their immediate line manager knowing they would be listened to and acted on.

There were processes in place to monitor the quality of the service provided and to understand the experiences of people who used the service. This was through regular communication with people and staff, returned satisfaction surveys, staff meetings, spot checks on care staff and a programme of checks, audits, senior management meetings and operational board meetings.

The provider demonstrated strong leadership. Staff felt committed to the provider's vision and values and involved in how the service developed and improved. Examples of the best staff practices were celebrated. The leadership team was proactive in its response to trends revealed by its detailed analysis feedback and lessons learned from accidents, complaints and incidents.

The provider worked closely in partnership with a range of external organisations that were leaders in their field, to continuously improve the standard of care offered by staff at Helping Hands.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were procedures to protect people from the risk of harm. People were protected against the risk of infection. Care staff understood their responsibility to keep people safe and to report any suspected abuse. There were enough care staff to provide the support people required. There was a safe procedure for managing medicines and staff recruitment.

Is the service effective?

Good

The service was effective.

Staff were trained and supervised to ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act 2005 and staff gained people's consent before care was provided. People who required support had enough to eat and drink during the day and had access to healthcare services.

Is the service caring?

Good

The service was caring.

Care staff provided a level of care that enhanced people's quality of life, and allowed people to remain independent and live at home. People were supported by care staff who they considered kind and caring. Care staff respected people's privacy and dignity. Most people received care and support from a consistent staff team that understood their individual needs. The provider supported staff in a caring way.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and people received a service that was based on their personal preferences. Care staff understood people's individual needs and were kept up to date about changes in people's care. People knew how to make a complaint and the registered managers and senior management

dealt promptly with any concerns or complaints they received, and monitored complaints for any patterns or emerging trends.

Is the service well-led?

Good

The service was well led

The provider's values put people at the heart of their service. The service was continuously improved by the provider, showing effective and responsive leadership. A thorough audit system continually reviewed and improved the quality of the service to ensure good standards of care were maintained. The provider invested in the service and responded to people's feedback to raise the standard of care they delivered. Staff were recognised for their contribution, and the provider worked with other organisations to enhance care delivery.

Helping Hands Live in National

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.

We reviewed the information we held about the service. We looked at information received from the statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

Before the inspection visits, the provider completed 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 found the PIR reflected the service provided.

The inspection was conducted by two inspectors on 28 June 2018 and one inspector on 29 June 2018. Two experts by experience contacted people by telephone to ask them what they thought about the service they received. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service.

Before our inspection visit we contacted 50 people who used the service, 50 relatives of people who used the service, and all the members of care staff providing people with care and support in their own home. We asked people to take part in a survey, and used the outcome of this survey to inform our planning of the inspection. We received feedback from 16 people who used the service, four people's relatives and 265 care staff. During the inspection process we received feedback from a further 34 people and 22 relatives of people who used the 'live in' service. We also received feedback from another 30 members of care staff and three commissioners of services.

During our inspection visits at the office, we spoke with the chief operating officer, the director of people and performance, the group operations director, the finance director, four registered managers which included a clinical lead manager, a senior quality assurance manager, the national support manager, a training manager, the head of the 'live in' service and two managers of 'live in' care teams.

We checked whether staff had been recruited safely, were trained to deliver the care and support people required and that staff received appropriate support to continue their professional development.

We looked at a range of records about people's care including seven care files. We also looked at other records relating to people's care such as medicine records, and the clinical support they received. This was to assess whether the care people needed was being provided. We reviewed records of the checks the registered managers and the provider made to assure themselves people received a quality service.

Good

Is the service safe?

Our findings

From the feedback we received, from 72 people or their relatives, almost everyone told us they felt safe with care staff living in their home. Comments from people included, "I feel safe knowing that they [care staff] are always here for me" and, "I have absolute trust with my care staff living here." However, one person commented that they did not always feel safe, as they did not always know the staff member before they came into their home.

