Safehands Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection of Safehands Services Ltd commenced on 13 September 2016 with a visit to the office from which the service was managed and visits to two people who used the service in the community. We carried out telephone interviews with staff on 15 and 16 September and spoke with seven relatives and five people who used the service on 20 September 2016. The inspection was announced and the service was given 48 hours' notice to ensure someone would be in the office.

The last inspection had taken place on 4 June 2014 when the service was compliant with all legal requirements inspected at that time.

Safehands Services Ltd is a home care provider offering care and support services to people living in their own home. The service is situated close to the centre of Bradford. At the time of our inspection the service was providing care and support for 49 people, with a further four people in hospital.

The service had a registered manager in place although they were absent on the day of the inspection. 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. The business manager, who was present during the inspection, had day to day responsibility for the running of the service.

People who used the service told us they felt safe with the care they received. Appropriate systems were in place to protect people from risk of harm.

Policies and procedures were in place regarding the Mental Capacity Act 2005 (MCA) and Deprivations of Liberty Safeguards (DoLS). This helped to make sure people's rights were protected.

People were provided with care and support by staff who had the appropriate knowledge and training to safely and effectively meet their needs. We saw the skill mix and staffing arrangements were generally sufficient for the current needs of the service although staffing levels had been recently stretched due to staff absence.

People told us staff usually turned up within the allotted time agreed with the management team but were sometimes later.

Recruitment processes were in place although these were not always followed. Checks to show staff were safe to work with vulnerable adults were undertaken prior to staff working at the service. However we saw some people had commenced employment before satisfactory references from the person's previous employer had been obtained.

Staff told us they had received induction and training relevant to their role and were offered opportunities for on-going development. Some supervisions and spot checks had taken place although some of these were not formalised or documented.

Staff were able to tell us about people who used the service, their care and support needs and how they treated people with dignity and respect. People we spoke with told us staff were kind, caring and respected their dignity and privacy.

We saw care and support was delivered in line with people's care plans and people were consulted about the care and support required. Care records were generally updated to reflect people's changing needs although we saw some person specific charts had not been fully completed. we saw care records contained basic information about people's likes, dislikes and preferences.

Medicines were not always safely managed, with poor documentation and a lack of medicines audits.

People were supported to access a wide range of healthcare professionals and we saw evidence people's healthcare needs were met.

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Where the service provided nutritional support, people's individual dislikes and needs were supported to enable people to consume a well balanced and healthy diet.

A complaints procedure was in place which enabled people to raise any concerns or complaints about the care or support they received. However, some people told us they felt concerns they had raised were not dealt with.

People using the service, relatives, staff and healthcare professionals we spoke with were generally positive about the management team. Staff said the manager was approachable and supportive.

There was a lack of quality assurance monitoring systems in place that could monitor and identify any shortfalls in service provision.

Small staff group meetings were held regularly.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not managed in a safe way.

Relevant and up to date risk assessments were in place in people's care records.

Staff understood safeguarding principles and what to do if they were concerned about people.

Safe recruitment processes were not always followed.

Is the service effective?

Good

The service was effective.

Staff received regular training appropriate to their role. This meant they had the skills and knowledge to meet people's care and support needs.

The service was working within the legal framework of the Mental Capacity Act 2005.

People's choices and preferences were respected.

Staff liaised with health professionals about people's healthcare needs.

Is the service caring?

Good

The service was caring.

People told us staff treated them with dignity and respect.

Staff knew people and their care and support needs and were committed to providing good care and support.

People were involved in the planning of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records and people's assessed needs were regularly reviewed although some care records were not consistently completed.

Where possible, people received calls around the agreed time period although people's preferred call times were not always documented. Staff completed required care and support tasks before leaving the calls.

A complaints policy was in place although a more robust procedure was required to document people's concerns when raised.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a lack of effective systems in place to monitor and improve the quality of the service provided.

Staff and most people who used the service spoke highly of the management team although some people felt their concerns were not addressed.

Regular small group staff meetings were held. Staff morale was good.

Safehands Services Limited

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.

Our inspection of Safehands Services Ltd took place on 13 September 2016. We gave the service 48 hours' notice because the location provides a domiciliary care service and we needed to be sure someone would be in the office.

