Helping Hand Care Company Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 August 2017 and was announced. Helping Hands Care Company Ltd provides care and support to a wide range of people living in their own homes including, older people, people living with dementia, and people with physical disabilities. The support hours varied from one half an hour call a day to four calls a day, with some people requiring two members of staff at each call. At the time of the inspection, 59 people were receiving care and support from the service.

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

We last inspected Helping Hands Care Company Ltd in June 2016 when four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. We issued requirement notices relating to safe care and treatment, need for consent, person centred care and good governance.

At our inspection in June 2016, the service was rated 'Requires Improvement'. We asked the provider to take action and the provider sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. The provider had not met the previous breaches of regulations and further breaches were found.

Staff were not given enough travel time between people's calls and sometimes they were scheduled to be in two places at once. Staff told us this placed them under pressure, and caused them anxiety and people told us this affected the level of care they received. The registered manager told us they were in the process of implementing a new call logging system that would automatically assign travel time for staff, which they hoped would improve this situation. Staff were not always introduced to people before providing support. They told us that they felt this was uncaring.

The registered manager and provider had made changes to the service without consulting with people or involving staff. Both staff and people we spoke with expressed concerns about the new electronic call monitoring system, and the fact they had been unable to feedback their concerns. Staff told us they did not feel as though they had been supported during its introduction.

People's care plans contained generic information regarding their health care needs such as diabetes and catheter care. Other guidance for staff, such as how to recognise pressure areas was also generic rather than individualised and there was no information regarding how to respond to any concerns. Some people had developed pressure areas and there had been a delay in seeking medical advice. Risk assessments regarding people falling had not been completed. When people fell, staff did not always inform the office or ensure people received appropriate support.

Medicines were not always managed safely. Staff had not recorded individual medicines they were supporting people to take. One person consistently run out of medicine and no action had been taken to support them with the ordering or delivering of their medicine.

Complaints were not always documented or analysed to look at ways of reducing the risk of reoccurrence. The registered manager did not review and analyse accidents or incidents to look for any trends or ways to prevent them from happening again. People had been asked their views on the service but feedback was not acted on consistently. There was no formal system of review to ensure the service was providing safe, effective care. The registered manager did check medicine records and people's care plans but had not identified the issues we found at this inspection.

The registered manager had not informed the Care Quality Commission of an important event that happened within the service, as required by law.

When people first started using the service an initial assessment was completed. Care plans were regularly reviewed. However, care plans were often generic in content and did not contain the level of detail needed to ensure people received person-centred care. People's mental capacity was assessed and everyone currently using the service was able to consent to their care. People told us they had built up strong relationships with staff and that staff were knowledgeable and well trained. Staff training in essential subjects such as safeguarding and mental capacity was up to date. Regular spot checks were completed by the management team, and staff received regular supervision. People were supported to eat and drink and everyone we visited had been left out drinks for the day ahead.

Staff were recruited safely. Staff told us they knew how to recognise and respond to abuse. The registered manager had raised safeguarding concerns when necessary.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not given enough travel time between people's calls and sometimes they were scheduled to be in two places at once. People told us this impacted on the level of care they received.

Risks relating to people's care and support were not always assessed or mitigated.

Medicines were not managed safely.

Staff were recruited safely. Staff told us they knew how to recognise and respond to abuse. The registered manager had raised safeguarding concerns when necessary.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always take action when people fell or needed medical attention.

People were able to consent to their care.

People were supported to eat and drink.

People told us staff were knowledgeable and well trained. Staff had received training in essential topics such as safeguarding and mental capacity.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Systems and processes were not in place to ensure people were consistently treated with respect.

People told us they had built up strong relationships with staff.

People were supported to maintain their independence where possible.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People did not always receive person-centred care. People told us they did not always receive rotas or know who was providing their support.

Assessments were completed when people started using the service.

Complaints were not always documented or analysed to look at ways of reducing their risk of reoccurrence.

Is the service well-led?

Inadequate

The service was not well-led.