The operations director explained, that although people may not know their care staff, they were always checked for their suitability and character before working in someone's home. The provider's recruitment process was thorough and ensured risks to people's safety were minimised. The provider's recruitment process consisted of an assessment and selection process where care staff were observed over a full week. Potential new care staff were continually assessed and were only employed at the end of this process if they met the provider's criteria around behaviours and values. Records showed the provider obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. Regular monitoring, supervision and feedback from people using the service helped ensure people received care and support from suitable staff.

The provider frequently employed care staff from other countries, holding recruitment fairs as a way of recruiting new workers. Where this was the case, the recruitment manager explained the recruitment process always involved checking staff were of 'good character' and their right to work in the UK, before their employment process commenced. Staff from overseas may be placed in England, and arrive to someone's home before they met them in person. However, people chose their care staff from pre-prepared profiles which detailed key characteristics about the prospective staff member. In addition, the provider had developed video profiles for members of care staff, so that people were familiar with the faces and personality of new care staff coming into their home before they started work. Video profiles were being rolled out further across the service.

Comments from people were; "They [Helping Hands] send me a profile on the one coming in a few weeks to cover for my regular one", "I was involved in choosing two members of care staff. The care staff provided was outstanding." However, one person said that in the past it had not always seemed like there were enough experienced care staff. They explained, "On one occasion they offered us new carers with no experience. However, we have been able to refuse carer profiles." Another person commented, "I did have one carer that was well meaning but ignorant. However, the company sorted out the issue quickly."

All care staff we spoke with had a good understanding of what constituted abuse and abusive behaviour and how to keep people safe. They understood their responsibilities to report this to their manager, the provider, or other external agencies if they suspected any abuse. One staff member told us," If I have any concerns I would record it and report it to my manager. I am confident the managers would look into it." Registered managers and the provider understood what was required and knew how to raise any incidents of abuse or potential harm, as all staff had regular training in how to recognise abuse and refer and

investigate any concerns. We found the provider notified us when they made referrals to the local authority safeguarding team, and kept us informed with the outcome of the referral and any actions they had taken that ensured people remained protected.

People told us there were enough care staff to provide their support. The operations director explained no-one was left without care and support, and backup arrangements were in place if care staff were taken ill, or needed to be replaced at short notice. They told us there had been no 'missed' calls at the service. Regional managers completed, alongside care staff, the required training that meant they could provide care to people in an emergency, or cover urgent placements. People said care staff arrived when expected and staff received a handover.

People generally felt they had continuity of care. People described having regular care staff, and regular cover arrangements if their usual care staff were off work.

People had an assessment of their care needs completed at the start of the service that identified any potential risks to providing their care and support. Care staff knew about individual risks to people's health and wellbeing and how these were to be managed. For example, care staff where instructed to check people's skin where they were at risk of skin damage. One person's care records, described how to support the person with applications of cream to their skin, and how their body should be positioned during hoisting, to avoid injuries occurring to their skin. All care staff we spoke with confirmed they referred to the information in risk assessments and care records to manage risks to people.

Risk assessments were in people's care records to show staff how risks to people's wellbeing could be minimised. For example, people had their daily routines described, which included how they liked to be supported, and what staff should avoid which might cause them distress or harm. In one person's care records we saw staff were instructed to encourage the person to move around when they became anxious, such as shrugging their shoulders and wiggling their fingers, as this minimised their stress levels.

The provider had systems in place to manage risks to their business. For example, they had plans on how to minimise the risks of systems failures, such as IT systems. Business continuity planning involved clear strategies on how systems could be protected from 'hacking' by using sophisticated fire wall systems, measures were in place to protect access to systems, and there were robust recovery protocols in place. This was to ensure access to people's care records kept electronically was protected.

People were protected from the risk of infection, as care staff completed regular training in how to prevent the spread of infection. Staff were provided with personal protective equipment, so that they had access to gloves, aprons and sanitizers where these were needed, to prevent cross contamination.