The inspection team included two adult social care inspectors and an expert by experience. 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 expert by experience used had experience of domiciliary care services.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and any statutory notifications the registered manager had sent us. We also contacted the local authority contracts and safeguarding teams and received feedback from the continuing care team. We asked the provider to complete 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. The registered provider returned the PIR and we took this into account when we made judgements in this report.

During our visit to the provider's office we looked at five care records of people who used the service, some in detail and others to check specific information, three staff recruitment files, training records, medicines records and other records relating to the day to day running of the service.

During the inspection we spoke with the business manager who was responsible for the day to day running of the service, visited two people living in their own homes and spoke with one relative and one care and support worker. We carried out telephone interviews with six care staff and two senior care staff on 15 and 16 September 2016. The expert by experience carried out telephone interviews with 12 people who either

used the service or their relatives on 20 September 2016.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with staff and made comments such as, "I do feel safe with them", "I feel safe with them in the house," and, "It's ok; we feel safe enough." A relative told us, "I am going away for a fortnight so you think, "Is everything going to be alright?", but I know [relative] will be safe with them."

The service had a safeguarding policy in place and had reported any concerns to the local authority adult protection team. We saw staff had received safeguarding training. Staff we spoke with had a good understanding of safeguarding and emergency procedures and what to do if they were concerned about the safety of people they were caring for.

Risks to people's health safety and welfare were assessed and plans of care put in place. Risk screening covered areas such as the environment, skin integrity and behaviours that challenge. A more detailed risk assessment was put in place where staff assisted with moving and handling which provided guidance to staff on how to perform the required moving and handling tasks safely. Records showed where two staff were required to ensure the person was kept safe during moving and handling this was consistently adhered to.

Emergency procedures were in place. For example, a procedure was in place instructing staff what to do if people did not answer their door and staff we spoke with were able to explain what action they would take. Instructions were present within care records of how to gain access to people's houses and emergency named contacts should there be a problem.

Daily records of care indicated there were sufficient staff to ensure a reliable service. They provided evidence that calls consistently took place and staff largely attended at appropriate times each day indicating there were enough staff deployed. Some staff we spoke with commented they felt rushed at times, particularly during 15 minute calls, travel times were not always sufficient to allow them to travel between people's houses and arrive within the agreed time frame and they often received texts asking them to cover other people's calls. However, other staff commented there were enough staff when all staff were there and people weren't off sick or on holiday.

The service employed an administrator for 24 hours per week and the business manager worked from the office on a daily basis. The service operated a weekend 'on call' system which was manned by two senior care staff.

Some people we spoke with indicated they received care and support from the same group of staff and others said they did not. Comments included, "We don't know who is coming but I do know them when they arrive", "Usually regulars and more or less on time", "I don't often get the same people", "We know who is coming" and, "It is usually the same pair that come." The business manager told us they allocated staff a particular area to work in to ensure people received the same care staff wherever possible but they had had a lot of staff absence over the summer which meant this had not always happened.

The business manager told us they gave people a half hour time slot during which their care and support worker would arrive. Some people agreed this happened and others felt they were left waiting longer. One person told us, "They turn up on time," whereas another said, "It's the time keeping; sometimes they are an hour late." The manager commented they had had a lot of sickness and staff leave over the summer but staffing levels had now improved. They said people would be contacted if their care worker was going to be delayed. This was confirmed by a person who used the service who said, "They do ring but it is very frustrating." However, another person told us they had not been informed and said, "It would be nice if they would let us know; no, they don't ring and the office doesn't open until 9am so any calls just go straight through to the supervisor and they are busy enough."

Medicines were not managed in a safe way. We reviewed six people's medication administration records (MAR) and in all six cases found numerous gaps where staff had not signed to demonstrate the support provided. This meant we could not confirm whether people had received their medicines as prescribed or the reasons why staff had not offered support. For example, in one person's records where staff supported them with medicines on numerous days the daily records stated 'see MAR chart.' for the medication support provided. On reviewing the MAR for those days, we saw it was blank.

Most medicines were supplied to people in dossette boxes. We concluded there had been a lack of diligence from staff in checking the medicines provided against the MAR chart in order to maintain an accurate record of administration. For example, one person was prescribed a medicine to be given twice a day, however staff had consistently only recorded that it had been given once a day. Another medicine was recorded on the MAR to be given once a day, however the MAR showed it recorded as given twice a day for a 9 day period in July 2016. For another medicine the MAR stated it had not been supplied that cycle but there were still entries against the medicine to state it had been administered.

