Helping Hands Watford Ltd

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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**

Overall summary

Helping Hands Watford provides care and support to people living in their own home. At the time of our inspection 26 people were being supported by at Helping Hands Watford.

The inspection took place on 9, 11 and 16 November 2015. This inspection was announced. We previously inspected Helping Hands Watford in September 2014 and found they were not meeting the standards in relation to safeguarding people and staffing. During this inspection we found they had not made the required improvements and were still not meeting the required standards.

At this inspection we found the service to be in breach of regulations 17, and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post who was also the provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People told us they did not always feel safe receiving a service from Helping Hands Watford. Staff were not always aware of how to keep people safe and risks to people's safety and well-being were not always identified and managed. People's care records were not always updated to reflect the change in their needs. There were sufficient numbers of staff deployed to support people. People kept their medicines in their own homes and were prompted and or supported by staff to take them. However, the support with medicines was not always managed and recorded appropriately.

People were not routinely asked for their permission before staff assisted them with care or support. Staff received intermittent supervision from management which helped them to feel supported and valued. They told us they felt able to seek assistance when they needed to. People received support to eat and drink regularly. People were assisted to access healthcare appointments as needed.

People's privacy and dignity was not always respected and promoted. People told us they were mostly treated with kindness and compassion by staff but a lack of continuity impacted on the ability to develop meaningful relationships with care staff.

People's care records were not always regularly updated to provide a detailed account of their needs and care. People told us they did not always feel confident to raise anything that concerned them with staff or management, as the issues were not addressed and resolved. Arrangements were in place to obtain feedback from people who used the service; however this work was incomplete and had not been evaluated to put actions in place to improve the quality of the service.

Summary of findings

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.

Medicines were not always managed safely.

Staff were not always aware of when to report abuse.

Recruitment processes were not robust.

There were sufficient numbers of staff deployed. However support was not always provided at the times people expected.

Is the service effective?

Requires improvement

The service was not always effective.

Not all staff had received appropriate training which supported them to perform their roles safely and effectively.

Staff explained what they were going to do before supporting people, but did not routinely obtain people's consent before providing care and support.

People were supported to access the GP and other health care professionals when requested. However staff did not always report or elevate concerns to enable appropriate intervention in a timely way to help ensure that their general health was being maintained.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were not always treated with warmth, kindness and respect.

People's dignity and privacy was not always respected or promoted.

Staff had a basic understanding of people's needs and wishes.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not always receive care that met their individual needs.

There was an appropriate process in place to investigate complaints.

Is the service well-led?

Requires improvement

The service was not always well led.

The provider did not have sufficiently robust arrangements in place to identify, and monitor the quality of the service.

Summary of findings

Audits had not identified issues and concerns which we identified as part of our inspection, and actions from the manager's audits had not addressed the concerns.

People did not have confidence in staff and the management team.

Helping Hands Watford Ltd

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.

This inspection was carried out by one inspector on 9, 11 and 16 November 2015 and was announced. We gave the provider 48 hours' notice of the inspection to make sure that appropriate staff and managers would be available to assist us with our inspection.

We reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us. We requested feedback from commissioners and other people who have had experience of the service and how it was managed.

During the inspection we spoke with six people who used the service, three members of care staff, the registered manager and a newly appointed manager, and two office staff. We also received feedback from the local authority health and community services team.

We reviewed care records relating to three people who used the service, three recruitment files and other documents in relation to the overall management and delivery of the service. We looked at processes that were in place to support staff.

Requires improvement

Is the service safe?

Our findings

We had received concerning information relating to the support provided to people who used the service. This related to safe practices around the use of equipment. During our current inspection we found that this was no longer an issue and had been addressed.

People told us they did not always feel 'safe' by the support they received from Helping Hands. One person told us, "I am never too sure if they are going to turn up or who is going to turn up and this causes me some concern". They went on to say "I never know if someone is going to be able to assist me or not". A second person said, "It depends who you have sometimes I feel safer than other." The person told us that the staff abilities varied and they had more confidence in some than others.

