Midshires Care Limited

Helping Hands Kensington & Chelsea

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 comprehensive inspection took place on 4 and 12 September 2018 and was announced on the first day. We informed the provider of our intention to return on the second day. Inspection activity was completed on the 26 September 2018. This was the first inspection of the service since it registered with the Care Quality Commission on 28 December 2017.

Helping Hands Kensington and Chelsea is a domiciliary care agency which provides the regulated activity of 'personal care' to people living in their own houses and flats in the community. The service is owned by Midshires Care Limited. Not everyone using Helping Hands Kensington and Chelsea receives regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection the provider was providing services for 16 people, which included four people who received personal care.

There was a registered manager in post at the time of our inspection, who was present on both days of the inspection. A registered manager is a person who has registered with 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.

Processes were in place to ensure the safety of people who used the service. The representatives of people who used the service told us that their family members felt safe and comfortable with their regularly assigned care staff, who were described as "very caring", "outstanding" and "marvellous." Staff had received safeguarding training and demonstrated a clear understanding of how to identify if people were at risk of abuse, harm or neglect, and what actions to take to protect people. Detailed recruitment practices had been implemented to make sure that staff had suitable skills and experience to support people who used the service.

Staff asked people for their consent before they provided care and support, and respected people's choices in relation to how they wished to be supported with their personal care. The provider followed the principles of the Mental Capacity Act 2005 (MCA) in planning and delivering people's care and support. People's needs were assessed by the registered manager before they began using the service and these assessments were used to develop individual care plans that considered people's needs, wishes and aspirations. Risk assessments had been created to enable staff to support people in a safe manner, while promoting their independence as much as possible. Staff had completed infection control training and confirmed that they were supplied with sufficient personal protective equipment (PPE) by the provider.

People were safely supported with their prescribed medicines. People's nutritional needs were understood and met where encouragement and/or assistance with eating and drinking formed part of their care plan, and they were supported to meet their health care needs where necessary. The provider worked in

partnership with other local health and social care organisations to ensure that people's needs were effectively met.

People's representatives informed us that the care staff were well trained, punctual, friendly and reliable. Systems were in place to support staff with their training and development needs, for example staff attended group meetings with the registered manager and also received regular one to one formal supervision.

People and their representatives received written details in relation to how the service operated, which included out of hours contact telephone numbers and information about how to make a complaint. People's representatives stated that they thought the registered manager would respond to any complaints in an open and professional way.

The registered manager sought the views of people who used the service and their representatives as part of the quality monitoring process. Regular checks were undertaken to determine whether people were happy with the quality of their care and support. The registered manager understood her legal responsibility to report safeguarding concerns and other notifiable events to the applicable authorities. Care staff informed us that they felt supported by the registered manager, who ensured that the service was operated in a way that reflected the provider's values and visions.

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.

Staff understood how to detect abuse and the required procedures to follow to protect people.

Risks to people's safety were identified and addressed, so that these risks were mitigated.

There were sufficient staff deployed to appropriately meet people's needs. Recruitment protocols were sufficiently rigorous to ensure that staff were suitable for their roles and responsibilities.

People were supported to take their prescribed medicines by staff with applicable training.

Is the service effective?

Good

The service was Effective.

People were supported by staff who had relevant training and supervision to understand and meet their needs.

Where necessary, people's care plans contained suitable guidance to enable staff to effectively meet people's nutritional and health care needs.

Staff respected people's rights to make their own choices about their care and support wherever possible.

Is the service caring?

Good

The service was Caring.

Staff supported people in a kind, respectful and thoughtful manner.

Individual care plans showed that people, and their representatives where applicable, had been consulted about their specific needs, interests, preferred routines and wishes.

Staff understood the importance of promoting people's independence, and maintaining their dignity and privacy.

Is the service responsive?

Good

The service was Responsive.

People's individual needs were carefully assessed and their care plans were updated if their needs and wishes changed.

