1st Hand Care Limited

1st Hand Care Limited - West Midlands

Inspection Report

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Summary of findings

Overall summary

Overall summary 1st Hand Care West Midlands provides domiciliary care support to approximately 25 people who live in their own homes. People are supported with their personal care needs to help them to be as independent as possible and support people to be able to remain within their own homes. There was a registered manager in place at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

People were supported in a safe way because detailed management plans were in place and staff understood the individual risks to people and how to support people safely.

Staff provided care in a kind and caring way and people told us that staff maintained and protected their dignity when they provided support.

Improvements were needed in the way that the service monitored and assessed the quality of the service provided. Systems were in place but these had not been undertaken regularly.

We found that the service did not always promote an open and inclusive culture for staff to feel empowered in providing their views about the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People who used the service were protected from abuse because the provider had a policy in place, staff had received training and understood how to identify and report possible abuse.

Care records contained details of individual risks and staff knew how to keep people safe whilst promoting their independence.

People's rights and choices were protected as staff were aware of their responsibilities under the Mental Capacity Act 2005.

People told us that they felt there was not enough staff available, but we saw systems in place to ensure that any staff shortages were covered. The provider had a system to assess the required care hours and the staff hours available and at the time of the inspection the staff hours were sufficient to cover the support required.

Are services effective?

We saw that people's preferences in care and individual choices had been gained before support was provided. Staff told us the individual needs of people which corresponded with the records we had viewed.

People's health and wellbeing was protected because staff were aware of the reporting procedures in place where there had been a deterioration in a person's health and in the event of an emergency.

Staff told us and we saw evidence that they received regular formal supervision which enabled them to discuss their development and training needs.

People told us they felt that some staff did not have the knowledge and skills required to provide support to people effectively. This meant that people were not protected from harm as staff training was not managed and monitored effectively.

Are services caring?

People who used the service told us they were treated with care and compassion and the staff responded well to their needs or concerns. One person told us, "They are wonderful, they are very reliable. I am more than happy". Another person said, "The carers are nice, polite and are absolutely spot on".

Summary of findings

People's needs had been assessed before they used the service. Records confirmed people's preferences, interests, and diverse needs had been discussed. Staff we spoke with told us how they ensured support was carried out in a dignified way and how they made sure that people were comfortable with the support received.

Are services responsive to people's needs?

We found that people and/or their relatives were involved in the planning of their care and consent to treatment had been obtained by the provider.

We saw evidence that people's care was reviewed which ensured that people's changing needs were current and support was appropriate to meet their changing needs.

The service were responsive to people's complaints. We viewed records that showed how the provider had acted on complaints and people told us they were happy with how complaints were responded to.

People told us that they often had late calls and they did not have the same care staff providing support. This meant that people's needs were not always provided at the right time to meet their needs and they were at risk of receiving inconsistent care.

Are services well-led?

Staff told us that they felt unable to make suggestions about the service. Staff told us that the provider was not always approachable and did not listen to them. This meant that staff did not feel empowered to make suggestions and the provider did not always promote an open and inclusive culture.

We saw evidence that the provider had audits in place to monitor the quality of the service and assess risks to people who used the service. The audits had not been carried out since October 2013. This meant that the provider had not used the system in place to monitor the quality of the service.

The provider carried out spot checks on staff performance and competency checks for medication training which ensured that staff were providing appropriate support. People told us that some staff did not have the skills to deal with specific conditions and techniques; such as manual handling. We looked at staff records and the training records and found that staff had received training but their competence in these areas had not been monitored or assessed.

Summary of findings

We saw positive feedback from telephone monitoring undertaken by the provider. People were happy with the care provided and the provider had a system in place to obtain people's views on their experiences of the care provided.

People were protected from harm because the provider had a whistleblowing policy in place and staff were aware of how they could use this if they felt people were at risk of harm.

Summary of findings

What people who use the service and those that matter to them say

An expert by experience spoke with people who used the service or their relative by telephone after the inspection had taken place. They spoke with five people to understand people's experiences.

People told us that they felt safe because the care staff made sure that they followed guidance to make sure they were supported safely. One person told us, "The carers always make sure I take my medication". A relative told us, "My relative is never hoisted by one carer and I am trained to provide support with the hoist too".

