HFH Healthcare Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This service is a domiciliary care agency. It provides nursing, personal care and treatment for children and adults living in the community with complex health conditions, disabilities and injuries. At the time of our inspection 40 children and 110 younger and older adults living in or around London received a home care service from HFH Healthcare. This agency specialises in supporting children and adults with spinal and brain injuries or neurological disorders, some of whom may also be living with dementia, have learning and physical disabilities, sensory impairments or mental health needs.

The service had a registered manager in post who was also the Chief Executive Officer (CEO) of the company. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At the last CQC inspection of this service in February 2016 we rated them 'Good' for the five key questions 'is the service safe', 'effective', 'caring', 'responsive' and 'well-led?' At this inspection we found the service remained rated 'Good' overall.

However, we have changed the rating for the key question is the service well-led from 'Good' to 'Requires Improvement'. Although people said they were happy with the care they received from their 'regular' care staff, we received mixed feedback from people, their relatives and professional representatives concerned about the high rates of staff turnover the agency had experienced in the last 12 months and new care staff not being so familiar with peoples complex health care needs, daily routines and preferences. This point notwithstanding most people felt staff retention had improved recently and their new care staff had begun to familiarise themselves with people's needs, routines and wishes. In addition, we received some mixed comments from people and their relatives and professional representatives concerned about poor communication from the agency. For example, people told us they were not always notified in a timely way about changes to care staff rotas and therefore they did not always know who their care staff would be and what knowledge, skills and experience they had.

We discussed the aforementioned issues with the registered manager who acknowledged the agency had faced a challenge in the last 12 months dealing with higher than average rates of staff turnover and a significant increase in the number and complexity of the health care needs of people they now supported. The registered manager told us they planned to improve the way the agency was managed by introducing new fixed hour contracts for all staff to increase staff retention and senior coordinator posts to oversee smaller teams of specialist care staff working in specific geographical areas. Progress made by the provider to introduce new staff contracts and senior coordinator positions will be assessed at the services next inspection.

The negative points described above notwithstanding most people felt safe using the agency and with their

'regular' care staff. There continued to be robust procedures in place to safeguard people from harm and abuse. Care staff were still familiar with how to recognise and report abuse. The provider had assessments and management plans in place to minimise possible risks to people, which included infection control and safe food handling measures. There was a 24 hours on call system in operation that ensured management and nurse support and advice was available for care staff when they needed it. Staff recruitment procedures continued to prevent people from being cared for by unsuitable care workers. Medicines were managed safely and people received them as prescribed.

Care staff received appropriate training and support to ensure they had the right knowledge and skills to effectively meet the complex health care needs of people they regularly supported. Managers and care staff adhered to the Mental Capacity Act 2005 code of practice. People were supported to eat healthily, where the agency was responsible for this. Care staff also took account of people's food and drink preferences when they prepared meals. People received the support they needed to stay healthy and to access healthcare services.

People and their relatives told us they were happy with the care and support provided by their 'regular' care staff. Care staff continued to treat people with dignity and respect. They ensured people's privacy was maintained particularly when being supported with their personal care needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People received personalised support that was responsive to their individual needs. People were involved in planning the care and support they received. Each person continued to have an up to date support plan. People felt comfortable raising any issues they had about the provider. The service had arrangements in place to deal with people's concerns and complaints appropriately.

The provider had an open and transparent culture. They routinely gathered feedback from people using the service, their relatives and care staff. This feedback alongside the provider's own audits and quality checks was used to continually assess, monitor and improve the quality of the service they provided. Care staff felt supported by managers and senior nurses.

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 remains 'Good'.

Is the service effective?

Good

The service remains 'Good'.

Is the service caring?

Good

The service remains 'Good'.

Is the service responsive?

Good

The service remains 'Good'.

Is the service well-led?

Requires Improvement

Some aspects of the service were not always well-led.

The agency's arrangements for communicating with people using the service and their professional representatives required improvement. In addition, the way the agency coordinated care staffs shifts were not always well-managed. This meant some people might receive care and support from care staff who were not so familiar with their complex health care needs, daily routines and preferences.

The service had a registered manager in post. Care staff said they enjoyed working for this agency and felt they received all the support they needed from managers and nurses.