There was no formal system of review to ensure the service was providing safe, effective care. People had been asked their views on the service but feedback was not acted on consistently.

The registered manager had not informed the Care Quality Commission of an important event that happened within the service.

The registered manager and provider had made changes to the service without consulting with people or involving staff.

Helping Hand Care Company Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 August 2017 and was announced. The provider was given 48 hours' notice because the location is a domiciliary care agency and we needed to be sure that someone would be at the office. The inspection was carried out by two inspectors on the first day and one inspector on the second day. An expert by experience made phone calls to people receiving care and support. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed all the information we held about the service, we looked at the PIR, the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the registered manager and the provider. We spoke with eight members of staff. We looked at eight people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys and audits.

We spoke with fifteen people who were using the service. Eleven people were contacted by phone and we visited four people in their homes. We spoke with two relatives whilst visiting people.

We last inspected Helping Hands Care Company Ltd in June 2016 when four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. At this inspection, there were three continued breaches and two new breaches of the regulations.

Inadequate

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "I am quite safe and very happy with the way I am cared for." Another person said, "I have no reason to feel unsafe." A third responded, "I have no concerns about the care staff at all, I feel very comfortable with them and we have a laugh." A fourth said, "I feel safe with the service, there are enough staff to suit me."

Although people fed back that they felt safe when staff were supporting them, they raised concerns about the amount of time staff had to travel between people. One person told us, "There needs to be a re-organisation of labour, regarding the time between calls and the way they are organised as there is no travelling time between jobs, therefore, they are short changing the customers."

Staff rotas showed that calls were often scheduled very close together or with no time at all between calls. Some calls were scheduled at the same time, indicating that staff were expected to be in two places at once. Staff told us that they sometimes ran late because there was very little time allowed in between visits to get from one to the next, and sometimes public transport caused further unexpected delay. Staff told us that scheduling issues such as close finish and start times, or overlapping of visit times caused stress and sometimes prevented them from ensuring that people always received good quality care.

The registered manager confirmed that the scheduling of calls was not always done correctly. They told us, "The timings currently are not very good. It only gives you five minutes travel time. It can be amended individually but this is not always happening. Hopefully our new system will improve this." The provider was in the process of implementing a new electronic call system, which they told us would allow them to schedule in more time between calls. We will follow this up at the next inspection.

People told us they timed taking their medicine around the time they were expecting carers to arrive. One person said, "I time my medication to the carers. I have to have food an hour later, so I take the meds before I know the carers will be coming to help me." This meant that if staff were delayed due to the incorrect scheduling people were taking their medicines at the wrong time. Other people told us that if staff were delayed they were left needing to use the toilet, which could cause them difficulties. One person told us, "I get a bit annoyed if I do not get a call if the carer is going to be late."

People told us they usually received care from regular staff that knew them well. However, when regular staff were unavailable, they sometimes were supported a by a staff member they had not met before. Staff did not consistently shadow existing staff when meeting a person for the first time. One member of staff told us, "I feel bad when you go in and people say, 'Where is my usual carer?' We are just left to get on with it."

One person said, "I think there are staff shortages, if I ring the office they cannot always confirm who is coming to me, so I cancel the call." One person told us that only certain staff members knew how to help support them with their personal care routine, which included applying specialist straps to aid with their healthcare condition. When different carers offered support, the person told us the straps were not applied. We spoke with the registered manager about this and they told us they would ensure more staff were

trained to support the person appropriately.

The provider and registered manager had failed to ensure that staff were deployed correctly. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, medicines were not managed safely. Medicine records were not checked consistently and regularly contained gaps, so there was no way of knowing if people had received their medicines as prescribed. There was no guidance or direction for staff when people required as and when medicine, for pain relief or other health issues. When staff assisted people to apply medicated creams there was no guidance available regarding the level of support people required and staff did not record cream application consistently.

At this inspection the guidance regarding cream application had improved and staff were now consistently recording when they applied people's creams. However, there was still a lack of oversight regarding medicines management and medicines were not managed safely.