We looked at how medicines were managed. Where care staff supported people to manage their medicines it was recorded in their care plan. People told us they received their medicines when they should. Comments from people included "I have prescribed medicines three times a day and care staff give them to me on time every day" and, "I could not do without their assistance [care staff] as I cannot do this myself."

Care staff told us they had received training to administer medicines safely which included checks on their competence. Care staff recorded in people's records that medicines had been given and signed a medicine administration record (MAR) sheet to confirm this. MARs were checked by care staff during visits and by managers during spot checks for any gaps or errors. Completed MARs were returned to the office every month for auditing. These procedures made sure people were given their medicines safely and as prescribed.

Good

Is the service effective?

Our findings

We asked people and their relatives if they thought care staff had received the training needed to meet their needs. Most people told us care staff were well trained, and had all the skills they needed to support them. Some comments from people included; "The staff are very well trained. They know how to support me as I can't stand unaided or transfer to a chair. They certainly display the right skills and knowledge to see to my care", "Certainly the staff are all good and well versed with what to do", "The ones I have now I am very happy with", "They are well trained to look after my complex needs. I am very happy with the service" and, "Helping Hands have clearly recruited high quality staff."

Some people told us staff may need further support to develop skills to prepare meals and to support them in their leisure activities. For example, one person told us their current member of care staff was unable to cook to their standard. Another person also commented on the poor cooking skills of the care staff they had been allocated previously. One person said they felt care staff did not always have adequate driving skills. One other person said they had also received care from staff who needed some support to improve their English skills.

The provider explained some of their staff were recruited from overseas and therefore may not be confident in their knowledge about the local area they were placed in. Managers worked with care staff during their first visit to an area to ensure they understood where local amenities were and to provide them any additional skills, such as driving lessons. A training manager told us, "Staff can have extra induction or training in specific areas where a need has been identified. For example, staff can have subsidised driving lessons if they are unfamiliar with UK roads and driving." They added, "Our training programme now also includes cookery skills, and how to prepare English cuisine." We saw recruitment systems also checked staff had language skills to communicate with people.

We spoke to the operations director and training manager regarding the training staff received. All care staff completed a full induction programme before being able to support people in their own homes. The induction training included the Care Certificate which sets the standard for the fundamental skills and knowledge expected from staff within a care environment. Care staff also received training in specific clinical conditions, or how to use specific equipment, which was tailored to the needs of the people they supported. The head of clinical care said, "Our clinical team and the people who receive the service are involved in training staff in the person's home, if they have specialist needs. For example, specialist equipment usage or mobility aids."

One member of staff commented, "Helping Hands are fantastic, I have never received such well organised, informative training." Another member of staff said, "Apart from the Induction training we have a continuous training updates. On top of that, we have direct observations of practical tasks such as moving and handling to make sure the procedures are done correctly and safely."

All care staff told us their knowledge and learning was monitored through supervision meetings and unannounced 'observation checks' on their practice. Staff told us regular meetings with a manager provided

an opportunity for them to discuss personal development and training requirements. A staff member told us, "I have regular meetings with my manager about every two or three months. I find these extremely helpful. We have another meeting at change over at the end of a placement."

Staff told us they could contact a manager at any time if they required support as there was an 'on call' telephone number they could use 24 hours a day, if they needed support. One staff member said, "We also have two email addresses to contact if we want a chat." Another member of staff said, "I receive weekly emails from the manager asking for feedback and any problems or issues I have so we feel supported." However, some staff said that communication with office staff could be improved, to ensure they always received a response to any queries they raised. These staff said the problem seemed to be around communication of messages, rather than their calls not being received. We saw examples of call logs and saw call entries were made and the actions taken.

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. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). The registered managers we spoke with understood their responsibilities under the Act. Relevant paperwork was completed to provide staff with information about when people needed assistance to make decisions, and who should be involved in making complex decisions. People were asked to consent to their own care and information sharing, such as when their photograph could be shared with other people in newsletters and marketing materials.