The provider routinely gathered feedback from people using the service, their relatives and care staff. This feedback alongside the provider's own audits and quality checks was used to continually assess, monitor and improve the quality of the service they provided. This included bi-annual spot checks and competency assessments of care staff on shift to ensure people received the care and support they needed.

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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 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.

The inspection was announced and took place on 9 October and 24, 28 and 29 November 2017. We gave the provider three days' notice of the inspection because managers are sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that the registered manager/CEO would be available to assist with the inspection. The inspection team consisted of an inspector 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 service.

As part of the inspection process we reviewed all the information we held about this service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

On the first two days of our inspection we contacted a range of people by telephone or email to seek their views about this agency. This included four people using the service, ten of their relatives, four community nurses representing various continuing care teams and local Commissioning Care Groups (CCG) and 15 care staff.

We visited the agency's offices on the third and fourth day of our inspection. We spoke face-to-face to a range of managers, nurses and care staff. This included the registered manager/CEO, the Director of nursing, the operations manager, the head of training and recruitment, three practice educators, a nurse assessor and five care staff. We also spent time looking at records, which included care documents in relation to ten people using the service, 15 care staff files and other records relating to the overall management and governance of the agency.

Good

Is the service safe?

Our findings

The agency continued to have robust procedures in place to safeguard people from harm and abuse. People and their relatives told us they felt safe receiving a service from this agency. One person told us, "I feel safe with my regular carers who know me and my family very well." Another person said, "Yes…I feel safe with the carers that usually come to my house." Community health professionals also told us the agency kept their client safe. One professional remarked, "Although HFH had been slow to respond to an earlier safeguarding case, they had responded appropriately in respect of two subsequent incidents."

We looked at documentation where there had been safeguarding concerns raised about children and adults using this agency in the last 12 months and were assured the provider had taken appropriate action to mitigate the risks associated with these incidents. We saw the registered manager always liaised with the relevant local authority about the concerns raised so they were aware of the outcome of the investigation and any learning to ensure people remained safe and to prevent reoccurrences of similar incidents. For example, following a number of investigations into medicines errors in the last 12 months care workers were reminded in a newsletter and at various individual and group meetings about the importance of accurately maintaining medicines administration record (MAR) charts. At the time of our inspection there were two on-going safeguarding investigations which the provider was working closely with the relevant local authorities to resolve.

The agency had measures in place to identify report and act on signs or allegations of abuse. We saw a copy of the staff whistle-blowing and safeguarding procedures were included in the care staff handbook. Records showed care staff had received up to date child protection and safeguarding adults at risk training. Managers and care staff demonstrated a good understanding of the different types of abuse that could occur, the signs they would look for and who they needed to report any safeguarding concerns to. One care staff told us, "I would immediately call the office if I was in anyway worried about the safety of someone I looked after."

Managers and nurses routinely analysed accidents and incidents to identify trends and learn lessons, from which they developed action plans for care staff to follow and minimise the risk of similar events reoccurring. The registered manager gave us a good example of how care staff had significantly reduced the number of incidents involving one person using the service when it became clear after a review what might trigger their challenging behaviour. Records indicated care staff who supported people whose behaviours might challenge the service had received positive behaviour support training.

The service respected people's equality and diversity. The provider had up to date equality and diversity policies and procedures in place which made it clear how they expected care staff to uphold people's rights and ensure their diverse needs were respected. Care staff received equality and diversity training and they demonstrated a good understanding of how to protect people from discrimination and harassment. This helped them to protect people from discriminatory practices or behaviours that could cause them harm.

Staff continued to assess, monitor and review risks to people posed by their specific healthcare needs. A

person's relative told us about the risk management plans that were in place to support their family member with their tracheostomy. Care plans contained up to date risk management plans that included detailed information for care staff about the actions to be taken to minimise the chance of accidents reoccurring. Where people were at risk of falls or choking, for example, detailed guidance was available to care staff that made it clear how to support people to eat and drink safely. We also saw risk assessments had been carried out in relation to people's home environment, which included health and safety, and fire safety checks. Staff we spoke with demonstrated a good understanding of the risks people they supported might face both at home and in the local community.