Another person was prescribed a medicine to be given three times a day. There were numerous gaps throughout the July to August 2016 MAR. In addition the MAR indicated it had not been administrated three times a day throughout the same period. Someone had also written Paracetamol onto the bottom of the MAR, but there was no other information to show by whom this had been authorised, the dose, or when or why it should be offered.

One person had been receiving medication support since January 2016 when their care package commenced. However the business manager was unable to provide any MAR for the person despite daily records clearly showing care staff were supporting them with medicines.

We visited another person's home and found there was no MAR chart in place despite daily records showing that care staff had assisted the person with creams and tablets. The person's relative told us they provided some assistance with medicines and organising tablets. However these arrangements were not specified within the person's care plan, which meant there was a risk that safe and consistent support was not provided. We spoke with the provider about our concerns who said they were not aware this was occurring and would investigate.

The business manager told us there was currently no audit of medicines records but they would ensure audit systems were promptly put in place. When we spoke with them after the inspection site visit they confirmed they were putting this action into place.

A medicines policy was in place. However the different levels of support which could be offered to people differed from the support levels specified on the provider's MAR chart. This could lead to confusion. We raised this with the manager who agreed to make amendments to the policy.

This was a breach of Regulation 12 (2) (g) Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

In some cases we identified safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included completing an application form, undergoing an interview, a Disclosure and Barring Service (DBS) check, and obtaining two written references. However, we identified in two out of the three staff files we reviewed references had been obtained after the person had commenced employment and the service was still waiting for the return of one reference. The service policy regarding recruitment stated 'the applicant will not be given a permanent offer of appointment until the reference has been received back and verified'. The references we viewed were all acceptable, however the business manager recognised that it was not acceptable practice for people to start work without these and was taking steps to address this.

We saw evidence accidents and incidents were recorded with detailed information provided, actions taken as a result and signed and dated by the staff member. We saw no accidents involving people who use the service had occurred since 2013.

Good

Is the service effective?

Our findings

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. In the case of Domiciliary Care, applications must be made to the Court of Protection. We found no people were currently subject to DoLS.

The business manager demonstrated a good knowledge of the MCA and assured us the correct best interest process would be followed should a decision need to be made for a person lacking capacity. Information was present within people's care files demonstrating people's ability to make decisions for themselves had been assessed. However in some instances we found a lack of evidence that people had signed and consented to their plans of care.

Daily records provided evidence people were offered choices; for example, about what they wanted to eat or if they wanted a shower or other personal care. We saw evidence in people's daily records where people's refusal of care and support were respected. We saw people's care records were kept at their houses with a copy securely stored at the service office. People we spoke with knew where their care records were stored.

Where people required assistance with food and drink this was clearly specified within their care and support plan. This included information on what people liked to eat and drink. Some of this information was highly personalised. For example, one person's care plan specified what colour they liked their toast in the morning. Daily records we reviewed provided evidence staff provided people with the agreed support in preparing and assisting with meals. The business manager told us food/fluid charts would be used to monitor people's dietary intake if they had any concerns, but at the time of inspection nobody's intake was being monitored.

We reviewed training records and saw staff training was up to date or had been booked. Some staff were being supported in NVQ (National Vocational Qualification) training and other staff we spoke with were going to approach the manager to discuss further training as part of their development. Staff we spoke with told us they had received training in key subjects such as moving and handling, first aid, infection control, food hygiene, safeguarding and culture awareness.

People we spoke with said most of the staff knew how to provide appropriate care and support, making comments including, "They seem well trained enough in what they do," and, "They all seem well trained and get on with things." Some relatives we spoke with commented, "They know what they are doing; they use gloves and aprons", "They all seem well trained," and, "They do everything they have to; they manage fine."

Appraisals and supervisions were held although some staff we spoke with told us they hadn't received a formal supervision for some months. We spoke with the senior care staff who explained they reviewed staff competencies through formal observations and when working with people. However, this wasn't always documented as a staff observation which would offer clear evidence of good practice.

People's healthcare needs were assessed and information on any medical conditions was present within people's care files for staff to refer to. Computerised logs provided evidence the service liaised with health professionals such as district nurses should concerns arise about people's health. For instance, one care worker told us how they had stayed longer at someone's house one day because the person was distressed after they had been discharged from hospital without any continence aids. The care worker liaised with the local district nurses and the continence service to organise stock accordingly.

