Happy Family Care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Happy Family Care Services is a domiciliary care agency. It provides personal care to people living in their own homes. This service specialises in supporting people of South Asian ethnicity. At the time of our inspection they were providing care to 11 people who lived at home.

People's experience of using this service and what we found
Staff's understanding of the Mental Capacity Act (2005) and the support people required to protect their dignity was limited which put people's safety at risk.

Quality assurance processes in place to monitor staff's knowledge and skills were not always effective to ensure good care delivery. Records for spot checks did not include medicines observations. We made recommendations about this.

People and their family members were happy with the care delivery. They found staff attentive and caring. Staff provided choices to people and helped them to improve their independence where possible.

Risk assessments associated with people's everyday lives were identified and assessed to ensure safe care delivery. People had support to take their medicines as prescribed. Staff understood the process of safeguarding people and followed safe infection control practices.

People had support from staff to contact the healthcare professionals when they needed it. Staff helped people to meet their nutritional needs when family members were not around to assist them. People's care needs were assessed and reviewed to meet their changing circumstances and health needs.

People's care plans were individualised and reflected people's choices and preferences. Information was shared with people via translated documents to ensure their involvement in the care delivery. End of life care was only discussed where people felt comfortable to do so.

There was a stable management team in place with shared responsibilities to support the staff on the job. The registered manager had developed good relationships with the families which helped to address concerns when things went wrong.

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

Rating at the last inspection
The last overall rating for this service was requires improvement (published 25/07/2019). At this inspection we have found evidence that the provider needs to make further improvements. Please see the effective and well-led sections of this full report.

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

Follow up
We will continue to monitor the service and information we receive about them. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Happy Family Care Services Ltd

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors, an interpreter fluent in Tamil and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

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

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because we needed to be sure that the registered manager would be in the office to support the inspection.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We visited the office location on 19 July 2021 and spoke with the registered manager, the case co-ordinator and the provider's IT administrator. We made calls to one person and six relatives. We also contacted six staff members for feedback about the service provision. We reviewed seven care plans and three staff records. We looked at how the provider managed medicines and examined audits in relation to the quality of care.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff training data and quality assurance records. We also received feedback from one healthcare professional.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good. This meant people continued to be kept safe and protected from avoidable harm.

At our last inspection we found that risk management plans were not robust and support to people with medicines was not appropriately documented. Staff also did not receive medicines training.

At this inspection we found that improvement had been made to address these areas.

Assessing risk, safety monitoring and management

- We looked at care plans in order to find out how risks associated with people's lives were managed. Risks related to falls, skin integrity and developing urinary tract infections were identified, assessed and guidance for preventative measures was available to ensure consistent and safe care delivery. This included ensuring a person wore their glasses when mobilizing to prevent the risk of falls.
- A healthcare professional told us that staff asked for "advice and recommendations" if they saw any risks increasing regarding the person they supported.
- Environmental risk assessments were in place and outlined any hazards or risks to people and staff in a person's home, such as loose carpets, wires and stairs.

Using medicines safely

- People received support with medicines management as and when they needed it. One family member said, "[Staff] give [my relative] medication and know what it is for and why [my relative] needs it."
- Staff signed MAR sheets after giving the medicines to people and there were no gaps in the records we viewed. Protocols for as and when required medicines were in place and information related to how and when these medicines should be given to people was recorded. Staff were up to date with the medicines training.
- Medicines risk assessments were completed concerning people's ability to manage medicines themselves, the level of assistance if required and the potential side effects of the medicines prescribed.
- The registered manager told us that within the month they planned to start using a phone application so staff could access and sign the MAR sheets on their mobile phones. This will be monitored in real time by the management team to ensure safe management of people's medicines.

Systems and processes to safeguard people from the risk of abuse

- Staff were aware of the safeguarding procedure and told us that any concerns they had would be reported to the registered manager. One staff member said, "Safeguarding is about looking after clients properly, and if something happens, we inform the [registered] manager straight away. Safeguarding means, for example not giving clients food, medication, abusing physically or emotionally." Another staff member told us that if a person confidentially shared some information with them, they would still report it to the

management if they identified any risks to the person or others.
•□Staff had access to the safeguarding policy and procedure which guided them on how to raise awareness making sure people were free from abuse and neglect.
•□We spoke with the registered manager and care co-ordinator about matters related to safeguarding procedures. They were aware that a referral to an agency, such as the local authority's safeguarding team would be required to be made should they suspect abuse.
•□During the inspection we identified a safeguarding concern, related to medicines management, which was reported to the local authority as necessary. We saw the registered manager taking appropriate actions to protect the person who was identified being at risk of abuse.