Maintenance records showed where care workers used specialist medical equipment to support people in their own homes, such as mobile hoists or ventilators; the provider ensured these were regularly serviced in accordance with the manufacturer's guidelines.

The provider's staff recruitment procedures remained robust. Records showed when an individual applied to become a member of staff, the agency continued to undertake comprehensive checks around their suitability to work with children and adults, which included looking at their right to work in the UK, employment history, previous work experience, employment/character references, criminal records and registration PIN numbers for nurses. Electronic records showed the provider carried out criminal records checks at three yearly intervals on all existing staff, to assess their on-going suitability. These arrangements helped to ensure only individuals that demonstrated the appropriate competencies, experience and knowledge would be deemed suitable to support children and adults using this agency.

Care staffs shifts were coordinated weekly by office based staff. We received some mixed comments from people, their relatives and professional representatives concerned about the high rates of staff turnover the agency had experienced in the last 12 months, which meant people had being matched with a lot of new care staff who were not so familiar with their complex health care needs, daily routines and preferences. However, this point notwithstanding most people told us they had seen an improvement in staff retention in the last few months. A few people said their relatively new care staff were now familiar with their needs, routines and wishes. Care staff told us their shifts were well organised by the care coordinators who ensured they had enough time to complete all their designated tasks during their shift. The registered manager told us the agency operated a 24 hour on-call service. This meant managers and nurses were always available to offer advice or cover in the event of an emergency.

Where the service was responsible for this, medicines continued to be managed safely. Care plans contained detailed information regarding people's prescribed medicines and how they needed to be administered. There were no gaps or omissions on medicines administration record (MAR) charts maintained by care staff, which indicated people received their medicines as prescribed. Care staff had completed training in the safe management of medicines and their competency to handle medicines safely continued to be assessed bi-annually.

People were protected by the prevention and control of infection. We saw the provider had an up to date infection control policy and procedures. Records showed care workers had completed up to date infection prevention and control training. Care staff told us they were always given ample supplies of personal protective equipment (PPE) when they were required to provide people with personal care, which included disposable gloves, shoe covers and aprons. People told us care staff who handled and stored food on their behalf did so in a hygienic and safe way. Care staff who were responsible for handling food in the homes of people they supported, confirmed they had completed up to date food safety training.

Good

Is the service effective?

Our findings

The agency continued to ensure care staff had the right skills and knowledge to deliver effective care to people they supported. People told us their 'regular' care staff were competent. Typical comments we received included, "My usual carers are very well-trained", "The carers who regularly come to see my [family member] are very good at what they do and always do a grand job" and "We're really fortunate that we've been given some well-trained, competent carers."

The agency has an in-house team of qualified nurses who act as practice educators delivering induction and on-going training to care staff. There is a fully equipment training centre at the offices where care staff receive their theoretical and practical training. Equipment available at the training centre includes a range of mobile hoists, ventilation machines and beds.

It is mandatory for all new care staff to successfully complete the providers nurse led induction, which includes shadowing experienced care staff on shift. All care staff receive an employee handbook which sets out the agency's philosophy, policies and procedures, and expectations regarding their behaviour at work. One care staff told us, "My induction was fantastic and the staff handbook is a really useful guide", while another said, "The most comprehensive induction I've ever received from a home care agency, and I've worked for a few."

An electronic training matrix showed care staff had completed all the training the provider considered mandatory. Care staff received additional clinical training if they were matched to support people with complex health care needs. For example, this might include specialist training in tracheostomy care, oral suctioning, mechanical and non-invasive ventilation, spinal cord injury and autonomic dysreflexia awareness, enteral nutrition, catheter care, bowel elimination, epilepsy, diabetes and skin care.

Care staff spoke positively about the training they had received and most said they had access to all the training, including specialist clinical training; they needed to perform their jobs well. One care staff said, "The specialist health care intervention training we receive from the practice nurses is the best", while another told us, "My training has been excellent so far…I found the practical demonstrations given by the nurses who work in the training centre and shadowing the more experienced staff on their shifts particularly useful."