All care staff we spoke with had completed training in MCA and knew they could only provide care and support to people who had given their consent. People confirmed care staff gained their consent before providing care and support. One person said, "Oh yes they ask me permission every time. [Name] wouldn't dream doing anything without asking me first."

The provider's systems assessed whether people could be supported more effectively with the use of new or different technologies, that might meet their needs. For example, a manager told us about one person who had a diagnosis of dementia. The person was very mobile and liked to go out. On several occasions they had left their home, without telling their family or care staff where they were going. The manager was working with the local authority and staff to assess whether the person needed restrictions placed on their movements. Assessments included whether doors should be locked, or other technologies could be used such as sensor mats, sensor alarms and personal tracking equipment. The person and their family were being consulted about what might be the least restrictive option.

People who were reliant on care staff to assist with meal preparation told us staff helped them shop and prepare meals according to their own wishes, that met their nutritional needs. Comments from people included, "Staff help me with everything and give me what I like for my meals. They make my breakfast for me and always asks what I want", "They are good cooks! All of my needs are catered for," and, "They prepare all my food for me and help me eat bringing it up to my mouth for me as I cannot use my arms. They take their time and cut things up so it is easy to swallow."

One person required their nutrition to be administered through a percutaneous endoscopic gastroscopy (PEG) tube. A PEG is a way of introducing food substitute, fluids and medicines directly into the stomach. A risk assessment had been completed and there were clear detailed instructions for care staff to follow about

how to manage the PEG. There was also information for staff about maintaining and checking the PEG regularly. Care staff had received training so they could use this equipment safely. Care staff knew how to monitor people's nutrition and hydration if this was required, to make sure people's nutritional needs were maintained.

A clinical care team who worked for the provider, were responsible for assessing and arranging people's care and support, where they had been assessed as high dependency based on their clinical health needs. The team consisted of a registered manager who oversaw the work of the clinical care team, and five nurses. The head of clinical care told us they were currently recruiting an additional staff member, to increase the flexibility of staff in the numbers of people they could assist. The head of clinical care completed regular quality checks on care records and the care people received, that made sure people received safe and effective care. The clinical team assisted staff with training, and how to use certain types of equipment, to ensure people received care that met their individual needs. They also completed observed practices of staff which assured them staff were competent to support people.

Records confirmed other health professionals were involved with people's care when required including district nurses, speech and language therapists and GPs. People were supported to manage their health conditions were needed and had access to health professionals when required. Comments from people included; "If I need to go to an appointment then my carer makes my appointments." One member of care staff explained, "If a person's needs change we are trained to get in touch with other health professionals. Helping Hands would also come out and re-assess someone's needs, if their health changes."

Good

Is the service caring?

Our findings

Ninety four per cent of people who responded to our survey, before our inspection visit, told us care staff always treated them with respect and dignity and that care staff were caring and kind. Comments from people included; "Staff are all very good, all very caring", "They are nice caring staff" and, "The staff are thoughtful and patient."

People told us they remained independent and to continue to live at home because of the care provided to them. People told us staff helped them to remain independent by encouraging them to do tasks for themselves, and keeping their skills and abilities up to date. One person said, "Staff are always encouraging me to do things for myself and now I can feed myself and also put my make-up on. They have given me confidence."

People told us that having someone live in their home was not always what they would have wished, but generally found care staff respected their privacy and dignity. Other comments from people include; "We have adapted well with staff living here. It was strange at first and gets a bit of getting used to that's all", "and, "The staff gave Mum the privacy she wants but were both excellent at being always available if needed without it being too much getting under your feet. I don't know how they do it." Only one person told us they felt care staff sometimes intruded on their privacy.

Staff explained to us how they protected people's privacy using a range of techniques, one member of staff told us, "I respect I'm living in someone's home. I don't open their post, and I give them privacy when they like to be alone. I knock on doors, and cover the person when I am assisting them to bathe." People's relatives confirmed these techniques were being used.