Staffing and recruitment
•□People and their family members said that staff arrived on time and only were late in exceptional circumstances. One family member said, "The carers come on shift. No complaints. If they are not on time they are stuck in traffic or driving. Then they'll ring. They are never late more than 30 minutes."
•□The provider used a mobile phone application called 'Care Connect' to monitor staff's attendance at people's homes. Staff had to sign in when arriving and sign out when leaving which was monitored in real time by the management team. The care co-ordinator told us they undertook the visits themselves to cover staff sickness or where they saw staff being delayed so that people had the support as necessary.
•□Appropriate checks were carried out before staff began working for the provider. Criminal records checks were undertaken with the Disclosure and Barring Service (DBS) to ensure staff were of suitable character to work with vulnerable people. We also saw copies of other relevant documentation including character references, records of employment history, interview notes and identification documents such as passports.

Preventing and controlling infection
•□We were assured that the provider was using PPE (Personal Protective Equipment) effectively and safely.
•□Staff wore the PPE as necessary. One person said, "I asked for a copy of [the provider] policy at the beginning of Covid-19. [Staff] are tested every week. [Staff] are wearing their masks and everything." A family member told us, "[Staff] wear gloves, masks and aprons. Some wear a face shield/ a visor. That helps when they are speaking."
•□Staff were provided with a policy and procedure to guide them on how to reduce the risk of contracting and/or spreading the CORONA-19 virus, including guidance on PPE wearing and waste disposal.
•□Staff received training for 'Coronavirus Awareness and Infection Control' to ensure they consistently applied the safe infection control management procedures.

Learning lessons when things go wrong
•□Records showed and the registered manager confirmed that there had been no reported safeguarding concerns, incidents and accidents or medicines administration errors in the last 12 months, prior to our inspection. We discussed this with the registered manager who was knowledgeable regarding the procedures they had to follow should these events take place. This was also evidenced when a safeguarding concern was raised during the inspection.
•□We asked staff about the actions they would take if they saw people being at risk of harm, including being abused and feeling unwell. Staff provided us with examples of how they would ask for immediate support from healthcare services such as ambulance and report their concerns to the management team and other authorities, including the CQC, as necessary.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection we found the provider had failed to ensure they supported staff to effectively carry out their work roles and responsibilities. Staff did not receive regular supervisions and spot checks and records relating to staff inductions were not appropriately kept.

We recommended at the time the provider to review guidance on induction and supervision and update their practices.

At this inspection we found that some improvement had been made to address staff support issue.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The provider did not always provide care consistent with the MCA.
- During the inspection we found that a person received their medicines covertly when they declined to take it, that is, without the person's knowledge or consent. A Mental Capacity Assessment followed by the best interests decision was not in place for this which meant the staff team did not follow the MCA principals as necessary. We raised this as a safeguarding concern with the Local Authority.
- Care plans contained a consent form regarding the sharing of information with external agencies, such as the CQC. However, none of these were signed by either people using the service or their representatives.

This meant that the provider had not always lawfully acted on the behalf of people and in accordance with the MCA. This was a breach of regulation 11 (Need to consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
•□Records showed that staff received regular supervisions and appraisals which provided them with opportunities to discuss any concerns they had and share their career goals. Induction records were now appropriately completed to ensure on-going support for staff. We also saw that regular spot checks took place to observe staff's performance on the job.
•□However, records for spot checks did not include medicines observations. The registered manager told us that medicines observations took place only that this was not recorded. There was a risk that any areas of concern identified were not followed-up as necessary as no record was made to monitor the progress.
•□We discussed this concern with the registered manager who told us they would increase the frequency of the spot checks and make records for medicines observations to ensure safe practice.
•□Records showed that staff were up to date with the required training courses and had very recently completed training in relation to supporting people's dignity and the MCA. Although some staff knew they had to provide choices to people, they did not understand the concept of capacity and consent to care which meant that people's capacity to make decisions was not monitored as necessary. Some staff could not provide us with examples of how they treated people with dignity.
•□We could not determine why some staff had lacked knowledge in these areas. It's either because their limited ability to speak in English or that the training provided was not fit for the purpose. Staff received training in English language which was translated into Tamil language by the management team during the training. The registered manager told us they found it hard to recruit staff who were fluent in Tamil and English languages but that the people they supported had requested Tamil speaking staff so they could communicate in their own native language.
•□Based on our findings, the registered manager told us they planned to recruit an assistant care coordinator to support staff's development and training needs. In addition, they would enrol staff to on-line English lessons to improve their English. We will check their progress at our next inspection.