People we spoke with told us staff responded to their healthcare needs. One person said, "If I am feeling poorly I just stay in bed and my [relatives] would call the Doc if needed." A relative commented, "My [relative] is very difficult and needs a lot of care; [person] is very fragile now but the girls (staff) are very good with [person]. I can go and have a rest because I know if [person] is unwell they recognise it and put [person] back to bed and see [person] is alright."

Good

Is the service caring?

Our findings

We spoke with a senior care worker who told us either they or the business manager would meet with people before they started to use the service to assess their needs and assess if the service was able to offer the care and support required. Once the care and support package was agreed, a plan of care would be implemented. We saw care plans were reviewed and updated annually or when care or support needs changed.

Daily records provided evidence people's opinions were valued around their care and support, and their preferences sought, for example about what they wanted to eat or drink. Basic information on people's likes, dislikes and personal preferences was present within care plan documentation. From speaking with people and reviewing care records we concluded people were involved in the planning of their care and support.

Provider survey results from people using the service and spot checks carried out by the service showed people were treated with dignity and respect. Staff told us how they treated people with respect, closing curtains and doors when providing personal care, requesting relatives give them privacy whilst providing personal care and using towels to cover people up to preserve their dignity. Staff told us they knocked on people's doors before entering the house and announced who they were before seeking entry. We observed a care worker during our visit to one person's home and saw they were kind and respectful in their manner.

A relative we spoke with said, "They are very nice, very respectful to my [relative]."
People we spoke with said, "They all treat you with dignity and respect", "They have a laugh and a joke. There's just the odd one you don't gel with", "I have had them two years and wouldn't change one of them", "We have a good laugh and I pull their legs a bit," and, "They are nice girls, very pleasant and helpful."

We saw staff were committed to providing good care. A staff member we spoke with commented about the care provided by the service and told us, "The care they provide is really good." Staff we spoke with knew people's likes, dislikes and care needs and information they gave us corresponded with that in people's care records.

Many staff we spoke with had worked with the people they supported for a long time and explained they were able to get to know people due to working in the same geographical area. Staff comments included, "I think the quality of care is excellent. We do extra and don't mind", "I've got some nice clients. They love me. I love them", "I love my clients. They make me smile", "I enjoy my job. I love it; meeting new people and having a laugh and a joke. I love them to bits," and, "I like caring for people; I like helping people. I am proud to work for Safehands. I think the quality of care is excellent."

Requires Improvement

Is the service responsive?

Our findings

Care records provided evidence of people's needs being assessed before they started to use the service. These included an assessment of needs in areas such as continence, moving and handling, washing and dressing and eating and drinking. This led to the development of a clear care and support plan which gave guidance to staff on what care and support tasks to provide at each visit.

In the case of one person who had complex needs we saw a very detailed daily regime had been put in place by the business manager to assist staff to provide appropriate care. This included details such as the colour and location of flannels to be used during personal care which helped staff provide personalised care. We did note in one person's house there was no care plan for staff to follow. The staff member we spoke with and the person told us it had been taken back to the office for updating. The registered manager confirmed this to us when we spoke with them.

We reviewed daily records of care to establish whether people received consistent visits from staff. Daily records demonstrated the service largely attended at a consistent time each day and staff stayed for an appropriate length of time, although there were a number of occasions where staff did not stay the full allocated time. However, daily records provided evidence the required care and support tasks were undertaken such as washing, dressing and hygiene regimes.

The business manager told us skin charts were put in place where people had been assessed as being at risk of their skin breaking down. Care workers were required to complete the charts to confirm they had carried out skin checks and provided pressure relief. We reviewed two people's charts and saw these were inconsistently completed with checks not recorded on a daily basis. For example one person had checks recorded on 3,5,8,9,18 and 19 July 2016 which demonstrated the records were not consistently completed.

The business manager told us care records were subject to annual review or when people's care and support needs altered. From reviewing people's care records, we saw reviews had taken place. Comments in care records review documentation showed people's opinions were sought on the delivery of their care and support. People we spoke with commented, "We had a care plan in the beginning and they do come and discuss things; they were out last week and we have had a questionnaire", "We had a care plan at the start and the manager lady comes in an evening to see us sometimes and see if everything is alright," and, "I had a full care plan when we started and the office have just rung to check." However, other people told us they had not had a care plan review. One person told us, "We haven't had a review or anything," and a relative commented, "I've had them four years; I can't remember anyone coming out for a review and we haven't had a questionnaire."