People and relatives said staff used a variety of communication techniques to encourage conversation and involve people in choices. This included staff utilising pictures, large print texts, visual signs, different languages and equipment. For example, we saw one person used hearing aids to assist them, care staff were directed to ensure the person always had these aids available and in working condition.

The provider had introduced an assistive technology policy, which instructed staff on how people could be referred to specialist organisations, health professionals, and charities to access new technologies or equipment that may assist them to maintain their independence or enhance their lives. Examples of where people had utilised extra resources were available from the provider as 'case study' information. The provider regularly assessed the experiences of people through this methodology to publicise successes to their staff, and other people who used the service. Case studies we reviewed showed where people had magnifiers to help them read and specially adapted electronic devices and programmes to assist with communication. It was clear these types of intervention enhanced the quality of people's lives.

In addition, the provider produced guidelines for people and their relatives on what new free applications were available to them, on laptops and phones. These ranged from applications that could monitor people's medicines, store health records, and reminder services to prompt people.

Some of the staff were from other countries. People told us of positive examples when care staff used their different cultural experiences and life histories to better inform people about who they were. For example, "Yes. Here's an example for you. I sometimes get carers to cook their national dishes so we get a varied flavour of the world. It is really good, I really do like that."

Most care staff told us they enjoyed working for Helping Hands, and felt supported and cared for by the provider and their managers. One member of staff explained why they felt this way, "On one occasion I became unwell, I was taken out of placement very promptly, and another carer put in place. I was offered somewhere to stay while I recovered."

People and their relatives told us they were involved in planning their own care, and making decisions about the support they needed. Assessments of care needs were done by local managers, or clinical team members, to ensure people received the care they needed.

Four people told us they would like more notice about who would be supporting them when their care staff changed over, as they sometimes did not receive care staff profiles until just before a change. People said this would help them feel more comfortable about who would be coming into their home, and this would help them plan activities and trips, as they were not always sure new staff would be able to drive. The provider told us they had systems in place to reduce this, their aim was to have profiles to people four weeks before a changeover.

To ensure people received a consistent service the provider regularly reviewed people's care by visiting them every six to eight weeks. They said part of the review process looked at how staff engaged with people, but to also speak with people to find out if they were happy or to resolve any concerns. They told us in the small minority of cases where people raised a concern about a staff member, attempts were made to find an alternative care staff member. However, back up plans were in place to supply care staff from other local Helping Hands Homecare hourly branches. One commissioner commented, "I have always found Helping Hands professional and pleasant to deal with. There have been times when the carers have not met my person's expectations, but normally Helping Hands are quick to rectify this and present the person with an alternative."

Good

Is the service responsive?

Our findings

People told us they received a personalised care service, as care staff lived in their own home. Most people told us this meant their personal preferences were met, as they directed their own care. This included matching what type of staff they felt comfortable with. For example, some people requested only male or only female staff. Other people were more specific around staff's age, interests and cultural backgrounds. Where people had expressed a preference, the provider tried to match staff accordingly. One person said, "I insist on English only carers which Helping Hands honour for me. I just feel more comfortable with them."

However, some people told us their preferences for staff were not always met. For example, one person told us they were not always offered staff that could drive. They said, "It is in my care plan as I need a driver to go out, otherwise I am housebound which has a detrimental effect on my health." They added, "I don't always get a driver though." A relative told us, "My relation has always asked for an English carer due both to her hearing problems making accents difficult. Hardly ever has one been offered." The operations director explained, "We are not always able to recruit staff exactly to people's requirements all of the time, but we offer people a choice of care staff wherever possible, and try to match people who have the right skills and qualities to meet people's preferences."

The provider was able to set up care packages at short notice. They explained their new customer team, now located in the same office as their care staff teams, could take new calls from prospective users of the service, and offer them care packages within a few hours. An intermediate care team was available who could respond quickly to people being discharged from hospital. They showed us an example of one person who had needed a care package set up immediately, and they had been able to respond within three hours.

