Safehands Care Limited

Safehands Care Limited Warrington

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 8, 9 and 15 February 2018. The inspection was announced, which means the provider was given 48 hours' notice as we wanted to make sure someone would be available. This inspection was conducted by an adult social care inspector and two experts by experience who completed a series of phone calls to people in their homes on the second day of our inspection.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. This was the services first inspection.

There was a manager in post. The manager was in the end stages of registration with the Care Quality Commission. A registered manager is a person who has 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.

People told us they felt safe using the service. One person gave mixed comment, which we followed up at inspection.

Staff were able to describe the process they would follow to report actual or potential abuse, this mostly consisted of reporting the abuse to the line manager. The service had a safeguarding policy in place, which we viewed and staff we spoke with told us they were aware of the policy. Safeguarding training took place as part of the induction for new staff and was refreshed every year.

Staff recruitment records showed that staff were safely recruited after a series of checks were undertaken on their character and work history.

Risk assessments were in place and were reviewed regularly or when people's needs changed. We did highlight at the time of our inspection that some risk assessments would benefit from being more detailed.

Staff were supplied with personal protective equipment (PPE). This included gloves, aprons and hand sanitizer. Staff we spoke with told us they were always able to ask for more PPE when needed. Staff had completed infection control and prevention training, and understood the importance of reporting outbreaks of flu and vomiting to the manager, so they could cover their work so as not to spread the infection.

People were supported with their medication in accordance with their assessed needs and in line with recent guidance.

The manager and the staff understood the principles of the Mental Capacity Act 2005 and associated legislation. However, documentation was lacking in some areas with regards to assessment of capacity. We have made a recommendation about this.

People were supported as part of their assessed care needs with eating and drinking and staff were aware of people's preferences.

Staff undertook training in accordance with the providers training policy. Staff told us they enjoyed the training. Staff spoken with confirmed they had regular supervision and appraisal.

Staff supported people to access other healthcare professionals such as GP's and District Nurses if they felt unwell.

People told us that the carers who visited were all very caring and would always ask them how they are feeling and ask them what they would like help with.

People told us overall, that they were always kept informed and involved in their care.

We did not observe care being delivered, however, people told us staff were kind and caring in their approach.

Care plans contained detailed information about people, what their preferences were and how they liked their care to be conducted. Information in care plans was regularly reviewed and updated in line with people's changing needs, which showed that the provider was responsive to people's needs and preferences.

Complaints were investigated in line with the complaints procedure and responded to appropriately.

Audits took place which checked service provisions and action plans were implemented to improve practice.

Feedback was gathered from people using the service. We received some mixed response concerning how feedback was gathered, however we saw this took place.

People and staff spoke positively about the manager.

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.

People received their medications on time.

Risks to people were assessed, and there was information with regards to how to manage the risk to people.

People told us they felt safe receiving care from Safehands.

Staff recruitment was robust and checks were undertaken on staff before they started working for the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Information around best interests was clearly documented. However there was no assessments of people's capacity stored in people's care plans. We have made a recommendation about this.

Staff had the correct skills and knowledge and undertook training relevant to their roles.

People were supported with their meal preparation in line with their assessed needs.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and treated them with dignity and respect.

People's preferences were reflected throughout care plans. This helped staff to get to know people and provide care based on their needs and preferences.

Care plans promoted people's choice and independence.

Is the service responsive?

Good

The service was responsive.

There was a process in place for recording, acknowledging and responding to complaints. People we spoke with told us they knew how to complain.

People received care which was planned and personalised in accordance to their preferences. Staff demonstrated that they knew people well.

Staff were trained to support people who were on an end of life pathway to remain comfortable in their home with additional support from other medical professionals.

Is the service well-led?

Good

The service was well-led.

A range of quality assurance audits were completed regularly to monitor and improve service delivery.

Staff we spoke with were positive in respect of the overall management of the agency and the support provided by the management team.

The registered provider had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service.

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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 checked 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 was the provider's first inspection.

At the time of our inspection, the service was providing personal care and support to 264 people.

The inspection was conducted by an adult social care inspector and two experts by experience who made phone calls to people in their homes after the inspection took place.

An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance, care for people at home.