The registered manager had reviewed and signed books that contained people's medicine administration records (MARs). Staff had consistently recorded on one person's MAR the words 'dossett box' instead of listing the individual medicines taken. This practice was unsafe, as there was no way of knowing which medicines the person had been given, or if they had taken all of the medicines they were prescribed. The registered manager agreed this was unsafe, but could not tell us why they had signed the MARs to say they had been checked and were completed correctly.

One person's MAR showed they were regularly running out of their prescribed medicine. The registered manager had again signed these MARs to say they had checked them. Although the management team had seen these MARs, no support had been offered to the person regarding ordering or picking up their medicine and no action had been taken to ensure the person was able to receive all of the medicines they required.

There were still no guidelines in place if people received medicines on an as and when basis. This meant there was a risk that staff would not support people to take these consistently.

Staff applied people's medicated patches for pain relief. Although staff signed to say these had been applied they did not record where on the person's body the patches were being applied. It is important that medicated patches are applied to different areas of skin, to protect the skin's integrity. Without records of where the patch was applied the provider and registered manager could not ensure this was occurring. After the inspection the registered manager emailed us to inform us they had implemented a separate medicines record for medicine patches.

The provider and registered manager had failed to ensure that medicines were managed safely. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection risks relating to people's care and support such as mobility and developing pressure sores had not always been identified. There was not sufficient guidance in place for staff to show how these risks were being mitigated.□At this inspection, there was now clear, step by step guidelines in place to assist staff to move people safely. However, other risks had not been clearly identified or mitigated.

Some people remained in bed and others were at risk of developing pressure sores. Although these risks were identified in their care plans and staff were provided with generic information about what different

pressure areas may look like, detailed guidance was not in place on how to prevent a pressure area from forming or what to do if staff had any concerns. Staff had documented in one person's daily notes that their skin was looking sore, eleven days later a district nurse had attended and the person's skin had broken down. The person had a grade four pressure sore which is the worst possible as grades 1 (minor) to 4 (severe) are used. There was a delay of eleven days for the person to receive the assistance they needed to manage their skin integrity. We discussed this incident with the registered manager as they had not notified the Care Quality Commission of the grade 4 pressure sore as required. They told us they were unsure how severe the skin breakdown was. They sent us a notification confirming the person's skin had broken down significantly. We raised a safeguarding alert regarding the possible harm to the person.

Some people had fallen. Staff had taken appropriate action initially and sought medical assistance. However, after the falls had taken place there had been no assessment of the risk of people falling again or guidance put in place for staff to support them to prevent it from occurring.

One person was at risk of developing a life threatening condition due to a spinal injury. If this occurred, they required immediate medical attention. The person's care plan stated that they were at risk of developing the condition but there was no further information for staff regarding what caused it, what the symptoms were and what they should do if it occurred. We spoke with the registered manager and provider regarding the condition and asked them to tell us about it. They responded, "I don't know to be honest." Staff had not received any training on this condition and were unable to tell us how to recognise it or what to do if it occurred. There was a risk that staff may not recognise this serious condition and the person may not receive the timely medical assistance they required.

Care and treatment was not always provided in a safe way for people. The provider and registered manager did not have sufficient guidance for staff to follow to show how risks to people were mitigated and not all potential risks had been assessed. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to staff when entering people's homes were assessed. For example, if it was poorly lit or there were trip hazards. The risks were assessed and staff tried to reduce them as much as possible.

Staff recruitment was clearly recorded, and all required and relevant information on the care worker was retained. For example, all of the 4 staff files we reviewed contained relevant information; from the application, through to interview, offer of employment and commencement of employment stages, with confirmation of identity, previous experience, references, and qualifications. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff were trained in how to protect people from abuse and harm, and were able to demonstrate awareness of the different types of abuse, and of what to do in cases of suspected abuse. Staff were aware of the whistleblowing policy and told us they would not hesitate to report any concerns to the registered manager who would take appropriate action.