We got mixed feedback from staff in terms of their understanding of 'abuse', some were able to describe what constituted abuse and what signs they looked for when providing personal care to people. However, others were not so sure and spoke about 'environmental risks and making sure the area they worked in was hazard free'. Staff did tell us that they would report any concerns to the manager.

However, we reviewed the records for one person and noted that a body map had been completed for the person. It detailed an apparent fall in July 2015 and the record described the person as having large bruises to the chest and hand. We noted that the body map had been completed three days after the alleged fall. We spoke to the manager about this as there was no medical intervention following the incident to check the person for further injuries. This demonstrated that the staff had not followed the safeguarding procedure by reporting the incident without delay or getting the person checked by a medical professional.

Staff had some understanding of the whistleblowing policy and how to elevate concerns. One staff member told us, "I would tell the manager if I suspected or saw any poor practice." They went on to tell us that they were sure the manager would take appropriate action but said if they did not they would contact the social worker.

We found that although care plans and risk assessments were in place, these were not always reviewed to show current risks to people. In some cases where risks were identified, they were not acted upon, leaving people at continued risk. For example, we found that in the case of one person whose records we reviewed the person had an on-going health problem and some of the symptoms recorded by staff were associated with the health condition the person had. However although concerns to the persons health were recorded they had not been elevated to a senior person for further investigation therefore the risk had not been mitigated.

People told us they were supported and prompted to take their medicines when they needed them. We saw that staff had been trained to support people with medicines. However, we saw there were gaps on the medicines chart (MAR) which were unexplained. We spoke to the manager about this and they were unable to give us an explanation about whether or not the person had been given their medicines on a particular day. We then spoke to the person concerned and they told us they had been given their medicines but they thought the staff had forgotten to record it.

The MAR charts we saw did not detail what the medicines were and therefore if a person missed a dose the staff would not know what the impact of this was on the person's health. For example if they needed to inform the GP they would be unable to say what the medicines were. The manager told us staff did not need to know what the medicines were as they were dispensed in a pod which all the tablets were in together.

Staff recruitment processes were not robust. We saw that although some pre-employment checks had been made they were not completed. For example employment histories were incomplete and gaps in employment had not been explored. We were told by the manager that they took up a minimum of two references but on one file there was only one reference and on another the address of the company providing the reference was incomplete. The manager was unable to demonstrate how they had obtained the reference. The references were not validated. We saw DBS checks had been made and the numbers were kept to evidence this.

People told us that they thought there was enough staff but there were always new staff coming and going. One person said, "One morning the manager arrived with two young people and told me they were my new care workers. I did not feel they had the skills to care for me safely." The person told us that the manager told them the 'girls' had

Requires improvement

Is the service safe?

just started working for the company and were undergoing training, which made the person feel that they were not yet skilled to provide care that was 'safe'. A second person said, "They are always changing the staff, it's difficult going through the routine all the time."

We reviewed the rotas and saw that there appeared to be adequate staff employed to meet people's needs. However, the rostering system linked to the telephonic monitoring system was not working and we could not see if people's care was being delivered in accordance with their care plans, or view historic information to assess staffing levels in relation to the needs of people who used the service. We did request this information from the manager but they were unable to provide it as the system had not been working for some time and they had just introduced new rotas.

Requires improvement

Is the service effective?

Our findings

People told us they thought some of the staff were trained to support them. One person we asked told us, "It varies from person to person, some are trained, some do not appear to be trained."

Staff told us they had undergone training relevant to their roles. However, they were a little vague when asked about when the training had been completed and the types of topics covered. Staff said they had an induction when they started working at the service and said it covered all the basic requirements. We saw that staff had certificates in their files demonstrating they had completed the training but again when asked they could not remember what the training had covered. This suggested that competency was not always checked. We spoke to the manager about how they check staff competency and they told us it was discussed as part of their one to one supervisions. However, from the three records we reviewed relating to supervision, the notes were extremely sparse and made no reference to competency having been checked. For example, one record said "will be organised" however it did not specify to what this related.