People told us that they had not had their care plan updated or they had been updated but not correctly. People told us that staff did not always record the care that had been provided. People also told us that they felt that the staff needed further training to enable them to carry out the care effectively and so that staff understood the particular illnesses that people suffered from. One person told us, "I only see the management when there are not enough staff. I never see them to update my care plan; I don't think it has changed since I have been with them". Another person told us, "I'm not sure that the care plan has been updated but my relative's care hasn't changed".

People and their relatives told us that staff were caring and that staff ensured that they always made sure that their dignity was maintained. One person told us, "The carers always get my relative's permission before providing care and it is always in private in their bedroom". Another person told us, "The carers pull the curtains across and never leave X (the person) uncovered".

1st Hand Care Limited - West Midlands

Detailed findings

Background to this inspection

We inspected this service on the 09 April 2014. The inspection team consisted of one inspector and an expert by experience. An expert by experience has either used this type of service or has experience of using a domiciliary care service.

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 and to provide a rating for the service under the Care Act 2014. The announced inspection was part of the Wave 1 testing process that we are introducing for all adult social care services.

At the time of our inspection 1st Hand Care West Midlands provided personal care and support to approximately 25 people in their own homes in their own homes. During the inspection we spoke with the provider of the service, senior staff and staff that provided support to people in the community. We were unable to speak with the registered manager on the day of the inspection as they were unavailable. After the inspection we spoke with nine people that used the service to understand their experiences.

Before we carried out our inspection we reviewed the information we held about the service, which helped us to decide on the areas that we needed to look at as part of the inspection.

At the previous inspection on the 03 December 2013 the service met the regulations that we inspected against at their last inspection.

Are services safe?

Our findings

We viewed five people's care records on the day of the inspection and found that each person who used the service had a detailed risk management plan in place. The plans we viewed contained individualised guidance that helped staff to keep people safe whilst promoting their independence. We spoke with staff who were able to explain people's individual risks and how they supported them to keep them safe from harm. We saw that support plans had been put in place for people who needed specialist equipment to help them with their mobility after they had been assessed by the appropriate professionals.

Staff we spoke with had a clear understanding of the actions required to safeguard vulnerable people from the risk of abuse. Staff told us the different physical and emotional indicators of abuse. We saw that staff had received training in safeguarding vulnerable adults and the service had an up to date policy available to staff. This meant that staff understood their responsibilities where abuse was suspected to ensure people who used the service were kept safe and protected from the risk of harm.

People's rights were protected because the service had systems in place that ensured people who lacked capacity had choices made in their best interests. Staff we spoke with were aware of their responsibilities under the Mental Capacity Act 2005. Staff told us how they supported people to make decisions and that they would report any concerns they had to their manager. People's rights would have been better protected had all staff received training on the Mental Capacity Act 2005.

The service had a recruitment policy in place. We saw that newly employed staff had received appropriate checks which ensured they were suitable to provide support to vulnerable people. Staff we spoke with told us that they had received an induction before they started work. One member of staff told us, "The induction was really good. I had plenty of training and I shadowed a more experienced care worker before I provided support on my own". This meant that staff had received the appropriate support and training before they provided support to people who used the service.

The provider had policies and procedures in place to ensure that staff had guidance on how to keep people safe from the risk of infection. Staff we spoke with told us that they were provided with gloves and aprons to use and they never used the same protective equipment twice. One staff member told us, "I always ensure I wash my hand thoroughly and wear gloves before I carry out any support. These are disposed of afterwards and I continuously use hand gel to ensure that both myself and people who we support are protected from cross infection". People we spoke with told us the staff always used gloves and aprons when they provided support.

People we spoke with felt that there were not enough carers employed by the service. One person told us, "The agency cannot cope with all the work they have" and "The carers are so tired they work very long hours". Another person told us, "We have had three different carers in the last for weeks. I don't think they have many staff". One relative we spoke with said, "The agency appears not to be able to cope with the work they have and carers are working from 6.00a.m until 11.00p.m on some days". We saw a system to ensure that the amount of care hours required and the amount of staff hours were enough to provide the care. The evidence viewed showed that there were a 100 spare care hours at the time of the inspection. We viewed the staff rotas at the office which showed us that the calls required were covered and the manager attended calls where there had been any instances of sickness. This meant that people felt that the service did not have sufficient staff but people were not put at risk because the service had arrangements in place to cover staff shortages.

Are services effective?

(for example, treatment is effective)

Our findings

Through a process called 'pathway tracking' we looked at five people's care records, spoke with them about their care and spoke to staff about the support provided. Pathway tracking looks at the experiences of a sample of people. This is done by following a person's route through the service to see if their needs were being met.