Requires Improvement

Is the service effective?

Our findings

Most people told us that staff supported them effectively with their health care needs. One person told us, "My carer was concerned because she noticed a swelling on part of my foot, initially I refused to call the GP, but next time she came and it was not showing signs of improvement I agreed." Another person said, "I had a fall just before the carer arrived, she called for an ambulance and stayed with me until it arrived, fortunately I did not have to go to hospital."

However, we visited some people in their homes and they told us that staff had not always taken appropriate action to assist them. We visited one person and they told us they had fallen the day before. They said, "I had a little stumble last night. I scraped my arm and hit my eye…It feels a bit funny and looks a bit red this morning." The person's eye did look red . We checked the person's daily notes, written by staff earlier that morning. There was no mention of the person's fall, or the fact that their eye was red. A member of staff from the service was with us, and immediately contacted the office. The person's relative was then informed and they received the health care assistance they needed.

There was a lack of accurate guidance regarding people's healthcare needs. Some people had a catheter fitted (this is a drainage tube for urine. This is a tube that is passed into the bladder when people cannot urinate normally.) People's care plans contained generic information informing staff that having a catheter fitted increased a person's risk of having a urinary tract infection (UTI). However, there was no information regarding how to prevent the risk of UTI (such as encouraging the person to drink and remain hydrated, or correct hygiene procedures) or guidance about what staff should do if they suspected one. There was no guidance for staff about what to do if a catheter became blocked and no information to inform staff when the catheter tube needed to be renewed by the district nurse. There was a risk that staff may not take action if people were unwell.

The provider and registered manager had not ensured that there was guidance in place to ensure people were supported appropriately with their health care needs. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. When people live in their own homes applications to deprive someone of their liberty must be applied for via the Court of Protection. No one was subject to an order of the Court of Protection. We checked whether the service was working within the principles of the MCA.

At our previous inspection people's care plans did not contain any details about how to support people to make decisions. There were no mental capacity assessments in place to show that people's mental capacity had been considered, what ability they had or what support they may need to make decisions. At this inspection, improvements had been made. People's capacity was now assessed when they started to use the service and people signed to say they consented to their care. People told us staff treated them as individuals and they were supported to make decisions about their care.

Most people we spoke with required minimal support with eating and drinking. The registered manager told us that no one was currently at risk of choking. Staff did support some people to prepare their meals and people told us this was also done so promptly. One person told us they had main meal cooked each day using fresh ingredients. Staff supported them to eat their meal, and they told us this was done in an "unhurried" and "sensitive manner." Some people required special diets due to their healthcare conditions, and staff supported people accordingly.

People told us that staff encouraged them to drink and ensured there was a drink available to them before staff left. Everyone we visited had a drink of their choice left by them. Some people had bottles of water and other people had large mugs of tea.

People told us they felt that staff were well trained and carried out their roles effectively. One person said, "Carers are well trained, no problems with them, it is at the office that things slip." Another person said, "The carers have definitely had good training, they are experienced people who know what they are doing." A third told us, "My carer must have had training; she knows what to do and does what I want." Records confirmed that staff had received essential training in topics such as safeguarding and mental capacity.

There was an induction process, which involved new starters shadowing more experienced staff until they were assessed as competent to work independently. New staff completed the Care Certificate as part of their induction, which is an identified set of standards that social care workers work through based on their competency.

Staff told us they were reviewed through a system of supervision, appraisal and spot checks. The spot checks were unannounced, and conducted by a field supervisor, who observed the care worker providing care to the person in the person's home. The spot check was recorded, and included criteria such as punctuality, appearance and identification card of care worker, correct use of personal protective equipment such as aprons and gloves, knowledge of the person's care plan, cleanliness and tidiness of work, correct methods of recording care provided, and completion of the care visit within the allocated time.