People and their representatives were supported to express their views about the quality of their care and knew how to raise any concerns or complaints.

The provider understood how to respond to people's changing needs, including how to liaise with people's representatives and other appropriate organisations if people became increasingly frail.

Is the service well-led?

Good

The service was Well-Led.

People's representatives told us that the service was competently managed and the registered manager was always helpful.

The staff team described the registered manager as being "approachable" and felt fully supported by the provider.

Efficient quality monitoring systems had been implemented to identify and speedily rectify any concerns.

Helping Hands Kensington & Chelsea

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 was the first comprehensive inspection of Helping Hands Kensington and Chelsea since its registration with the Care Quality Commission (CQC) on 28 December 2017. We were not aware of any serious incidents or concerns about the service. The inspection was conducted on 4 and 12 September 2018 and was announced. We concluded the inspection on 26 September 2018, following our telephone calls to the relatives and representatives of people who used the service. The provider was given two days' notice of our plan to conduct this inspection because we needed to ensure that a member of the management team at the service would be available to participate in the inspection process. The inspection was undertaken by one adult social care inspector.

Prior to the inspection we reviewed the Provider Information Record (PIR). The PIR 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 also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the provider is required to send to us in line with legislation.

We spent both days of the inspection at the office location to meet the registered manager and care coordinator, and look at various documents. This included two care plans for people who used the service, staff files for recruitment, training and supervision, the complaints log and compliments folder and medicine administration records. During the inspection we spoke with the care coordinator, the registered manager, two regional heads of home care, and a regional quality assurance partner.

Following the inspection, we spoke by telephone with the friend of one person who used the service and the relatives of three people. We also contacted two care workers and spoke with them about their experiences of working at the service. We contacted a local health and social care professional with knowledge of using this service for their patients and received their written comments.

Good

Is the service safe?

Our findings

The relatives and representatives of people who used the service informed us that their family members and friends felt very safe and relaxed with their care workers. Comments included, "The staff are always very polite and respect that they are in my [family member's] home. They provide excellent care and companionship, [he/she] likes to talk with them" and "I have never felt concerned about [name of person's] safety. [He/she] speaks highly of [his/her] carers and [registered manager] makes sure [he/she] is visited by the same few carers."

Records showed that staff had received safeguarding training and the staff we spoke with demonstrated a thorough understanding of how to recognise different signs of abuse. Staff told us they would immediately inform the care coordinator or registered manager of their concerns and were confident that a member of the management team would take appropriate action to ensure people's safety and welfare. We noted that the registered manager understood her responsibilities in the event of a safeguarding concern and provider's safeguarding policy and procedure contained information about external authorities that needed to be informed without delay.

The care staff we spoke with confirmed that they had been told about how to whistle blow during their induction training and they were familiar with the provider's whistleblowing policy. Whistleblowing is when a worker reports suspected wrongdoing at work. Although staff were aware that they could report concerns to relevant external bodies if necessary, for example the police, social services or the Care Quality Commission (CQC), this was not stipulated within the whistleblowing policy or the staff handbook. We discussed this finding with a regional head of home care, who informed us that the provider planned to amend the whistleblowing policy.

Risk assessments were in place to identify and reduce risks to the safety and wellbeing of people who used the service. The risk assessments we looked at contained guidance for staff to support people to safely mobilise and identified actual and potential hazards within people's own homes for example any loose rugs or cables that people, their visitors and care staff could trip on. This enabled relatives and friends to make any necessary changes to minimise the occurrence of accidents or incidents due to possible dangers in people's home environments.

Recruitment processes were sufficiently robust to ensure that people received their care and support from staff with suitable knowledge and experience to appropriately meet people's needs and wishes. Staff files contained two references, proof of identity, proof of eligibility to work in the UK and a Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to assist employers to make safer recruitment decisions.

