Hand On Heart Care Services Limited

Hand on Heart Care

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 March 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service. At the time of the inspection Hand on Heart Care provided personal care and support for 2 people in their own homes. The service currently worked with older people and the nominated individual informed us that the service was seeking more clients to support.

This was the first inspection of the service since registration in April 2017. As a result of this inspection the service was rated as Good.

There was no registered manager in post due to the departure of the former registered manager. The nominated individual for the company that is registered to operate the service had applied for registration with the Care Quality Commission [CQC] and this application was being processed by CQC. A registered manger is a person who has registered with CQC to manage the service and has the legal responsibility for meeting the requirements of law; as does the provider. The nominated individual was present during the inspection.

Procedures relating to safeguarding people from harm were in place. Staff we spoke with understood what to do and who to report it to if people were at risk of harm. Two of the three staff we spoke with had an understanding of the systems in place to protect people, one was a little unsure when asked about types of abuse but did know that they should keep people safe.

The service operated safe staff recruitment procedures and ensured that all staff were suitable for their role before beginning any care work.

Medicines were managed safely and the service was currently supporting one person to take their medicines.

Risk assessments provided staff with guidance on how to mitigate people's individual personal risks. Risks had been clearly identified and risk reduction measures were identified and acted upon.

Staff were provided with a suitable induction as well as on-going regular training and supervision to support them in their role, which records confirmed.

People were involved in planning their care as far as possible. Staff knew the people they supported and people and their relatives felt that they were treated with dignity and respect. Care plans were person centred and included information on how people wanted their care to be delivered as well as their likes and dislikes.

People and their relatives were provided with information on how to make a complaint and their views were obtained and acted upon. People who used the service, relatives and stakeholders had opportunities to

provide their views about the quality of the service and the provider monitored the performance of the service.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were provided with training and guidance to enable them to recognise abuse and how to report it appropriately.

Risk assessments provided staff with appropriate guidance on how to identify and mitigate specific risks.

The provider kept records of the medicines taken by the one person that currently required assistance. Medicines were administered safely.

The provider followed safe staff recruitment practices.

People received a continuity of care and usually had the same staff visiting them. Staff were on time and stayed the correct amount of time with people.

Is the service effective?

Good

The service was effective. Staff received regular training and had all received an induction in line with the care certificate standards.

The service worked in line with the Mental Capacity Act 2005 (MCA) and verified who had power of attorney to consent on people's behalf if they were unable to for themselves.

People were supported to have snacks and drinks but staff were not involved with assisting people with main meals.

Is the service caring?

Good

The service was caring. People were treated with respect and staff maintained privacy and dignity.

People were encouraged to have input into their care and their views were respected. We were informed that care staff responded with kindness and respect for people and paid attention to them when providing care.

Is the service responsive?

Good

The service was responsive. People's care was person centred and planned in collaboration with them, which people and relatives confirmed.

People knew how to make a complaint. There was an appropriate complaints procedure in place and no complaints had been made.

Is the service well-led?

Good

The service was well led. People were asked about their views on the support they received from the service and these views were acted upon.

The nominated individual had a monitoring system in place to ensure care was assessed, audited and that people's needs were met. Although formal spot check monitoring was not as yet established there was very regular contact made with people using the service and relatives.

Hand on Heart Care

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 12 March 2018. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the nominated individual would be present. The inspection was carried out by two inspectors, one of whom made phone calls to a person using the service, relatives and staff.

Before the inspection we looked at information that we had received about the service and any formal notifications that the service had sent to the CQC. We looked at two care plan records and risk assessments, five staff personnel records and other documented information related to the management of the service.

During our inspection we tried to make contact with both people using the service and were able to speak with one person using the service and two relatives. We spoke with three care staff and the nominated individual.

Good

Is the service safe?

Our findings

The person we spoke with after the inspection told us they were satisfied with how they were treated by staff. They told us staff were "Very kind."

A relative told us that their relative who uses the service is "Safe when staff are providing personal care. Staff are competent with regular care workers which is very important to the family and [relative] person using service."

The service had a safeguarding adults policy that described the ways in which the service would respond to any concerns of abuse. The policy and procedure commented upon people's right to be protected from abuse regardless of their heritage or other diverse needs and the right to be treated with dignity and respect. Types of abuse and the action that must be taken if abuse was suspected was also outlined. Staff were trained in safeguarding during their induction and had received this training prior to being able to begin to deliver care. No concerns about any alleged abuse had been raised. Two of the three staff we spoke with had an understanding of the systems in place to protect people, one was a little unsure when asked about types of abuse but did know that they should keep people safe. We raised this with the nominated individual to ensure this member of staff was given clarification about the procedure which they stated they would do as soon as possible.

