UR Hands Care Limited

UR Hands Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
UR hands care is a domiciliary care service providing personal care to people living in their own houses and flats in the community. The service was supporting 13 people at the time of the inspection.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found

People were not safe because the provider had not assessed risks related to their needs and complex health conditions. People were not supported by a staff team who were sufficiently trained, and peoples care plans offered little to no guidance.

The provider had not ensured that recruitment procedures were safe. People were put at risk of harm because Disclosure and Barring Scheme (DBS) checks had not always been completed, employment references had not always been obtained and many staff members had gaps in employment history. This meant that staff members employed may not have suitable character or skills to care for people.

Peoples were not receiving medicines safely. Specialist medicines for people were being given to people without appropriate guidelines and instruction for staff. As and when required medicines had no guidelines in place for staff to follow and many people's medicine administration records (MAR) had gaps where people may not have received their medicine with no reason recorded.

Staff competency was not being checked. The management team were not checking if staff were supporting people safely. Staff received training, but the management team were not checking if this training was effective. We found some shortfalls in staff skills and knowledge which the management team were not aware of.

People's abilities were not assessed to enable them to make their own decisions. People's permission to receive care and support was not sought.

People did not have holistic care assessments and reviews in place to check that they were having a positive experience from the service. The management team were not identifying any areas requiring improvement to the care being delivered.

Care records did not contain any information about people's choices and personal preferences. There was no information about people's life history, preferences and cultural needs.

People did not have any end of life care plans in place despite providing care for people at the end of their lives.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service did not promote a positive person-centred culture which promoted good outcomes for people. Audits and checks at the service were not effective in identifying where improvements could be made. Feedback was not consistently being collected from people and their relatives to inform and possibly improve the service.

Rating at last inspection
The last rating for this service was good (report published on 04 July 2017). At this inspection the service is now rated as inadequate.

Why we inspected
The inspection was prompted in part due to concerns received about staff members being employed without barring and disclosure checks (DBS). The commission also received intelligence suggesting staff members were working for the service with multiple criminal convictions and the provider not having adequate risk assessments in place to monitor staff with such records. A decision was made for us to inspect and examine those risks.

We have found evidence that substantiated some but not all of those concerns. We found concerns in relation to staff employment checks, staff training, management of risks, medicines, leadership and care records. Please see the safe, effective, responsive, caring and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to person centred care, safe care and treatment, good governance, staffing, need for consent and fit and proper persons employed.

We have taken urgent action to impose conditions on the provider's registration as a result of our findings. These conditions lay out immediate action the provider was to take in response to the concerns raised at this inspection. A further condition restricts the provider from taking on new care packages without our written consent.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive. Details are in our responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

UR Hands Care

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by two inspectors.

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

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

Notice of inspection
This inspection was unannounced. Inspection activity started on 28 October 2019 when we visited the office location and ended on 30 October 2019.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-

We spoke with four members of staff including the acting manager and care staff. We spoke with five people who used the service and four relatives about their experience of the care provided. We reviewed a range of records. This included four people's care records. We looked at five files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse, assessing risk, safety monitoring and management

● There were few processes in place to safeguard from abuse. The service had a safeguarding policy in place however staff members had not read this. When we spoke with staff they had a limited understanding of how to keep people safe from abuse.

● People received care in their own homes, however the provider had not ensured they assessed safety of equipment used in people's homes such as hoists to ensure that people were supported safely.

●Most people did not have thorough risk assessments in place. Only one person's risk assessment had been completed. Many people needed specialist equipment to support them to move and were at increased risk of falling. Some people were at risk of developing pressure ulcers and another person had highly specialised health care needs which staff needed to monitor. There was insufficient guidance for staff to meet these needs for people safely. This meant that people were at risk of receiving unsafe care and support as staff did not have appropriate guidance to follow to reduce risks for people.

Using medicines safely

● Medicines were not being administered safely. People did not have enough information about prescribed medicines. We looked at people's medicine records some of which needed specialist medicine. However, there was no information or guidance for staff around safe administration. Some staff were dispensing medicines from dosette boxes filled by family members. This meant people were at risk of harm as staff did not understand people's medicines or have any guidance on how these should be administered safely.

● Staff were administering people's as required medicines however there was no guidelines or protocols in place for when these should be given to people and no record of why these had been administered.

● Medication administration records (MAR) were not completed accurately. One person's medicines had not been administered on five occasions over a two-week period and no record of why these were not administered had been recorded. The records did not demonstrate that people had received their medicines as prescribed. This placed them at risk of harm.

Poor risk management within the service with people not having risk assessments in place, unsafe management of medicines and lack of processes in place to safeguard people from abuse placed people at risk of harm. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Recruitment procedures were not safe. Staff did not always have barring and disclosure checks (DBS) completed and where DBS checks were on file these were often completed by a previous employer and were not up to date. Not all staff members had employment references completed or a full work history in place. Many staff members did not have an interview record on file with any care related questions or record of assessment taken place to ensure people had the skills and knowledge needed for the role. This meant that the provider was not ensuring people employed were of suitable character or safe to support people which put people at risk of receiving unsafe or poor care.