Staff we spoke with were clear about their role and explained how they provided support to people who used the service. The staff knew people well and were able to tell us about the different needs of the people we had pathway tracked. One staff member was able to tell us in detail how they helped a person with communication difficulties and the tools they used to communicate. The care records we viewed confirmed these methods were used. This meant that people's care needs were assessed and carried out in conjunction with their agreed plans.

We viewed the care records within the office of the service and found that care plans had been completed and contained the involvement of people and their relatives. Most people who used the service confirmed this. The provider may wish to note that one person we spoke with told us that staff did not always complete the daily records of support. They said, "When I have questioned carers about writing in the daily record, they say they will, but then they don't".

We saw records that showed staff had reported concerns with people's health and wellbeing and these had been reported to the appropriate professionals involved. Staff we spoke with told us their actions if they thought there had been a deterioration in a person's health. One member of staff told us, "I know the people well and I can tell if they are not themselves, so I would report this to the office or if it was an emergency I would call for an ambulance". This meant that people were supported with their health and staff were aware of the procedures to follow in the event of an emergency.

We spoke with seven members of staff who told us they received formal supervision and appraisals of their work. Supervision is a tool used between an employer and an employee to ensure that updates to work practices and staff development needs can be discussed. One member of staff told us, "I have had supervisions and I find them useful." Another member of staff said, "Supervisions give us the opportunity to discuss any concerns or issues." This meant that staff's performance and development needs were regularly assessed and monitored.

We saw records that staff had received appropriate training to support people who used the service. Six people we spoke with felt that staff needed further training in several areas. One person told us, "Some carers don't know how to manoeuvre by relative, I had to train them" and "They need to understand the illnesses, they need a lot more training". We saw that competency assessments had not been carried out for all of the training provided. This meant that the training that had been undertaken had not always been effective. This is a breach of Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Are services caring?

Our findings

On the day of the inspection we spoke with staff who told us how they supported people with their needs. The staff we spoke with showed compassion and care in their explanations of how they treated people when they provided support. One staff member told us, "I always make sure I am patient with people and I talk and chat with people always explaining what I am doing". Another staff member told us, "I always make sure people feel comfortable. I have a good relationship with the people I support and they trust me, which is really important". This meant that staff we spoke with were caring and treated people with dignity and respect.

People who used the service told us that staff treated them with dignity and respect and were compassionate in their approach. One person told us, "The carers are very good, we have a laugh together". Another person told us, "The carers always pull the curtains when providing personal care". One relative told us, "When X (the person) is going to the bathroom the carers close the curtains and they put a towel across X when they supporting them". This meant that people felt that their dignity was respected and they were treated by caring staff.

One relative we spoke with was very happy with the care provided and told us, "This is the service that made a difference to my mum; absolutely fantastic. I couldn't have asked for anything better, I was given advice, support and guidance. All the staff were fantastic".

We viewed the quality assurance calls that had been carried out by the service to gain feedback from people who used the service. The comments we saw were very positive such as; "The care is very good I would not want it to change" and "I am very satisfied with the care".

We saw that all staff that provided support to people had signed a confidentiality statement to ensure that people's privacy was maintained. We found that confidential information was stored securely in locked cabinets. One staff member we spoke with raised concerns that the staff rotas contained details of all the people they were supporting. These rotas were signed by each individual person and there was a risk of confidential information being divulged which included the name of the next person and the support they needed. This meant that the privacy of people who used the service had not been fully considered to ensure that their personal information was protected.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

1st Hands Care West Midlands had a 'service user guide' available to people who used the service which provided information about the service and what people could expect when they received support. This was routinely provided to people before they started to use the service. This meant that people were given information that helped them to choose the right service to meet their needs.

We saw records that showed people who used the service had consented to care and treatment. The files we viewed had been signed by people who used the service or their relatives and contained people's likes and dislikes in care. The care plans were personalised and showed people's diverse needs and how staff needed support people in the way that they chose. This meant that people had been involved in the assessment of their needs.

Staff told us how they supported people to make decisions about their care. One staff member told us, "It is important that we help people to make their own choices in care and if they lack capacity these decisions need to be made in their best interests". Another staff member told us, "I always ask people what they need and listen to how they want their care providing". This demonstrated that staff considered people's choices and preferences when providing support.