The supervision and appraisal sessions recorded a discussion between the registered manager and staff, which included feedback on staff's performance, interactions with people and other care workers, completion of care records, any achievements or training completed. There was also a note made of any further training requirements.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring. One person told us, "My carer is kind and understanding, we have a good happy relationship, I feel comfortable having care, she knows the routine and gets on with it." Another said, "I have the best carers. No riff raff." A relative told us, "I cannot fault it [the service]. I could not do without them now. [My loved one] looks forward to seeing them." Another relative said, "I like the carers. I must admit they are professional, polite and they always wear their ID badge."

Although staff were kind and caring we found that the systems and processes in place meant that people were not always treated with respect. People expressed concern about the impact the lack of travelling time was having on the staff providing support to them. They also told us that they did not always receive care from a staff member who knew them well. Staff echoed these concerns. One member of staff said, "It is not very caring to just turn up when you do not know someone. I like having a relationship with my regular clients, but when they [the office] chop and change things, you feel bad."

People did not always receive their medicines as required and staff had not always taken action when people informed them they had fallen or when their skin became sore. The registered manager reviewed people's daily notes and medicines records but did not always identify issues that had occurred. This meant people were at risk of receiving undignified care that did not meet their needs.

People and their relatives told us their privacy respected. Staff told us that they always closed people's doors and shut their curtains when they were assisting people with their personal care. One member of staff said, "I always use towels to cover people up." Another staff member told us, "I know what confidentiality means. I never speak about people in public as that is their personal business."

Staff had built up strong relationships with people. One person said, "My carer is brilliant, we have a good relationship and I would not have a word said against her." Another person told us, "[Staff member] is the best carer I have ever had. They will walk in and say your asthma is not right or your back is hurting. They know me better than anyone." A relative told us, "The only time I hear [my loved one] laughing is when they are here."

People told us that staff encouraged them to be as independent as possible. One person told us, "My carers allow me to be as independent as I can be, physically I have to rely on them but I guide them to do as I want." Another person said, "I like to be as independent as I can be, they know this and let me do what I can, but will listen and do as I ask; the carers are friendly and caring, I have got to know them now, and we chat about all sorts."

People's care plans contained details about their preferences regarding their drink choices and how they liked their bath or shower. People confirmed that staff adhered to these preferences.

Staff told us that most people did not require support to help them make decisions about their care, and those who did were supported by their relatives. No one at the time of the inspection was being supported

by an advocate. (An advocate helps people to make informed choices.)

Inadequate

Is the service responsive?

Our findings

People told us that staff were responsive to their needs. One person said, "I have no problems with personal care; I have selected my own carers over time, they are all good, one who has been coming for two years is exceptional." Another person said, "Because of a (medical) problem I have to have help in the shower, although I was very reluctant at first, I am now comfortable with it; the carer is kind and jolly, we have a good laugh."

At our previous inspection assessments were not carried out before people started using the service. Now, people confirmed they had taken part in an assessment before their support started. One person told us, "Someone from the office came before they started and did a care plan, I think they might have checked it twice since." Other people said, "I had an assessment before they started, a friend who had been a carer was with me for support, periodically they might ring from the office to check things are alright." And, "I had an assessment when they started coming, but as I have improved, they have withdrawn the service and do not come so frequently." Information regarding people's medical conditions and needs was gathered and a detailed task list of what staff should complete at each call was compiled.

Although there were detailed task lists in place, we found that other information regarding people's needs was generic and there was a lack of person-centred guidance regarding each individual. One person told us that they did not like staff to wear strong perfume or smoke before coming to visit them. They had asthma, and this could affect their breathing. They told us, "Twice I have been to hospital because a carer had a strong perfume on." The registered manager confirmed that this was the person's preference, but this was not written in their care plan, so there was no way of ensuring staff were aware they should not wear strong perfume when visiting the person.