The relatives and representatives of people who used the service told us that the provider consistently delivered a reliable and punctual service that ensured people received their care from regular care workers that they were familiar with. One relative stated, "[My family member] has the same staff that we have got to know. The visits are covered by the same three staff and they are all extremely good. We don't have to keep

explaining how [my family member] wishes to be supported, the staff are very competent and know exactly what to do."

Records showed that staff had received training in relation to how to safely administer medicines. People's care plans clearly stated if they needed any support with their medicines, which could be prompting or other assistance in accordance with people's needs and wishes. Where people required staff support to put on prescribed topical creams and lotions, the care plans contained body maps that clearly showed where these items needed to be applied. We noted that the management team carried out regular checks to determine whether staff had correctly completed the medicine administration record (MAR) charts. The minutes for the staff meetings showed that the registered manager reminded staff about the importance of adhering to the provider's medicine policy and procedure.

There were systems in place to protect people who used the service from the risk of cross infection. Records demonstrated that care staff had received training in infection control and prevention and the care staff we spoke with told us they were provided with personal protective equipment, for example disposable gloves and aprons. The relative of one person who used the service informed us that it was important for the regular care staff and any other staff from the agency to properly follow infection control and prevention procedures, and they were particularly pleased with how staff met these responsibilities.

We saw that robust processes were available to ensure that any accidents and incidents were comprehensively recorded, so that the registered manager could carry out their own analysis and identify where improvements could be made, if necessary. At the time of the inspection there had not been any accidents or incidents. We spoke with the registered manager about the possible actions they would take if a person who used the service experienced a fall at home. The registered manager explained that she would speak with the person and their chosen representative to seek their views and check whether relevant health care professionals had been informed, for example the GP or district nurse. Where necessary, care plans and risk assessments would be reviewed and updated.

Good

Is the service effective?

Our findings

The provider ensured that the needs of people who used the service were assessed before their care packages commenced. The registered manager told us that the assessment process was used to make sure that the agency could meet a person's individual needs and to check whether the appropriate equipment was in place, for example if a person required support from care staff with moving and positioning.

We received positive remarks from the relatives and representatives of people who used the service in relation to the skills and knowledge of the care staff. Comments included, "I would describe the staff as being quite outstanding and very able" and "They are intelligent and know what to do. [The provider] appoints staff of a high calibre, they are very professional."

Staff were required to successfully undertake the Care Certificate, which is an agreed set of standards that sets out the skills, knowledge and behaviours expected of specific job roles in the health and social care sectors. It is made up of 15 minimum standards and forms part of a robust induction programme. Although this training was originally designed for care staff who were new to roles in the social care sector, the registered manager confirmed that all newly appointed care staff were required to successfully undertake the certificate during their probationary period.

The care staff we spoke with told us that they had received induction training and opportunities to shadow experienced staff when they began working at the service. Records showed that staff had completed mandatory training, which included moving and positioning, equality and diversity, understanding mental health needs, dementia awareness, basic life support and food hygiene. Staff told us they felt supported by the registered manager and clear systems to formally support staff were evidenced through one to one supervision meetings, team meetings and annual appraisals. We noted that staff spoke individually with the registered manager about their training and development needs, and the group meetings were used to collectively advise staff about the provider's training requirements.

The care plans showed that people were supported to meet their nutritional needs, where they were assessed to require support with eating and drinking. We noted that the care plan for one person who used the service provided detailed information to enable staff to understand the person's food preferences and contained straight forward guidance for staff as to how the person's health care needs could impact on their ability to maintain a balanced diet.

The registered manager informed us that there were limited opportunities at the time of the inspection to work in partnership with other health and social care organisations, because the people who used the service did not have large care packages and/or frequent input from local health care teams. The registered manager told us that staff had worked closely with an occupational therapist to support a person following their discharge from hospital. We received information from a health and social care professional in relation to how the service supported a person with complex needs who formerly used the service. The person's relative had reported to the health and social care professional that the quality of the care was usually good and certain care workers had been very good, although they had been dissatisfied with other members of

the care staff team.