This inspection took place on 19, 26, 27 March 2018 and was announced. The provider was given 48 hours' notice as the service provides domiciliary care, and we wanted to be sure staff and people who used the service would be available to speak with us.

Inspection site visit activity started on 19 March 2018 and ended on 27 March 2018. We visited the office location on 19 and 26 March 2018, to see the manager and office staff and to review care records and policies and procedures. We also made phone calls to people in their own homes on 19 March 2018. We made further phone calls to staff on 27 March 2018.

Before our inspection visit, we reviewed the information we held about Safehands. This included notifications we had received from the provider about incidents that affect the health, safety and welfare of

people who used the service. We accessed the Provider Information Record (PIR) we received prior to our inspection. 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.

We spoke to 14 people who used the service via telephone and 10 family members who cared for their relative. We spoke with 10 staff, and the manager. We looked at the care plans for four people and other related records. We checked the recruitment files for three staff. We also looked at other documentation associated to the running of the service.

Good

Is the service safe?

Our findings

We received the following comments with regards to how people perceived their safety and how family members perceived the safety of their relative. "I have the same carers which makes me feel safe", "I feel very safe that they come and see me", "Having a stable team is brilliant", "All needs are met they are great", "Can't fault the carers", "Continuity is good" and "Timekeeping is good". Two people said they felt safe, however staff were sometimes late. One person also said sometimes different staff came. We raised this at the time of the inspection with the manager and this had been addressed. Other people we spoke with however, did not raise concerns.

We looked at how rotas were managed by the service. We viewed a selection of rotas for staff and saw that call times were adequately spaced, with enough travel time in between calls for staff. This meant that the service was ensuring that staff were on time for their calls. Staff we spoke with told us that they were happy with their rotas and they mostly visited the same people.

We discussed the procedure for Electronic Call Monitoring (ECM). ECM is a technology where carers 'sign in' to their calls either using a smartphone or the person's home telephone. This then alerts the office or out of hours on call that a carer has attended that call and it helps to avoid missed visits from occurring. The manager currently had ECM in place and was using the data collected from the ECM system to check when staff were late, or had not logged in at all.

Staff where able to explain the course of action that they would take if they felt someone was being harmed or abused. This was reflected in the organisations safeguarding policy. Staff we spoke with said they would 'whistle blow' to external organisations such as CQC if they felt they needed to. Staff had received training in safeguarding and their responses were in line with procedures set out in the service's safeguarding policies. Information regarding safeguarding for people who used the service and relatives was readily available on the noticeboards in the office and the service user guide. People we spoke with confirmed they knew how to raise concerns should they have any.

Accidents and incidents were accurately recorded and were subject to assessment to identify patterns and triggers. Records were detailed and included reference to actions taken following accidents and incidents.

Staff completed risk assessments to assess and monitor people's health and safety. We saw risk assessments and management plans in areas such as falls, manual handling, pressure care and nutrition. Each care plan contained task and situational risk assessments which showed the relevant risks, control measures and how to mitigate the risks associated in respect of each individual task staff were required to complete; such as medication administration and personal care. We saw however, that one person who had a Percutaneous Endoscopic Gastrostomy (PEG). This is an endoscopic medical procedure in which a tube (PEG tube) is passed in the person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. We saw staff were specially trained to support this person, however there was no detailed risk assessment around how to support the person safely when using their PEG, such as to prevent blockages. We raise this at the time with the manager, who has since

completed a more in depth assessment.

Each care file contained an environmental risk assessment which had been completed on each person's home during the initial assessment process to highlight any potential hazardous working conditions for staff such as pets or stairs. Action had been taken to minimise risk to both staff and the person they supported.

We reviewed three personnel files of staff who worked at the service and saw there were safe recruitment processes in place including; photo identification, employment history, two references and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments. We saw that some staff had chosen to TUPE over to Safehands from a previous care provider. TUPE stands for Transfer of Undertakings (Protection of Employment). Which means that the care staff were employed in accordance with the conditions on their existing contracts.

Staff were supplied with personal protective equipment (PPE). This included gloves, aprons and hand sanitizer. Staff we spoke with told us they were always able to ask for more PPE when needed. Staff had completed infection control and prevention training, and understood the important of reporting outbreaks of flu and vomiting to the registered manager, so they could cover their work so as not to spread the infection. We saw for one person, infection control processes and the importance of them were detailed throughout their care plans as this person was more at risk of developing infections.