Training records we looked at indicated that staff had received updated training in relation to safeguarding people from abuse. However, we noted that two staff member records relating to safeguarding training were incorrect and related to other staff members. We spoke to the manager about this to establish how this could have happened. The manager could not explain this. At the time of the training one person was not yet employed at the service and the second record related to a female member of staff when in fact the records being reviewed were for a male. This suggested that the certificate of training did not belong to the person whose name appeared on it. This meant that we could not be confident that staff had received appropriate and up to date safeguarding training.

Staff told us that they had regular meetings with their manager, one member of staff said they had supervision every two to three months. We spoke to the manager about the content of supervision notes and recording as they did not cover any discussions about the people they supported and did not review objectives or identify areas for development. The manager told us that they would review these and were trying to improve the effectiveness of the support arrangements.

The lack of appropriate training and support for staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were unable to tell us how they obtained consent. However, they did say they offered people choices and would respect people's wishes if they refused care. Staff told us that they explained to people what they were about to do and waited for people to agree. One staff member told us, when asked about obtaining consent, "I would check with the person and if they did not give consent I would check with the relatives and if not I would ask the manager if they had given consent." We asked the member of staff if they had received training about obtaining consent and they said they had received this training but could not remember when. We saw that there was a policy and process for staff to follow on obtaining consent. However, although staff had all signed to say they had read and understood various policies that were in place, the procedure for obtaining consent had not been signed. We brought this to the attention of the manager who told us they would put things in place including relevant training to ensure staff had the knowledge about obtaining consent to care treatment and support.

People told us their family would support them with attending healthcare and GP appointments when they needed them. One person told us that care staff had arranged an optician's appointment for them and told us that if they were unwell, care staff would arrange to call the GP. However we found in one person's care notes repeated entries about the person being unwell and having difficulties breathing. This was not reported to the manager for intervention. Furthermore an audit of these records did not pick these concerns up either and this meant the person may have been exposed to further risk to their health. We referred this concern to the local safeguarding authority. However we then received information from the person's social worker to explain this was an ongoing condition which was being managed. The records were not effective in demonstrating the position.

Requires improvement

Is the service caring?

Our findings

People told us that some of the staff were caring and treated them in a dignified manner. One person told us they thought that sometimes, "The staff in the office were not very caring." They told us that recently a male driver arrived at their home with their care worker. The person told us they asked him to leave and wait in the car. The person went on to say they had not been asked in advance if this was okay and they did not feel that this was a very caring gesture. Another person told us that, "Two trainees' attended my home recently with the manager and I was not expecting them." The person went on to say, "If only they would think about how we feel. It's our home and we need to be kept informed."

Staff told us they cared for people as they would their family. Staff said that they tried to develop positive and caring relationships with the people they supported. We asked staff how they met people's needs and preferences in a kind and compassionate way. They told us they treated people respectfully and with dignity. One care worker told us, "I always ensure people have privacy, I talk to them when I support people with personal care. If they have family, I always maintain their confidentiality. I do not discuss their personal business with people".

People told us they did not feel that staff always had the experience and this detracted from them providing support in a caring way. The person told us, "They seem nice enough but were learning the ropes." Another person said they felt the service lacked consistency and that was an element of care that was crucial.

In another person's case they told us they were happy with the care they received. They said staff were very nice and, "Do their best." Staff told us that people were involved in their care planning and reviews of care. However, there was little evidence of people's involvement in the care records we reviewed. The manager told us they would make sure people signed to confirm their involvement and not just sign to say they have seen their care plan.

One person said, "I have no special needs myself, but I am sure if people needed support staff would be willing to assist."

We spoke to staff and managers about how they ensured the service provided met the needs of people with specific ethnic and cultural needs. Staff and managers told us they always asked people about specific needs when they undertook the initial assessment and this information would be included in the care plan.