Basic information was present within care plans about people's interests and religious needs. Some information was present within care plans on people's preferences such as what they wanted to eat. However in four out of five care plans we looked at there was no indication of the person's preferred call time. We spoke with one person who told us staff had not asked them what time they wanted their visits to take place and times were not always appropriate. We reviewed their recent call times and found they were

mostly consistent. However in the absence of an agreed call time, people's expectations may not be properly managed and this was an area of concern expressed when we spoke with people and their relatives.

We saw the service had a complaints procedure in place although a formal complaint had not been documented since March 2014. People we spoke with told us they knew how to complain. Comments included, "I have never had to complain really or ring them overmuch", "I have no problems and I have all the paperwork and phone numbers," and, "I would ring up if I needed to." However, some people told us they had complained about staff timekeeping and one told us, "If you ring up they are nice enough but they don't do anything about it."

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place although they were absent on the day of our inspection. The business manager had day to day control of the service and was planning to take over as registered manager once the current registered manager had deregistered.

The business manager demonstrated a good knowledge and understanding of the people they were caring for, developed through experience in the role and day to day contact with the people the service was caring for. During our inspection we observed them speaking on the telephone with several people who used the service and it was clear they knew people well and had a good rapport with them. They demonstrated a good understanding of the service and how it operated and had been employed by the service for many years.

We saw there was a lack of documented audit or quality assurance systems in place. This meant there were no systems and processes in place to enable the service to identify and improve where quality and safety was being compromised. For example, medicine administration records were not subject to audit and during the inspection we found MAR charts were poorly completed. Another example was the lack of auditing of care records. We found gaps in completion of skin charts where people were at risk of skin breakdown. These areas should have been identified and rectified through a robust system of quality assurance. The business manager agreed they needed to make improvements and had commenced an action plan to address this when we spoke with them the day following the inspection.

This was a breach of Regulation 17 (1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We concluded from speaking with the business manager they were committed to providing the best possible care and support for the people using the service and were open to ideas for improving service provision. For instance, they were starting a pilot of an electronic care system in people's home where staff could input live care and support data with the use of tablets.

Most people we spoke with told us they felt able to approach the management team with any concerns. One person we spoke with said, "[Business manager] came initially and had a long chat (about care and support needs)," and, "They are very helpful when you ring up." Other comments included, "We are very satisfied with it", "We are really happy with it; 100% really", "They are good in the office and you can just ring them if you need anything," and, "I have had a lot of agencies and this one does seem alright." However, another person told us, "It should be better," and a relative we spoke with commented, "I've given up ringing the office; nothing changes."

Staff we spoke with unanimously told us the business manager was approachable and offered them support. Comments included, "I get plenty of support from [business manager]. If I need any advice I just ring [business manager]", "I can speak to [business manager] about anything and you can speak to [business manager] whenever you want", "I can speak to [business manager] on the phone or pop into the

office", "Feel supported," , "[Business manager's] very good; very approachable," and, "Couldn't have asked for a better manager; fantastic boss; can go to [business manager] and [business manager] will sort it; can't fault [business manager] in any way."

We saw a service user questionnaire had been recently completed and actions taken as a result of the responses. Some people who used the service had been asked to participate in a pilot of an electronic records system. We spoke with one person who confirmed they were asked if they wanted to participate and was happy to do so. This demonstrated the service involved people in the service and it's development.

The business manager told us about and showed us plans for an afternoon tea event to be held at the service later in the year, in the foyer of the centre where the service was located. This was to involve staff and people who use the service, both in the planning stages and at the event itself. They told us they were hoping if the first event was a success they would involve other local services based at the centre in further events. This demonstrated the service promoted a positive culture and encouraged involvement by people.

Small staff meetings were held regularly at the office, giving staff members an opportunity to discuss concerns and issues. We saw results from a recent staff questionnaire had been assessed and actions taken as a result, with some responses used for individual discussions. Staff morale amongst those we spoke with was good.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed in a safe and proper manner. Proper and safe management of medicines; Regulation 12 (2) (g) Health and Social Care Act 2008 (Regulated Activities)Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of quality assurance and audit procedures in place to improve the quality and safety of the services provided. Systems or processes must be established to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.