Requires Improvement

Is the service effective?

Our findings

People we spoke with who used the service and their family members were positive when we asked questions relating to the staff members skills and knowledge.

We viewed the training matrix in place for the staff. We saw that staff had completed their mandatory training and some were booked to attend training refreshers in the next few weeks. Training was practical sessions, which took place on site at the service's registered premises. Staff were also required to complete a competency assessment to ensure they were able to administer medication, this was signed by a senior member of staff.

We checked certificates for staff training courses attended against the training matrix and found that the dates matched for the courses attended. This meant that staff training was up to date. New staff were inducted in accordance with the principles of the Care Certificate. The Care Certificate requires staff to complete a programme of learning and have their competency assessed before working independently. Staff attended formal supervisions every eight weeks and received an annual appraisal.

We saw that where possible, people had been pre-assessed before their care package commenced. We saw however, that on some occasions there had not been the opportunity for the senior care staff to meet people before they started receiving support from Safehands, due to the urgency of the care package needing to be in place. We did see, that where this was identified, the care plan from the local authority was requested and put into place for the staff to refer to until the person could be visited by a senior member of staff to discuss their more individualised needs and preferences. This usually took place within 72 hours of the care package being commissioned. This demonstrated that the service was working effectively with other services to ensure people were supported in the best way possible. Care and support delivered focused on people's individual outcomes and what they wanted from their care package. For example, one person only required support with personal care, so their care plan focused on that. However someone else required support with 'sit in' services to help their family member support them. The care plans was written in a way which took this need into account.

People we spoke with and their family members told us that the staff helped them prepare their meals in accordance with their needs and wishes. One person said, "They [staff] always ask me if I want anything else to eat before they leave." Also "They make sure I have a drink of coffee, they know how I like it."

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 the processes for assessing people's capacity and gaining consent. Our conversations with staff and the manager indicated that they understood the principles of the MCA and everyone we spoke with

confirmed that staff asked for consent before they provided care. Care plans contained evidence that the service had arranged and attended best interest meetings for people who were not able to make some complex decisions without support. We saw minutes of these meetings. However, we did not see any actual mental capacity assessments in place which assessed the person's capacity in relation to the decision. When we raised this with the manager they informed us that other healthcare professionals who had been involved had completed these assessments. The manager had requested copies. We highlighted that due to the fact the service were not assessing people themselves first, and there was not a record of this in people's care plans, therefore it was confusing as to why best interests had been implemented. Going forward the manager informed us that they would be completing their own assessments in relation to people's capacity.

We recommend the provider reviews their processes relating to the MCA and takes action accordingly.

Staff we spoke with told us they had often called the GP or the District Nurses for support and advice when they had been asked by the person they supported. This also included calling 111 for advice with regards to medication and the administering pharmacy. We saw from care plans that visit times incorporated any planned visits from District Nurses. We also saw occasions were people's call times had been adjusted to enable them to attend medical appointments. One family member we spoke with said "I sort out the medical appointments. The staff will help me with the wheelchair if needed."

Good

Is the service caring?

Our findings

We received positive comments about the caring nature of the staff. Comments from people who use the service included, "Very caring staff, can not do enough for me". "Staff respect me and my home". Also, "Staff and office staff listen to my needs", "Really happy with my carers", "They really do care". Also "Very caring they feel like family", another person said "The staff take the time to listen and pay an interest".

People we spoke with said that the staff promoted their independence as much as possible. One person told us, "They always encourage me to make decisions." Care plans were respectfully written in a way which encouraged staff to respect people diverse needs. For example, one care plan stated, 'When staff visit (person) please offer a freshen up wash.' Other people we spoke with were able to describe how staff behaviour and attitude towards them made them feel staff cared about them. One person said the staff member was "Worth their weight in gold." One family member told us that one of the care staff had bought fish and chips for their relative because they had not been eating much and said they 'fancied it.'

Staff had received training in relation to quality and diversity and the provider had an equality and diversity policy in place. Equality and diversity considerations were written into people's care plan, and we saw some good examples of this, for example one care file documented; 'Please ensure you say hello and goodbye to (person), they like this.'