Overall people felt that staff were kind and caring but that things could be improved in this area by having a more consistent workforce. This was an area that required improvement.

Requires improvement

Is the service responsive?

Our findings

One person told us the staff and managers did usually respond to their needs but sometimes there were last minute changes and this "upset things" A relative told us, "They do their best, we are very grateful for their support they can't get it right all the time."

We saw that people had a folder in their homes which contained copies of all relevant documents including care plans, risk assessments and out of hours contact details. This meant that staff were able to access information and guidance about how to look after people.

Support plans were not always written in a person centred way. We also saw that care and support plans did not sufficiently detail what people were still able to do for themselves and this meant that staff may well be assisting with tasks that people could still do for themselves. For example, several people told us they wanted to be supported with minimal support from staff to maintain their dignity as well as their independence. One person said, "They often assume, I tell them I can do some things myself." The person told us they wanted to remain as independent as possible and not become more reliant on the support of staff.

The care plans we reviewed confirmed that people's needs had been assessed and were reviewed periodically, or whenever there was a change to the person's circumstances or abilities. Likewise with risk assessments, although the changes were not always clearly documented. For example, they did not always clearly state the date the changes had been implemented.

People told us they would know how to raise a concern if they needed to. We saw that there was a process for recording complaints. Staff told us that if people raised any concerns with them they would let the manager know and they would deal with it. We saw that complaints had been recorded and investigated with outcomes recorded. We also noted that there was a process for recording compliments and noted the service had received a number of 'thank-you' cards from people who had been very happy with the service they received.

Requires improvement

Is the service well-led?

Our findings

The service had a registered manager in place and a new manager had recently been appointed. We found that the service was not consistently well managed. We found some of the processes that were in place were ineffective in identifying and acting on issues that were identified as part of our inspection. For example, he managers were unaware of concerns relating to people who used the service and although audits had been completed the audits had not picked up issues of concern.

The manager told us that staff had recently taken on new roles and these were in the process of being 'embedded'. Staff were vague about their roles and responsibilities. We saw that the telephonic monitoring and rostering system was not working and had not been working for some time. It was difficult to establish if people were receiving care at the correct time or if visits were being missed or late. The manager told us that spot checks were being undertaken, however we found these were done approximately once every eight weeks and so would not be frequent enough to pick up late or missed visits.

We spoke to the manager and staff about the arrangements for supporting people when the office was closed. The manager told us the telephones were diverted and there was always a manager or senior person on duty to provide support to staff and people who used the service. However, the manager was unable to show us records relating to how the service worked as they told us these had been archived at their other office. Later in the day they agreed to try and locate out of hours records so we could assess the responsiveness of the service. The manager could only locate one record covering a three week period in August 2015. There was no other information to enable us to assess the robustness of the out of hour's service or whether it met people's needs. This demonstrated poor record keeping in relation to the out of hour's service.

The manager told us that now that they had the new manager on board they would be implementing new processes and would be looking for ways to improve the quality of the service.

The manager told us they had 'commissioned' an external company to obtain feedback from people via a survey. However, the work was incomplete and had not been followed up by the manager. The manager told us that they had communication with the company in August informing them of a 'lack of response' but this was not followed up or evaluated to see what there had been a poor response or to consider what they might do differently in the future. The lack of follow up indicated that this area of work was not a priority and the manager agreed that they would follow this up following the inspection.

Overall we found that the manager did not have a robust system in place to audit and monitor the quality of service provided. The culture of this service was not open or transparent and it was difficult to obtain information in a structured and concise way.

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

The manager did say that more robust processes would be put in place. For example, the supervision process would be reviewed, along with regular team meetings, so that appropriate support arrangements were in place. The manager was receptive of feedback and was keen to improve systems and processes. The audits that were in place were being reviewed to include audits of care records and progress notes. Staff were also going to be trained in appropriate recording and actions they were required to take when concerns were identified. This approach would help to ensure that issues identified through monitoring would be properly acted upon in a timely way.