We recommend the provider consider current guidance on the requirements to train staff and monitor their performance so that they have the necessary knowledge and skills to support people safely.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•□Family members told us that people's care needs were reviewed as necessary, with one relative saying, "I felt I'd like a review of [my relative's] needs. [My relative's] dementia is getting worse and more strategies are needed as it's progressed. We're in the process for a date to be scheduled."
•□People's care plans included a detailed 'Personal Moving and Handling Profile' which informed staff on how a person could be moved safely and what equipment was required to do it. All equipment, such as the hoist, mobile shower commode, positioning wedge, sliding sheets and riser recliner had individual risk assessments attached to ensure good practice. All staff had recently received training in moving and handling.

Supporting people to eat and drink enough to maintain a balanced diet
•□Family members told us that staff provided the necessary support with eating and drinking for their relatives. One family member said, "[Staff] give [my relative] a little bit of food at the time. [Staff] makes sure [my relative] drinks enough."
•□People's nutritional needs were assessed when people started using the service. Most meals were provided by family members of people using the service; staff had limited involvement in this. Care plans

included information related to people's preferred meal choices and routines. This was used when family members were not around to assist.
•□Where risks were identified to a person's health, staff applied preventative measures to mitigate these risks, including promoting the intake of fluids.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
•□Family member told us that staff contacted the healthcare professionals as and when required. They said, "[Staff] called the G. P. several times when [my relative] had a cough or chest pain" and "Three times I had to call [staff] in the middle of the night, and they came to help. We also had to call an ambulance for the fall that [my relative] had."
•□Care plans contained information for staff concerning what their role was and how staff could assist visiting healthcare professionals.

Good

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

Ensuring people are well treated and supported; respecting equality and diversity
•□Family members told us that staff were kind and friendly. Comments included, "The carer said that she likes my mum. I felt touched. It's more than a job to them. I'd recommend this service to my friends in the way they care", "[Staff] are very helpful and friendly" and "[Staff] are keeping my relative comfortable."
•□Staff's caring nature and values were evidenced during the conversations we had with them. One staff member said, "I like working for elderly, I see them as part of my family." Another staff member told us, "I like spending time with clients, it gives me happiness."
•□Care plans contained detailed guidance for staff regarding dietary requirements associated with people's religion and ethnicity.

Supporting people to express their views and be involved in making decisions about their care
•□Family members told us that people were provided with choices, including "[Staff] always asks what [my relative] wants for breakfast: bread, Weetabix, or oats" and "The carers would say: 'What would you prefer?"
•□Staff provided us with examples of how they helped people to make day to day decisions. Comments included, "In relation to decisions, I give three or four options, for example what food to eat or clothes to wear. Clients choose from the options I give them and this way it is easier for them to choose" and "If it comes choosing the clothes, we open the wardrobe and ask to choose. We go with what [people] are telling us to do."
•□A healthcare professional said to us that staff sought a person's permission before they provided care to them.

Respecting and promoting people's privacy, dignity and independence
•□Family members told us that staff supported people's privacy by shutting the bathroom door when providing personal care and asking a caller to ring back if they were in the middle of care delivery.
•□A family member told us that staff carried out some exercises with their relative to maintain their physical health and independence as much as possible.
•□Staff provided us with examples of how they encouraged people's independence. They said, "We would let [people] do what they want to do and keep an eye to make sure nothing goes wrong. If the client is trying to do something, we support 100%" and "We support what [people] can do for themselves and capable to do, like dressing up."
•□Staff did not have access to people's records if they were not supporting them on a regular basis. They were only given temporary access to the person's records, if they covered annual or sick leave, to protect confidentiality.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good. This meant people's needs were now met through good organisation and delivery.

At our last inspection we found that care plans were not person centred and people's wishes in relation to end of life care were not documented.

At this inspection we found that improvement had been made to address these areas.

End of life care and support
- There was no end of life care provided by the service at the time we carried out the inspection.
- Where appropriate, the end of life care plans were reflecting the religious beliefs of people and included information concerning the need to be sensitive around discussing death and dying.
- The registered manager told us that some of the families were not ready or prepared to discuss the end of life care due to the sensitivity of the subject and because of their cultural believes which the staff team had respected.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs
- The care plans we looked at were person centred. It was possible to gain an insight into the person's beliefs and views regarding their care. Information related to personal, social and spiritual histories was recorded so that staff could have meaningful conversations with people.
- Care plans guided staff on the support people required to meet their health and care needs. This included the assistance people required who were living with dementia. Their care plans provided information on how to de-escalate situations where a person presented with behaviours that challenged, including use of body language and distraction techniques, for example talking to them about members of their family.
- Family members told us that staff were aware of people's care needs. Comments included, "[Staff] know everything they need to know" and "[Staff] do know [my relative's] health condition."
- Staff used electronic care plans which they accessed via an application on their phones. This helped to find information quickly when needed.
- The registered manager told us that each staff member had a small number of people to support which ensured they knew the people they cared for well. A family member told us, "Now [my relative] has two new regular carers. I like the stability." Another family member said, "The regular carer knows [my relative] very well. She's very comfortable with the carer. They don't keep changing."