We received mixed comments from people with regards to gender choice of their carer. However, people also said that this did not bother them.

We spent time speaking to staff, who all told us they enjoyed their roles. Staff spoke about people they supported in a caring and compassionate way. They were able to demonstrate their knowledge of people and tell us what was important to people, their likes and dislikes and the support they required. Staff were able to provide us with examples of how they ensured people's dignity and respect was upheld while they were supporting them. Our conversations with staff showed that they were aware of the importance of gaining consent from people. Staff also explained that people were able to choose what care staff supported them. One staff member said, "I love getting to know the clients, everyone is different. We have to find out what they like and not just assume."

No one was receiving support form advocacy services at the time of our inspection, and most people had families who they lived with or who visited often, or people did not require this type of support.

Even though care plans we viewed did not always contain signatures of the people who used the service, people told us they were involved in their care plans. Comments included, "I was involved in the care plan and reviews". Additionally, family members told us, "I was involved in the care plan and any additions they talk to me about or I talk to them to make changes" and "Any changes to the care plan they listen and make changes".

Good

Is the service responsive?

Our findings

Care plans viewed contained details about people's likes, dislikes and routines. We saw that care was responsive to people's needs. This was because care plans were person centred, which means people were getting care which was right for them, in accordance with their needs and not the needs of the organisation. For example, in addition to the task being outlined, which the carer must complete for the person while visiting them, such as medication, wash, dress, make supper, there was also very specific information. One person's information stated, 'Please make sure you offer me ginger biscuits.' Other care plans contained information regarding what time people liked to go bed, and any additional tasks they liked staff to do. This shows that the service is taking time to get to know people and encouraging staff to support them in a way which they were comfortable with.

Information was in place around people's specific communication needs. For example, we saw that one person communicated by blinking, and this was referenced throughout their care plan. Including how many times the person would blink if they required something specific.

Staff were trained in end of life care. People were supported to remain at home if they wished, supported by staff and other medical professionals. People had information in their care plans regarding what arrangements would be needed to be made in the event of their death. The service had recorded and responded to people's deaths appropriately and sensitively.

People and their relatives told us they were aware of how to make a complaint and they would have no problem in raising any issues. The complaints and comments that had been made had been recorded and addressed in line with the complaints policy. We checked some recent logged complaints and saw they had been responded to in line with the provider's procedures. The policy contained details of the Local Authorities safeguarding procedures as well as the contact details for the Local Government Ombudsman (LGO) if people wished to escalate their complaint.

Good

Is the service well-led?

Our findings

There was a manager in post who was in final stages of registration with CQC. We received mostly positive comments about the manager. One person raised that they felt the staff were not always appreciated, however, staff spoken with raised no concerns.

There were some mixed responses when we asked people if the office staff came out and gathered feedback. Some people said they did not. However, we saw forms were being sent out to people and the feedback was being analysed. Other people we spoke with said the office staff came out regularly and spoke to them. On the whole, people were complimentary about the management of the service.

We looked at the quality assurance systems and processes to monitor how the service was operating and to drive forward improvements. A range of audits and checks were undertaken. The manger completed a management audit each month. The checks included care files, staff training and medication. Senior staff completed medication audits in people's homes each month. We checked these audits over the last few months and saw that where errors had been highlighted they had been promptly followed by robust action plans for the care staff to follow. Completed medication administration records (MAR charts), were checked when they were returned to the office. We saw that the manager had implemented a change in the MAR chart to incorporate more robust recording of creams, as it was highlighted on an audit that this was not always being documented.

The service worked well with the local authority to facilitate care packages at short notice where possible.

Team meetings took place every month. We were able to see minutes of these, and saw agenda items such as staffing, call times, training and health and safety.

The staff that we spoke with were motivated to provide high quality care and understood what was expected of them. They spoke with enthusiasm about the people that they supported and their job roles. Each of the staff were positive about the support and quality of care offered by the organisation.

The service had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

We observed, and heard how good practice was recognised and celebrated in the organisation through an initiative entitled 'Carer of the year' whereby staff were rewarded for good practice.

The registered manager was aware what was required to be reported to CQC by law. As this was the services first inspection under the new provider's registration there were no requirements for previous ratings to be displayed.