The use of unsafe recruitment procedures meant people were placed at risk of harm and this was a breach of Regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The provider had no systems in place for recording of incidents or accidents. There was no record of how the provider learnt from lessons following incidents or accidents to improve quality of care to people.

●The provider had an action plan in place following audits and visits from external stakeholders such as the local authority. Actions to prevent things going wrong had not been completed, although this action plan had been in place for four months. This meant that actions were not always taken when things went wrong.

Preventing and controlling infection

● The provider had no infection control policy or procedures in place, which meant staff did not have effective guidance in ensuring appropriate infection control measures were taken in line with best practice guidance.

● Staff had received infection control training. We observed staff to wear appropriate protective equipment such as gloves and aprons when required to support people in their homes.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People did not have an assessment completed to ensure that the service could meet their needs prior to care being delivered. This meant that the service provided care for people without fully assessing their needs and choices. This put people at risk of receiving care from staff who did not fully understand their health conditions or preferences in how care was delivered.
- The provider had no assessment process or policy in place to ensure people's needs were assessed prior to receiving care. There were no ongoing reviews of their care to ensure people's needs were being met effectively.

Staff support: induction, training, skills and experience

- Staff did not always have the right training, skills or experience to support people effectively. All staff received training which consisted of up to two days face to face training which covered up to 17 topics in each day which included first aid and moving and handling practical and assessments. When we spoke with staff we found that staff had limited knowledge of areas that they received training in. This meant that staff did not have adequate skills and knowledge to support people safely.
- The provider was not completing any staff competency checks following training to ensure they had the skills to support people safely.
- Staff did not receive an effective induction before starting work at the service. Inductions consisted of a checklist completed by the registered manager on their first day at the service. This covered a total of 60 topics which had all been signed off within one day for new staff members.

The provider did not support staff to ensure they had necessary training or understanding to support people with complex needs. This meant that people were at risk of receiving unsafe care. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us that staff supported them with their food and drinks. One person said, " Staff tell me what's in the fridge and we can choose."
- One person told us staff supported them with a (PEG) feeding tube for medication administration, however staff had not received training around supporting people to do this safely. A PEG feeding tube is a percutaneous endoscopic gastrostomy. This is a medical procedure in which a tube (PEG tube) is passed into a person's stomach. This provides a means of people receiving food and fluid when they are unable to

swallow safely.
● Staff were supporting people to eat and drink and told us they support people to prepare meals. Staff told us they offered people a choice of meals, however staff were unclear how they monitored people's food and fluid intake during care visits. Staff did not know what they would do if there were concerns someone was not eating or drinking enough.
● There was no information about what people wanted to eat and drink at meal times in people's records. The registered manager and provider did not have systems to check that staff were supporting people to have choice with food and drinks and that people were having enough to eat and drink.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA
● The provider was not ensuring consent was given prior to delivering care and support to people. Where the provider believed someone may lack the mental capacity to make a decision for themselves they had not completed any mental capacity assessments for people.
● Staff received training in the MCA, however, when we asked staff about their understanding of the MCA no staff were able to tell us.

The lack of regard to the MCA meant people were at risk of receiving care without their consent or not in their best interests. This was a breach of Regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● The provider did not ensure people's changing health needs were documented thoroughly to ensure that the service could continue to meet people's needs safely. There was no system in place to update care staff of any changes to a person's needs and how this could impact the care being delivered.
● People's care plans were not fully completed, not reviewed and not updated regularly to reflect specific health needs and support requirements. Not all people's files contained their general practitioner's (GP) contact details which meant that staff would be unable to contact a person's GP if they had concerns regarding a person's health or well-being.
●The service had no handover system in place for staff to pass on important information from people and relatives to the rest of the team. This meant that staff did not always have up to date knowledge of people's health needs and how this could impact the person.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

●People told us that staff did support them with privacy and dignity. One person said, "Yes (staff) are good." A relative said, "(staff) always support my relative well for personal care." However, we found the service was not promoting people's dignity and independence consistently.

● Some staff struggled to answer our questions about how they promoted people's privacy and dignity. These members of staff did not have a clear understanding of what this looked like and the importance of promoting this. One member of staff talked us through how they did this when they supported people with their personal care.

● The daily log books completed by staff did not describe the care provided in a respectful way. Daily log books were task led and did not reflect how people were supported with dignity or their independence promoted.

Supporting people to express their views and be involved in making decisions about their care

● People's care plans did not contain personal details in relation to what people's preferences and choices where. Care plans for people were basic, incomplete and task led which often consisted of a tick box of care tasks which care staff needed to complete.