People told us the staff in their homes responded to their requests for assistance in a timely way, comments from people included; "My carer is always there when I need her", "The carers are really good and will go out and get anything extra I want if I ask them" and, "Nothing is too much trouble for them."

Care staff told us there was information in care plans about how people liked to receive their care and to inform them what to do on each call. If people's needs changed staff referred these to local managers so plans could be updated. One member of staff said, "We have a duty of care to people and we need to keep the records up to date." The managers used a digital system to record information straight away.

In one person's care records we saw information was not completely up to date, which was an oversight. The care records stated the person should be assisted to move with a hoist. However, the person was actually using a stand aid (a different piece of equipment). A manager explained the record needed to be altered, however, the member of staff on site was trained to use the equipment in the person's home when they began supporting them, and therefore would know how to transfer the person safely. The care records were altered during our inspection visit to state the correct equipment.

People had regular reviews of their care, which were conducted every six months. Plans we saw had been reviewed and signed by people or their relatives, which showed they had been involved in planning their

care. For those people who wished to engage with staff regarding end of life care planning, this was offered to people who used the service and their relatives. This process included an assessment of whether people wanted any medical interventions at certain points in their care, and whether they had any cultural or spiritual wishes.

Care staff told us they read care records and had a planned handover with the previous member of staff when they started work in someone's home. The care records included daily information from the previous member of care staff which updated them with any information they needed. One person told us, "They [staff] exchange all information very well when handing over."

People told us the care staff also helped them to meet their spiritual and cultural needs, by helping them to attend worship at their local church, and to take part in interests and hobbies they enjoyed. One person told us about how staff supported them to do puzzles, read books, and keep active mentally. They said this enhanced their quality of life.

We saw information on one person who had been supported by staff to take a much needed holiday. Comments from people included; "Staff support me to the pub for a drink or lunch and a walk, also to the cinema" and, "They [staff] get me out and about and are always asking me what I would like to do or where to go."

Additionally, the management team promoted events and recognised specific calendar days of the year for people who received care from Helping Hands. For example, on the day of our inspection visit we saw one person had been asked to attend a cake sale where staff were raising money to support a charity, specifically organised to support people in Motor Neurone week. The person who was diagnosed with the condition met staff and promoted the importance of supporting charities that researched treatment of diseases and disorders.

One hundred per cent of the people who responded to our survey before our inspection visit told us they knew how to make a complaint. The provider had a written complaints policy, which was contained in the service user guide which each person had in their home. Most people told us they were satisfied that any concerns or complaints they had were listened to and acted upon. A typical comment from people was, "A carer that was not compatible was swapped quickly when I asked."

A small number of people told us they were not always pleased with the responses to complaints or issues they had raised with Helping Hands in the past. We found when we spoke with the operations director, investigations were held into any complaints that had been received at the provider's office. They explained, we have made improvements to the way we answer and log calls from people who ring into the office when we moved all our staff to these offices last year, and have improved our systems.

We looked at how the provider learnt from complaints. Complaints were discussed at monthly operational meetings, an analysis of complaints at these meetings looked for any patterns or trends and if there was any shared learning or improvements that could be made. Any actions were cascaded by senior management to staff. If the person who complained was not satisfied, the operations director looked into the complaint to manage them through to a satisfactory conclusion. Where people's complaints were not always resolved, those people were signposted to seek support with their complaint, from the Local Government Ombudsman. Where complaints involved staff, the provider had taken the necessary action, such as further observations of practice, additional training, or consideration of continued employment.

Good

Is the service well-led?

Our findings

Although this was the first time we had inspected this service under its current registration, the service had previously been inspected at a different address. The provider had moved offices and re-organised their service to become more responsive to people's needs, and to expand part of their service. The service had previously received a rating of 'Good' in all areas.