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

impairment or sensory loss and in some circumstances to their carers.

•□The service specialized in providing care to people of South Asian ethnicity. The provider ensured that staff spoke the language preferred by the person they cared for which supported people's communication needs. One person said, "I talk to [staff]. We talk the same language." A family member told us, "[Staff] can understand what [my relative] needs, [staff] speaks the same language."
•□Care plans were translated into people's first language to ensure their involvement in the care delivery.
•□Documentation shared with people, such as 'Service user guide' was available in a variety of languages, such as English, Hindi and Tamil. There were also easy read guides in print for those that required them.

Improving care quality in response to complaints or concerns
•□Family members told us they felt comfortable raising any concerns they had. Comments included, "I know the manager and I can contact and complain, but it is not at all needed" and "I always call the manager when staff are late and not doing their job properly. They will talk to the staff and it gets sorted out."
•□People were provided with the 'Service user guide' when they first started using the service which contained information about how they could make a formal complaint, either to the provider or external agencies such as the Local Government Ombudsman.
•□Records showed that the service received only one complaint in the last 12 months which was investigated and actioned as necessary.

Requires Improvement

Is the service well-led?

Our findings

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

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

At our last inspection we found the provider had failed to effectively monitor the service and drive improvements as regular audits were not carried out.

At this inspection we found that some improvement had been made to address this concern.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Records showed that people's care plans were audited and updated monthly. The provider undertook monthly care review analysis which monitored the level of care required for each person. This was represented in graph form for ease of use. We were told that additional support was put in place where a person's care needs rose to ensure their safety.
- Medicines management was audited monthly and included checking the MAR sheets and safe storage of the medicines. MAR sheets were collected from people's homes on a weekly basis and audited before being returned.
- The registered manager told us that staff's knowledge and skills were regularly tested during the team meetings and supervisions to ensure they understood their role responsibilities as necessary.
- However, we found that governance systems were not always operated effectively because they had failed to pick up and/or act on the issues we identified during our inspection. This included issues in relation to how they monitored staff's knowledge and skills to ensure they carried out their role responsibilities as necessary.
- We also found that the MCA was not always understood and followed effectively by the staff team making sure they only provided the care that people consented to.

We recommend the provider to review their governance systems to ensure they effectively assessed and monitored staff's performance to drive improvements.

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

- The management team had developed close working relationships with the people and their family members which helped to ensure good communication between the parties. Family members described the registered manager as "easy to contact and very friendly", "good at keeping in regular contact" and "very kind and friendly to talk to."

•□Staff whose first language was not English, had access to the policies and procedures in their preferred language so that they fully understood their role responsibilities and regulatory requirements.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
•□Family members told us that the service was well-led. Comments included, "[The team] is very organised, including during COVID-19" and "We contact [the management] and they visit. [Management] always ensure coverage. The routine is well organised."
•□Staff found the registered manager very supportive and available for advice when needed. Comments included, "Very good management. Any problem, you call the [managers], they help you" and "The management is very good, they are like family. We can address any concerns we have with them."
•□A healthcare professional told us that the management team responded well to feedback and used feedback as an opportunity to improve the quality of service provision.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•□Family members told us they were asked for feedback about the service delivery, with one of them telling us, "I am always asked by the [managers]: 'Are you happy with the care and the care agency? They call me for feedback." Another family member said, "We've only been with the service for three months and already received one questionnaire."
•□We viewed the results of the last feedback survey, carried out in June 2021. The results were very positive. Any actions arising from the survey were carried out by the management team quickly to improve the care provision as necessary, for example where a family member indicated a need for a review meeting.
•□Staff team meetings took place and meeting minutes were shared with those who could not attend so they were aware of what was discussed. The staff team used a phone application, called WhatsApp, for updates and communication as necessary.

Working in partnership with others
•□A healthcare professional told us they had a good working relationship with the service which included "good communication" with the staff team.
•□The registered manager told us they worked with other agencies as necessary to ensure the safe and effective delivery of care. This included supporting a person to seek assistance from the healthcare professional to address their health concerns and following up on the referral made to the Speech and Language Therapy team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who use the service were not protected against the risk of receiving poor care because their consent to care was not always sought. Regulation 11(1)