We saw records that showed reviews had been undertaken that ensured people who used the service were receiving the correct support and any changes in their needs were taken into consideration. We saw that people who used the service and their family members were involved in the reviews which gave people the opportunity to state their preferences in how and when they received their support. Some people we spoke with told us that they had their care re-assessed and updated regularly and some were unaware whether a review had taken place. One relative told us, "The manager calls round every so often and makes a note of anything that is needed and if the carers have completed the records correctly".

We found that the service had an effective complaints procedure in place. We saw that complaints were logged and had been responded to appropriately in line with the provider's policy. Staff told us that they would discuss any concerns with the person first and if they were unable to rectify the problem they would pass the concerns to the manager. People we spoke with told us that they knew how to complain and who to complain to. One person told us that a complaint that had been raised was dealt with appropriately and they were happy with the action taken. This meant that the provider was responsive to people's feedback and took action that ensured people were happy with the care provided.

We asked people who used the service if they received their support on time. People we spoke with told us that the support is often provided late and this can have a negative effect of their day. One relative told us, "The time keeping is awful. Sometimes they might not come for an hour and not turn up at all, this has happened in the last four or five weeks. I have to get X (person who used the service) ready myself or they would miss their day out. One day this week they couldn't get anyone out to us". Another person told us, "The carers have sometimes been two and half hours late". This meant that the service were not always responsive to people's needs as support was not provided at the right time to meet their needs. This is a breach of Regulation 9 (1) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people whether they had consistent staff providing the support. People told us that they received different carers each week. One person told us that they had a member of staff who they had not met prior to providing support. One person told us, "Sometimes carers walk in whom I have never met". Another person told us, "We never know who are coming. The carers tell us if they are coming back but we are not given a rota of who is coming". This meant that people were at risk of receiving inconsistent support. This is a breach of Regulation 9 (1) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Are services well-led?

Our findings

We spoke with staff who told us that they felt that the branch manager for the service was approachable and they could take any issues or concerns to them. We were told by staff that the registered manager was not always available as they were busy attending calls and driving staff to calls. Staff told us that the provider (owner of the service) was unapproachable, could be defensive and did not listen when issues were raised about the service. This made some staff feel unable to challenge decisions that were made and make suggestions to improve the service provision. This meant that staff did not always feel empowered to make suggestions about the quality of the service and the provider did not always promote an open and inclusive culture.

We saw that the provider had a system in place to review the quality of the service provided and to assess and monitor risks. Included concerns identified for people who used the service, complaints, cancelled and missed calls safeguarding referrals. We viewed evidence that showed where actions had been taken when concerns had been identified. We saw that these had fallen behind and the last audits were undertaken in October 2013. The branch manager told us that they were aware that these were behind but they had not had time to undertake the audits as required.

We saw that competency checks on staff after they had received medication training had been completed to ensure that staff were able to carry out medication administration safely. Training in other areas had not been carried out and concerns were raised by relatives that staff were not competent in manual handling and did not understand specific conditions of people who used the service. This meant that some of the training provided had not been monitored to ensure that staff were competent.

We saw that spot checks had been undertaken on staff performance when they provided support to people. This identified good practice or areas of concern. We viewed evidence that showed that actions were put in place to resolve any concerns. The spot checks were carried out every 3 – 6 months and included personal care, appearance, dignity and privacy, communication and people were asked their views on the service provided. The comments we viewed included, "Very good care I would not want it to change" and "Happy with carers they are very polite and helpful".

We saw that accidents had been recorded appropriately to record any accidents that had occurred. We did not see any evidence to show how these had been reviewed to ascertain if there were any trends or what actions had been put in place that prevented a reoccurrence. This meant that there was not a system in place to monitor and assess the risks to people who used the service.

Staff we spoke with told us that they had received training in whistleblowing and they were able to explain what this meant to them. One staff member told us, "I know that whistleblowing protects me if I had concerns about the treatment of someone, I am not afraid to report any concerns if I thought someone was being abused". We viewed an up to date whistleblowing policy which was available at the time of the inspection. This meant that people were protected from the risk of harm because the provider had a policy in place and staff were aware of their responsibilities and how they were protected.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	Regulation 9 (1) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and Welfare of People Who Use Services. The service were not always responsive to people's needs as support was not provided at the right time to meet their needs and staff who provided support were inconsistent. Regulation 9 (1) (b) (i).

Regulated activity	Regulation
	Regulation 23 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting Workers. People were not protected from the risk of harm because staff training that had been undertaken had not always been effective and not all staff had the skills and knowledge to undertake the support required.