The majority of people we spoke with were happy with the service they now received. Comments included, "It is very good", "I'm very satisfied with it all", "I am happy with the people looking after me here."

Some people who used the service commented on the support they received from office staff and their local manager (since the provider had re-organised their offices and staff structure) saying, "The support from the local manager has been good since Easter when a new one started. This hasn't always been the case." Other comments included; "The manager comes in to see the care staff and us quite often", and "A line manager comes in regularly and is very approachable." This indicated that people were generally happy with the support they received from their local manager. However, three people described the finance department as still needing to improve, especially in their response time to people's queries, although this did not affect their care delivery.

A commissioner of the service told us, "My experience of working with Helping Hands suggests strong management and effective leadership. Any issues raised are always dealt with quickly and effectively."

The organisation was a large national provider, who based their offices for the full 'live in' service at this location. The service was divided into regions, North, South, Central and East. Each region had a registered manager assigned to manage that part of the service. In addition, a registered manager was assigned to manage the clinical team, that support people's health care needs. At the time of our inspection visit there were three registered managers in post. Two newly recruited managers were progressing their registration with CQC, one of which was due to start their employment.

As part of the re-location the provider's other services had been separated, so that the 'live in' service was managed separately to their other regional domiciliary care agencies. This was to improve the responsiveness to people and staff using their 'live in' service, and showed a considerable investment in resources to build and improve their business. This was in response to feedback from people, in previous satisfaction surveys the provider had recognised a trend in people's comments regarding the time it took to respond to people's queries.

The operations director told us moving their service to an alternative location had allowed all their care and support teams to work in the same building. This had improved communication and helped to forge and build team relationships. The provider employed local managers who worked with care teams to ease communication between office and care staff. Dedicated 'live in' care managers had been put in place nationally, who oversaw the care of approximately 30 people each, to improve staff knowledge about individual care packages and to respond quickly to any customer concerns. The structure also supported

staff to have access to managers who knew about their working environment.

The directors and registered managers encouraged a positive and open culture and embraced the input of staff. The provider employed a range of means to obtain the views of staff. For example, weekly meetings with their manager, regular supervision meetings, social media platforms, a dedicated whistle-blowing line, a 24 hour' call line and yearly satisfaction surveys. The provider's openness extended to staff having the opportunity to share their views directly with the chief executive by phone or email. Where the provider received feedback about how they could improve their service, this feedback was acted upon.

The provider had introduced a number of initiatives to improve internal communication. These included the creation of a group chat application on social media, and local managers using a 'skype' application from tablet computers to care staff each week. Weekly emails were sent to care staff to update them and tell them about good news stories and initiatives. These weekly messages also contained video messages and directed staff to useful training updates they could access on-line. The provider also issued staff with a regular newsletter about successes, achievements and initiatives. In addition, the provider planned to introduce communications training to all staff, at the time of our inspection visit managers were taking part in this training.

Staff at all levels throughout the organisation embraced the values of Helping Hands, which were to focus on people, excellence, listening and understanding. Each new member of staff received a booklet during their induction which contained the vision and values of the provider. We looked at the most recent staff satisfaction survey the provider had implemented in December 2017, this showed 87% of staff would recommend Helping Hands as an employer, and 89% would recommend them as a care provider. A recent staff survey undertaken by an external recruitment organisation had rated the service as one of the top 25 employers in the UK. The chief executive had also been awarded the title of the best chief executive in 2018 by the external recruitment organisation.

To improve staff training, for example, in cooking, the provider had responded by creating a dedicated training department to ensure staff had the knowledge and ability to meet people's needs. The team coordinated and delivered training across a range of media including classroom sessions, workbooks and online through e-learning and webinars. A dedicated training suite was set up where staff received their initial induction and training, which provided staff with accommodation for their five day induction and access to kitchens so they could prepare meals.