● One person's care plan contained information which related to a different person with completely different health needs. This meant that this person's plan did not contain any accurate information in relation to their individual needs, wishes or preferences.

● People had not been involved in their care planning. Therefore, plans did not reflect any information regarding people's choices and preferences.

Ensuring people are well treated and supported; respecting equality and diversity

● People's records did not include any information on their history, background or culture. Staff we spoke with could not tell us about people's backgrounds and history. This meant that was no information for staff to be able to follow to understand a person's cultural needs, wishes or preferences and their history.

●We observed staff to communicate in a kind way with people during care visits however these were task led rather than meaningful conversation with people.

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care was not personalised. People's records did not capture people's interests, preferences and backgrounds and provided little to no information on a person's likes or dislikes. This meant that staff members did not have the guidance or knowledge to provide care to people which was person centred.
- Person-centred care is a way of doing things that fully involves people in planning, developing and monitoring care to make sure it meets their needs to get the best outcome. Staff we spoke with did not have any understanding of person-centred care and what this could mean for people.

Meeting people's communication needs

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

- People's communication needs were not recorded in their care plans despite some people having limited communication. This meant that staff had no guidance on how to communicate with people effectively.
- People's communication had not been assessed to ensure that information was available that people could understand.

End of life care and support

- The provider was supporting people with end of life care. However, people had no end of life care or support plans in place to ensure that people's wishes, and preferences were followed when delivering end of life care.
- Staff members had not received any training in providing end of life care. When we spoke with staff they were unclear how they would support people with dignity at the end of life.

The service was not providing personalised care to people. This is a breach of Regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

- There was a complaints policy in place in the office however when we spoke with people and their relatives they were not sure how to make a formal complaint. One person told us, "I think I would just call the office and speak with the main person there."

● The provider was not recording complaints clearly, there was no record of any complaints or feedback at the service.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong, Working in partnership with others

● The provider was not checking the effectiveness of the quality of care it was providing. Effective systems had not been created to ensure people received their care visits on time and the service had no system in place of a formal staff rota to ensure that clear records were in place allocating staff to care visits.

●The registered manager had not engaged with people who used the service in a meaningful way to ensure their care and records reflected their needs, wishes and preferences. Staff practice and knowledge had not been reviewed to see if improvements could be made to the service.

● People's records were not reviewed regularly to ensure that information was up to date and accurate. This meant that many people's records did not reflect their current care needs.

●The provider had not been open and honest when working with stakeholders to ensure quality of care was improved. We saw an email of actions following an audit from a local authority who funded care at the service in May 2019 which identified multiple areas of concerns in relation to staff recruitment and staff training and competencies. Management had responded to this email confirming all actions had been completed. However we found that the majority of these concerns identified had not been acted upon and no improvements had been made.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Risk management systems were not in place to support people safely. Only one person had a risk assessment in place, the provider had failed to identify the need for people with complex health needs to have detailed risk assessments in place to reduce risks and improve care for people.

● The management team had recently implemented new policies, however staff had limited knowledge of any of these and policies in place were not being followed within the service. A recent policy for recruitment stated that any new staff member must have a DBS completed by UR Hands Care limited, two employment references and full work history. However, we found that no staff records we reviewed had this in place.

● Audits were not effective in identifying the shortfalls of the service. Where shortfalls were identified there was not a robust plan in place to start working on them. There was only one service audit completed at the service in July 2019 which had identified some of the areas we found during inspection. However no action

had been taken to ensure that these areas had been improved to ensure people's safety and improve quality of care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care.

- Staff members did not always receive regular supervision, one staff we spoke with who had worked for the service for a year had not yet had a supervision. We viewed five staff members files some of which had not had a recorded supervision in up to one year.
- The registered manager was not completing regular team meetings to ensure that staff were kept up to date with overall service and individual people's needs.
- The registered manager was not always reviewing people's experiences of their care to see if this could be improved upon. There was no quality assurance policy in place being clearly followed.
- There was not a culture of continuous learning. Effective systems were not in place to enable the service to improve.

The lack of effective quality monitoring systems meant people were at risk of receiving poor care. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had no mental capacity assessment processes in place to ensure people consented to care and support being delivered in their best interests.

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 9 HSCA RA Regulations 2014 Person-centred care People were not receiving personalised care

The enforcement action we took:

Urgent notice of decision to impose conditions.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not being assessed for people to ensure that people received care and support which was safe . Medicines were not being administered safely.

The enforcement action we took:

Urgent notice of decision imposing conditions on providers registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems and processes were not adequate to ensure people received safe care

The enforcement action we took:

Urgent notice of decision to impose conditions on provider registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not in place to ensure staff were staff to support people.

The enforcement action we took:

Urgent notice of decision to impose conditions on providers registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

Staff did not receive adequate training or support to ensure they had the skills required to support people with complex health needs.

The enforcement action we took:

Urgent notice of decision imposing conditions on provider's registration.