We viewed the risk assessments for the two people using the service. In each case people had risk assessment and risk reduction measures included in their care plan files. These were tailored to environmental common risks and any personally identified risk that the service needed to consider when providing care. The provider's risk assessment policy stated that risk assessments should be reviewed regularly, which was happening, and the care planning policy also referred to risk assessments being included during care plan reviews.

The service followed safe recruitment practices although in one previous case had not done so. No one was reported to have come to harm as the result of this and we noted the swift action that was taken by the provider as soon as this issue had been identified.

Recruitment files for the staff currently working at the service showed pre-employment checks, such as two satisfactory references from their previous employer or character references if not having been previously employed, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. Where staff members required home office permission to work in the UK, this was documented. This minimised the risk of people being cared for by staff who were inappropriate or unsuitable for their role.

Each member of staff was assigned to work with a specific person. Staff were employed part time and the hours, and days, each week that they worked were arranged in line with the needs for visits that people using the service required. There was a two week staff rota system so that people who needed visits at different times of day and over the whole week had staff available to carry out these visits. This helped to

ensure continuity and consistency of the care being provided.

We looked at the arrangements in place to cover the care needs and call times that had been agreed with people. One report of a missed call had been made, the provider identified this very quickly and had taken steps to ensure care staff attended to the person. The service required staff to make a call to let the agency know if they were running late or unable to visit the person they needed to. The nominated person was on call outside or normal office hours.

Training records showed that all staff had undertaken medicines training since starting to work for the service. We were told by the nominated individual that one person required assistance to take medicines. This had only recently commenced. The medicines, dose, strength and time to be administered were recorded on the person's care plan file. The nominated individual told us that the completed chart for the first month had not yet been collected from the person's home, but this was later supplied to us. This showed that the medicine name, dose and times to be given were all completed and the chart had been initialled by the staff member who had given the medicine.

All staff were provided with personal protective equipment such as gloves and aprons that were supplied by the provider. We were informed that no-one using the service had any infectious illnesses or other conditions and that staff were required to use the equipment provided when carrying out intimate personal physical care.
The service recorded any incidents that had occurred and it was reported by people and relatives, as well as staff, that no significant incidents had taken place apart from one when a person using the service had not received a visit from staff when expected. The service responded appropriately to this event and had been transparent with the person and the funding authority about what had taken place. We saw information regarding the communication that had been made with the person and local authority and what the service had done to respond as quickly as possible and the steps to guard against similar future events of that kind. This showed that the service had responded quickly and had learnt from what had occurred whilst also being open with their communication with all involved.

Good

Is the service effective?

Our findings

A person using the service told us that staff helped them but did not go into further details about how.

A relative told us "I feel relieved that [relative] is receiving a service from the agency, better than the last one."

Each person's care plan that we looked at had been compiled from an initial assessment of the person's needs. Due to people having received a service from the agency for only a few months none of the care plans yet required a review. The nominated individual informed us that reviews would be carried out should anyone's care and support needs change before a review was due. This too was referred to in the care plan policy. Details of the involvement of people, and their relatives if also involved, were included in care plans and showed consent to care had been obtained.

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.

We checked whether the service was working within the principles of the MCA.

The provider was aware of, and understood, their responsibilities in relation to meeting the requirements of the MCA and the service had assessed people's capacity. People's capacity to consent to different decisions about their care had been documented and was included in their care plan records. Where people were unable to be involved in planning all of their care, relatives had been consulted and best interest's decisions were made. This was referred to on people's care records and the details of who had been involved and their relationship to the person were also included. The service was not involved in any activity that required the use of deprivation of liberty safeguards to be applied. Neither person using the service had capacity and the service had verified that power of attorney, under court of protection procedures, had been obtained by their respective relatives.

Care staff received regular supervision, which is a meeting to discuss their work and professional support. Almost all care staff were new recruits so had only just begun to engage in the supervision process. Records of staff supervision confirmed the three month frequency for longer term staff in line with the provider's supervision policy.

The five care staff who were currently working with the agency to provide care were appointed within the last twelve months due to the service not beginning to operate until May 2017. Most staff were part time employees. An annual appraisal was not yet required for any of the care staff and the nominated individual informed us these would be diarised to happen at the time each member of staff was approaching the anniversary of starting to work for the service.

Induction included training in line with the Care Certificate, which is a national set of standards for the training of people working in adult social care. Staff induction covered necessary core skills, for example medicines, moving and handling and keeping people safe from harm. Staff told us about their induction and felt that this provided them with the information and background to how the service operated that they needed.

Care staff usually only provided light meal preparation for people where this was required. This was heating food up for people or making a snack such as sandwiches. All staff had been trained in food hygiene and nutrition. Where people required support with meal preparation or encouragement to eat, care plans documented people's likes and dislikes regarding food.