The provider and registered manager had generic sheets of information about people's healthcare conditions such as diabetes and lymphedema, for example. These were not specific to the individual. The information regarding lymphedema gave staff an overview of both primary and secondary lymphedema, but did not inform staff which type people had. Some people required additional support with their lymphedema, such as staff applying specialist straps, and there was no information in their care plan about how these should be fitted. People required these straps each day to remain healthy and well, and told us that if there was staff supporting them they did not know the straps were not fitted. This left them at risk of their condition deteriorating.

Many people told us they no longer received a copy of the rota and did not know which staff would be providing their support. Whilst some people told us this did not pose a problem for them other people told us it made them feel anxious. The registered manager told us that they had asked people who wanted to receive a paper rota or an electronic copy, but there were people we spoke with who told us they wanted a rota who did not receive one. Staff confirmed that people had not received a rota for the previous week as they were changing systems.

The provider and registered manager had failed to ensure that people received person-centred care. This

was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The service had a complaints policy in place, which the registered manager had recently reviewed. There was one complaint recorded in the past twelve months, this related to communication with staff in the office. Although this had been responded to in line with the provider's policy there was no follow up action noted to ensure that office staff were aware of the complaint and had received advice on how to communicate better with people.

We spoke with people who told us they had raised concerns with the office. One person told us that their carer had not arrived at the pre-agreed time. This had a big impact as they were scheduled to go out for the day. They told us they had complained, and they wanted assurances that this would not happen again. We spoke with the registered manager and the provider and they confirmed that staff had been late for this person's call. Other people told us they had requested more staff be trained in how to assist them, and been told that this was not possible due to staffing constraints. They told us they had complained about this.

These incidents were not recorded as complaints, and although staff had dealt with each issue as it had arisen there had not been any investigation into how these incidents had occurred or how they could be prevented in the future. People and their relatives did not receive any formal feedback from the registered manager regarding the concerns they had raised. Without a record of these complaints and the themes and outcomes there was a risk that the registered manager would not be aware of them and therefore, not use this to improve the service.

The provider and registered manager had failed to ensure that complaints were always documented, investigated and responded to. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People told us conflicting views about the management of the service. Some people were positive, one person said, "I think it is well run, if I ring the office, they know who I am and deal with my questions, they are all just like a family." Another person told us, "I have minimal dealings with the office, but find everyone business like and adequate." However, other people told us that the management team was not effective and they felt improvements were necessary. One person said, "Management leave a lot to be desired, they do not know who is coming to me, carers routes are not well planned, I am never contacted." Another person said, "Things leave a lot to be desired, the service is not well run, staff are disgruntled, no wonder they are leaving."

We found that although people were complementary about the care staff supporting them, the management team did not have oversight of the service as a whole. We last inspected Helping Hands Care Company Ltd. in June 2016 when four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. We identified breaches relating to safe care and treatment, person-centred care, good governance and need for consent. We asked the provider to take action and the provider sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. The action plan stated that the service would be compliant by January 2017. We found three continued breaches of the regulation, one new breach of the regulations and one further breach of The Care Quality Commission (Registration) Regulations 2009 regarding notifications. The provider had not complied with their action plan. Since our last inspection the previous registered manager had left the service, and a new registered manager had been appointed.

At our previous inspection, the provider and registered manager had failed to identify the shortfalls at the service through regular, effective auditing. Feedback was not being gathered from all stakeholders to improve the quality of the service. At this inspection no improvements had been made regarding the governance and oversight of the service

There was no system of audit across the organisation to gather information on the quality of service and care provided, and to identify trends or patterns. The provider told us that they employed external auditors to complete thorough checks on the service. However, since our previous inspection, there had been no external review of the service. The provider showed us an email sent to an independent auditor in September 2016 but there had been no reply. No further action had been taken to complete a full review of the service. There were no internal systems or processes in place to ensure the provider and registered manager knew if the service was providing safe, effective care.

There was no analysis of accidents or incidents to look for trends or patterns or to reduce the risk of events happening again. The registered manager showed us the current call logging system and we saw that staff did report incidents when they occurred to the office. We asked if any analysis was completed of these reports, and the registered manager responded, "We do not do it." Complaints were not always documented and analysed to look for trends or ways of reducing the likelihood of issues arising in the future.