People were supported to meet their identified health care needs and were supported to attend health care appointments, if this was an agreed part of their care plan. The care plans we looked at contained information for care staff about people's health care needs, for example we noted that there were brief explanations about how specific medical conditions impacted on people's wellbeing and their ability to manage activities of daily living. This guidance assisted care staff to acquire a better understanding of how to effectively support people and enable people to retain as much independence as possible, where applicable.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We noted that staff had received MCA training and the care staff we spoke with demonstrated their understanding of the principles of the MCA. Care staff told us they always asked people how they wished to be supported and respected people's wishes. The care plans showed that people were asked to sign their care plans if they had the capacity to do so and at the time of the inspection all the people who used the service could demonstrate that they had consented to their care. The registered manager told us that she would liaise with people's representatives and external health and social care professionals if there were concerns about people's capacity to make decisions about their care and support. Where people had a Lasting Power of Attorney in place, the registered manager followed the provider's policy and ensured that a copy of the original document was obtained. Therefore, staff could be assured that they were communicating with the correct representative(s) with the legal authority to make decisions on behalf of the person who used the service.

Good

Is the service caring?

Our findings

People's relatives and representatives told us that the staff were kind, caring and thoughtful. Comments included, "[Person who used service] is very happy with [his/her] carers. They tell us the carers are excellent and we think that too" and "[My family member] finds the staff very approachable, the companionship is as important as the care for [him/her] as it prevents feelings of isolation and loneliness. They are charming care staff and so helpful." Our discussions with care staff demonstrated that they had formed positive relationships with people who used the service and they spoke fondly about the people they provided care for.

People's care plans showed that their care was planned in a manner that considered their individual needs, wishes, likes and dislikes, and preferred routines. We noted that people who used the service were asked about their current or former occupation, hobbies and interests, and the registered manager told us that she tried to match people with care staff with similar interests. Prospective clients, their relatives and representatives were supplied with written individual profiles for care staff who worked at the service so that they could request staff that they might be compatible with. The care plans demonstrated that people were asked for their opinions about how they wished to receive their care, for example people were asked if they would like a care worker of the same gender to deliver their personal care and their wishes were adhered to.

The provider supplied people with written information about how the service operated, for example how to contact the out of hours team and how to make a complaint. The management team were aware of their responsibilities in relation to the Accessible Information Standard (AIS). Since 1 August 2016 all organisations that provide NHS care and/or publicly funded adult social care are legally required to follow the AIS. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services and their informal carers with a disability, impairment or sensory loss. At the time of the inspection people who used the service included people who received publicly funded care. We discussed the AIS with the registered manager and noted that people who used the service did not require information in a different presentation. The registered manager stated that information could be produced in other formats, for example Braille or large print.

Staff had received training about the importance of respecting people's right to privacy, dignity and confidentiality. The relative of one person who used the service told us their family member was a very private person and this was recognised and appreciated by their care staff. We spoke with members of the care staff about how they ensured people's privacy and maintained their confidentiality. One care worker told us, "We knock on doors before entering, and make sure that doors are shut and curtains pulled before we assist people with their personal care. We use towels to cover people's bodies when they are getting in and out of the shower and always make sure that people are comfortable to proceed with their personal care." Staff confirmed that they would not disclose people's names and other personal details if they were contacted by their line manager while travelling to and from a person's home, unless they could be assured they would not be overheard.

Good

Is the service responsive?

Our findings

The relatives and representatives of people who used the service confirmed that the registered manager had carried out detailed assessments of their family member/friend's needs prior to beginning a service.

We noted that these assessments were used to create individual care plans for each person who used the service. The care plans we looked at showed that people and their chosen representatives were supported by the provider to participate in the drawing up of their care plan. The care plans we looked at contained appropriate guidance for staff about people's needs and wishes, and how they wanted to be supported. The care plans were written in the first person and looked at the impact of people's health care needs on their emotional as well as physical wellbeing. Staff encouraged people to maintain their independence, in line with their own aspirations and abilities. People's care plans and associated risk assessments were regularly reviewed.