The service was clear about obtaining consent to care and had done so for each of the people using the service. These people had each required a relative to provide signed consent to the overall care plan but staff were required by the provider to check with people if people were ok for them to carry out care tasks at each visit. The relatives were legally authorised to provide signed consent and the provider had obtained confirmation of this.

The nominated individual informed us that care staff told did not routinely attend healthcare appointments. However, a relative told us that staff had been very good at helping their relative at short notice when they had to attend medical appointments with another member of their family.

Good

Is the service caring?

Our findings

A person using the service and relatives were invariably positive about the attitude of the staff. A person told us, "Care workers are very kind."

Relatives told us, "Staff are good" and "They are "doing the best that they can."

Care staff told us "I know about respecting person's privacy and dignity. The person [they support] chooses what they want to wear and what they want to eat" and "I give the person choice and ask for their agreement when providing care."

Staff supported people in making day to day decisions about their care. People and their family members told us that staff talked to them and discussed how people liked things to be done. A person told us "I am asked for my agreement about care and my privacy is respected."

A person's relative told us, "I feel fully involved and listened to. I am kept well informed by the agency about the service." Another told us, "I think it is well run from my experience. I would definitely recommend it." This person went on to say there was very good communication. "He [nominated individual] calls back immediately."
People did not make many comments about whether the agency or care staff showed consideration for their cultural or religious beliefs or heritage. One relative did say that they appreciated that care staff had been provided who were able to speak their relative's first language and they understood their religious and cultural heritage. The care staff employed were reflective of the two people's cultural and religious heritage. The nominated individual was very clear in discussion with us that respecting diversity was seen as highly important and policies and guidance for staff reflected this.

From the views that people did share with us it was evident that care staff respected people's privacy when providing personal care. Most people did not tell us in great detail about whether the believed their dignity and privacy were respected, however, from the comments that were made these areas did not seem to be anything of any concern to people.

Good

Is the service responsive?

Our findings

Care plans were person centred and included people's likes and dislikes and the way they wished to be cared for. Information contained within care plans was specific to the type of support they required. For example, if people needed help to wash and dress this was included with details of how staff should do this in the way that people preferred. If people needed help to have a meal or carry out domestic chores staff were given guidance about how this should be done.

Care plans were specific to the agreed care that staff were required to provide in line with the initial assessment of care needs. The service had a daily log recording the care provided to people at each visit. People did not have needs that required specialised care, for example assisting people due to complex health conditions or disabilities. The nominated individual told us that log sheets were always held in the person's home and the older log sheets were returned by care staff each month for review and holding on each person's central care records. We saw examples of these on one person's care plan records. Relatives and staff made reference to the fact that care staff wrote a record of each visit they made about the care and support they had provided.

A person told us, "Definitely very happy with the service." A relative told us, "I can contact the agency anytime and if there are any issues the manager always contacts me" and "I wouldn't hesitate to raise a complaint or concern with the manager and am very confident that it would be addressed."

People and relatives were provided with information on how to make a complaint when they began using the service. From the feedback that we received above it was evident that people had felt able to raise day to day matters or concerns if they felt the need to and that the service had responded in a way they were satisfied with.

The service did not provide end of life care.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service did not have a registered manager in place as the previous manager had left. The nominated individual who had relevant qualifications and experience had taken on this role and informed us they had applied for registration with CQC. This application had been received by CQC and was being processed.

The service provided care and support that was of a good standard and people were happy with it, but evidently felt able to raise anything about the service they wished to.

A person using the service told us when asked about how well the agency was managed that the manager [nominated individual] "was good and that it was a good agency."

Relatives told us, "I can communicate with the [nominated individual] in a range of ways, text messages as well and he is always responsive and gets back to me quickly" and "I am asked for feedback about the service and feels it is well run and would definitely recommend it."

The service had systems in place to ensure that care staff abilities in spoken and written English were assessed and support was provided to improve this if required. The nominated individual told us that they had links with a local language tuition organisation they could use to help staff who required improvement to their spoken or written English. This demonstrated that the provider acknowledged the importance of both verbal and written communication. Records showed the care staff communicated suitably clearly with the agency and others as required.

People using the service were asked about their views although it was too early for an annual survey to have been carried out. The nominated individual informed us that a survey would be carried out in due course although it was evident from what people told us that there was very regular communication between the agency, people using the service, their relatives and care staff.

The nominated individual took responsibility for monitoring of care for people at home. There was no formalised spot check system on place and when we asked about this we were told, and records showed, that the two people using the service were contacted very regularly. It was evident in care and other records that people's care and support needs, as well as any changes to these needs, were known about and people's views about the standard of their day to day care were obtained.

The service had appropriate, up to date policies and procedures in place which were available to staff to guide on various areas of their work. The policies we viewed included, infection control, safeguarding people from abuse, equal opportunity, medicines management and complaints. These policies had been introduced when the agency was first registered and were not due further review at present. The policies were appropriately detailed for a service of this type.