The registered manager and senior staff did check paperwork completed by care staff. However, these checks failed to pick up the issues we identified regarding medicines at this inspection. Care plans had been reviewed by staff but these reviews had not identified that information was generic and did not ensure staff provided person-centred care.

We visited people in their homes and found that staff had not always reported changes in people's healthcare needs. They did not always document concerns relating to people's health in their daily notes or inform the office. Staff had not taken appropriate action when one person's skin was sore and they had developed a pressure sore.

There were now a number of methods used to gather feedback on the service, including spot checks and regular service calls. However, where gaps in quality had been identified, actions to rectify these were inconsistent. When people had raised concerns about staff we saw records of disciplinary processes that had been started with staff, but not completed,. There was no outcome or decision from the disciplinary to show if there was any trend in poor care being delivered or if any training or further monitoring for the staff member was required. Quality assurance had not been embedded within the service to ensure continuous improvement.

The provider and registered manager failed to ensure that systems were established and operated effectively to ensure compliance with the regulations. The systems and procedures in place to assess, monitor and drive improvement in the quality and safety of people were not effective. The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records. This was an continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action has been taken. One person had developed a grade four pressure sore. They had been living with this for some time. This is a serious injury, and something CQC should have been informed about. The registered manager was not aware that they needed to inform CQC when a person developed an injury such as this. The registered manager and the provider had not submitted notifications, as required by law, in a timely manner.

The provider and registered manager had failed to notify CQC of notifiable events. This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Staff we spoke with were clear about their roles and responsibilities and people's feedback regarding staff interactions was also positive. However, some of the staff we spoke with told us they did not always feel well supported by the management team. Most staff we spoke with told us they had raised issues regarding their travel time and the scheduling of calls, but this feedback had not always been listened to. The provider and registered manager were in the process of introducing a new electronic call monitoring system. They told us that many of the issues staff had raised and that we identified at the inspection, particularly regarding the timings and scheduling of calls would be rectified with its introduction.

However, most of the staff we spoke with expressed concern about how this was being implemented. One staff member told us they had not been shown how to use the system, even though it was being launched the next week. Staff had attended a staff meeting regarding the new system, however, the training manager confirmed that there had been no training regarding how the new system would work in practice.

People we spoke to also expressed concern about the information they had been given regarding the new system. The management team had not provided people with any information about the changing system. One person said, "I only know something is changing because the care staff have told me…They have put a gadget in the book. I know someone who used a similar system and their phone was stolen and they were able to hack the information." Another person said, "I don't have a problem with it [the new system] but I think someone from the office should have told me." People had not been asked for their feedback on the introduction of the new system, or been given an opportunity to ask questions about its implementation. The management team had not informed people that they would no longer need to sign for their care, as care staff would confirm they had provided care electronically. One person told us they were not happy with this change. They said, "I like signing for my own care. That way I can say I am happy with what the carers have done."

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating on a notice board in the main office and on their website.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager had failed to notify CQC of notifiable events.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had failed to ensure that information within people's care plans reflected their assessed needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider and registered manager had failed to ensure that complaints were always documented, investigated and responded to.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager had failed to ensure that staff were deployed correctly.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to ensure that medicines were managed safely. Care and treatment was not always provided in a safe way for people. The provider and registered manager did not have sufficient guidance for staff to follow to show how risks to people were mitigated and not all potential risks had been assessed. The provider and registered manager had not ensured that there was guidance in place to ensure people were supported appropriately with their health care needs.

The enforcement action we took:

We issued a Warning Notice and asked the Provider to become compliant by 9 October 2017.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to ensure that systems were established and operated effectively to ensure compliance with the regulations. The systems and procedures in place to assess, monitor and drive improvement in the quality and safety of people were not effective. The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records.

The enforcement action we took:

We issued a Warning Notice and asked the Provider to become compliant by 9 October 2017.