To ensure managers were up-to-date with best practice, the provider had developed an internal management programme that aligned with level 5 qualification of the Health and Social Care diploma. The qualification and leadership programme had been developed with Skills for Care, a recognised centre of excellence in social care training. Managers told us they passed on their learning to staff in team meetings and supervision sessions to improve the delivery of care and support to people. Following this programme being implemented Skills for Care had awarded Helping Hands with a centre of excellence award, for staff training initiatives.

The provider recognised the valuable contribution staff made to their business, and offered staff incentives to support high quality care. They celebrated achievements to reinforce good practice. Staff were nominated each month for an employee of the month award, to recognise their contribution. The chief executive awarded staff who had improved the quality of people's lives with an award for excellence. We found that when people, relatives and healthcare professionals forwarded compliments about staff, efforts were made by senior managers to ensure this was acknowledged. Other success stories were published for staff to read online and in the provider's newsletters. Staff were also offered rewards programmes such as

childcare vouchers and access to an employee support service.

Several members of staff spoke about how they felt their placements in people's homes sometimes isolated them. This was because they were not near to their home, or local amenities, or were placed in an area they were not familiar with. The provider had recognised this as an area where Helping Hands needed to support their staff further. Managers now visited new staff members in their first placement within a week of them starting work. This was to ensure staff had an opportunity to discuss any concerns with their manager at an early stage of their placement Training options had been updated to include driving lessons and orientation of staff members to their local area, if this was required. In addition, the provider had recently introduced a mentoring programme. This involved experienced staff supporting newly recruited staff, through training and communication, to reduce any feelings of isolation.

A dedicated quality assurance team working alongside staff in the office, used a range of techniques to gather information and assess the quality of care people received. These techniques included (but were not limited to) yearly satisfaction survey for people, relatives, stakeholders and audits of care paperwork, and medicines. Local managers visited or telephoned people and asked them their thoughts on the quality of service, if they had concerns, or if they had ideas for improvements. Reviews of lessons learnt from complaints, feedback, investigations into accidents and incidents and any safeguarding concerns, which were assessed and analysed to monitor any emerging trends or patterns. Accidents, incidents, and any events that required investigations were reviewed every two months by the clinical governance team. We saw an example of where an incident in someone's home had been connected to carbon monoxide, this information had been cascaded to teams to alert them to how they could spot any issues with carbon monoxide, and what they should do if they suspected it was a problem.

Regular management team meetings were held to discuss the outcome of quality assurance checks. These included monthly board meetings of the directors, operations team meetings following the board meetings to discuss outcomes and how and trends or issues could be resolved, and team meetings for staff to discuss action plans and to gather staff feedback. These range of meetings meant the senior management had up to date knowledge and awareness of how the business was performing. Previous action points were reviewed at each meeting to monitor and progress improvements and action plans.

The provider worked with other organisations to continually learn and improve their service. They did this by keeping up to date with developments in the care industry. The operations director told us they were also members of the United Kingdom Hone Care Association (UKHCA) which offered support, policies and advice to domiciliary care agencies in the UK. The provider used best practice guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal Pharmaceutical Society to train clinical staff and develop medicines policy. The provider also offered other organisations an opportunity to learn from them. For example, the provider was working alongside Public Health Wiltshire to develop a baseline assessment with regards to nutrition and hydration for people reliant on carers. The provider told us they had also organised a specialist Dementia Workshop & Networking Event which was attended by the health secretary, for family members of people with dementia. This gave people an opportunity to take part in the provider's 'sensory dementia training' which involved role play and people being deprived of some of their senses, such as sight, to more closely understand the aspects of dementia and how people with dementia perceive their environment.

Planned improvements for the forthcoming year included the introduction, alongside digital care records, a digital log of people's medicines and when they were administered. This would allow real time audits to be completed, as alerts would be sent to managers if tasks were not completed on time by care staff. The provider was updating how staff could access training materials, by further developing an interactive

learning application staff could use on their mobile phone to access information and training materials.