We looked at the daily records completed by staff after each visit. These records were periodically brought in to the agency office and read by the registered manager, to ensure that people were being supported in accordance with their agreed care plan. The relatives and representatives of people who used the service told us that the management team and staff were responsive to people's needs, and we saw that the provider's monitoring systems enabled the management teams to meet people's changing needs. The registered manager and the care coordinator carried out spot checks at people's homes and monitored the quality of the service through telephone calls to people and their chosen representatives. Care plan review meetings took place once every six months. Staff told us they were encouraged to report any changes and concerns in people's welfare and wellbeing to the management team as soon as possible.

People's relatives and representatives informed us that they had received information about how to make a complaint, and felt confident that any complaints would be managed in an open and transparent way. At the time of the inspection the relative of one person told us they had made a complaint and stated that the registered manager was investigating their concerns. A local health and social care professional stated that the registered manager had responded promptly and professionally in relation to a concern raised by the relative of a person who formerly used the service. The registered manager told us that checks were made by the regional management team to ensure that complaints were dealt with in line with the provider's complaints procedure and timescales.

At the time of the inspection the provider was not supporting people who were receiving end of life care. The provider had a policy and procedure for end of life care to support staff to respond to people's needs. The registered manager stated that the service had previously supported people with complex needs, including end of life care needs, and links had been established with specialist local community nursing services. The service also had access to the provider's own clinical team that could offer advice and support.

Good

Is the service well-led?

Our findings

We received positive comments from the relatives and representatives of people who used the service about how the service was managed. The registered manager and the care coordinator were regarded as being friendly, obliging and approachable. The registered manager had prior experience of working within a managerial team at a domiciliary care agency. At the time of the inspection the service has been registered with the Care Quality Commission for less than one year, therefore the provider had not undertaken an annual quality assurance survey for people who used the service, their chosen representatives, staff and stakeholders. However, the service had received written comments and compliments, which showed that people were pleased with the quality of care.

The care staff we spoke with told us they enjoyed their roles and felt satisfied with the training they received. Working for Helping Hands was described as "rewarding" and "a really good company to work for." Staff reported that the registered manager was accessible, helpful and sociable.

We noted that there were initiatives and incentives in place to recognise individual members of staff for their hard work, for example staff were sent cards for going the 'extra mile' to support a person who used the service and a 'Carer of the Month' prize was awarded. The registered manager explained that the provider consistently endeavoured to show all the staff that they were valued and appreciated. This included ordering pizza for staff to enjoy during their team meetings and taking staff out for a celebratory meal at a local restaurant. The management team and the care staff demonstrated a distinct understanding of the provider's vision and values. We were informed that the organisation was owned by members of the family that set up the first branch and there was a strong commitment to support people to stay in their own homes with individual care, in line with their own wishes.

There were regular checks in place to ensure that care staff and office staff carried out their duties in line with the provider's expected standards. The registered manager told us that although people who used the service and their chosen representatives were informed that a 'spot check' quality monitoring visit was due to take place this information was not disclosed to the care staff. Therefore, the registered manager or care coordinator could effectively check if care staff followed required procedures in relation to a range of practices, including the correct completion of documents kept at people's homes, supporting people with their medicines and protecting people from the risk of cross infection.

The provider's quality assurance team carried out their own monitoring visit at the service, which included checks on care plans, training records, financial receipts and other documents. This monitoring visit took place prior to the inspection and we saw that the registered manager was working towards meeting the identified areas for improvement. The registered manager hoped to implement other improvements at the service. This included inviting 'guest speakers' to team meetings to expand the knowledge and interest of staff. These speakers could be local health and social care professionals but could also be people who use services. This would enable staff to learn about health and social care issues from different perspectives.

The registered manager was aware of the need to inform the Care Quality Commission of any notifiable

events at the service, in line with legislation.