Care staff had sufficient opportunities to review and develop their working practices. Records indicated care staffs competency to effectively carry out their duties was appraised bi-annually by nurses who directly observed their working practices while they were on shift. The registered manager told us about several instances of experienced care staff being temporarily suspended from duty in order to be retrained because they had failed to successfully pass their bi-annual competency assessment.

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

make 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. Any application to do so for people living in their own homes must be made to the Court of Protection. At the time of our inspection, a person who lived in a 'supported living' setting was subject to a DoLS authorisation. We confirmed that the relevant paperwork was in place, the authorisations were up to date and any conditions were being met.

Care plans included guidance for care staff on consent and the person's capacity to make decisions. The provider reminded care staff to explain the care and support they provided and offer choices to people routinely. We saw people using the service, or their representatives, signed care plans to indicate they agreed to the support provided. Care staff told us they asked people for their consent before delivering care or treatment and respected people's decision if they refused support.
People were encouraged to eat and drink sufficient amounts to meet their needs, where the service was responsible for this. The level of support people required varied and was based on people's specific health care needs and preferences. For example, some people were unable to swallow and required food be administered by Percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted directly into the stomach so the person can receive food through it). Care staff worked closely with various health care professionals, such as speech and language therapists, dieticians and enteral specialist nurse to ensure they provide safe and appropriate care for people with specific eating and drinking requirements. Care plans contained detailed nutritional assessments. Care staff monitored the food and drink intake of people who had been assessed as being at risk of malnutrition or dehydration to ensure these individuals continued to eat and drink adequate amounts.

People were supported to stay healthy and well. People had access to health care professionals when they needed them. A relative told us, "The carers that usually come here are very aware of my [family members] complex clinical needs. In the past they [carers] have been really on the ball and were quick to call an ambulance when we needed it." We saw care staff maintained accurate records in respect of people's health during their shift. This meant others involved in people's care and support had access to up to date information about their health and wellbeing. When staff had concerns about an individual's health and wellbeing we noted they notified their line manager so that appropriate support and assistance could be sought from the relevant health care professionals. Care plans included personalised details about people's past and current health needs.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about their 'regular' care staff and typically described them as "kind" and "compassionate". Comments we received included, "The carers that usually look after to me are all marvellous", "I am completely happy with the two carers I've got at the moment…They're both so nice" and "We've had the same carer for a while, whose very conscientious and reliable…I trust them and think they've built up a good rapport with my [family member]." Records indicated that everyone who had participated in the provider's most recent annual satisfaction survey had said their 'regular' care staff always treated them with kindness and compassion. In addition, most of the compliments the agency had received in the last three months also echoed this sentiment.

Care staff continued to treat people using the service with respect and dignity. People told us their 'regular' care staff always respected their privacy. Relatives said when their family member was being provided personal care, care staff were always discreet. Several relatives gave us examples of how care staff ensured their family member remained covered with a towel when they were having a bed bath. Records indicated all care staff had completed training in how to respect people's privacy and dignity. In addition, the staff handbook contained a detailed code of conduct which care staff were expected to follow when they were on shift. This code made it clear to care staff they were a guest in a person's home and must act accordingly. Rules for care staff to follow included always asking people how they wanted to be addressed and never to enter a person's home or any of their rooms unannounced.

Staff communicated with people in appropriate and accessible ways. Care plans included a communication passport which contained detailed guidance for care staff about people's specific communication needs and preferred methods of communication. For example, one care plan developed for a person with communication difficulties made it clear care staff should always speak clearly and concisely, and allow plenty of time for this individual to respond verbally to their questions. Another care plan which had been developed for someone who did not use the spoken word referred to the importance of care staff understanding non-verbal cues, such as face grimacing, which indicated this individual might be in pain.

Staff used a ranged of tools and techniques to enable them to talk and listen to people with communication needs, including talking-mats, eye-gaze technology and easy to understand pictures and symbols. Talking-mats are mats to which simple pictures can be attached and rearranged to communicate a person's wishes, whilst eye-gaze is a computer system that enables people to generate speech or a write a message by controlling keys on a screen with their eyes. The registered manager told us communication was covered as part of new care staffs induction and Makaton training was available for care staff who supported children and adults who used this method of communication. Makaton is a recognised language programme that uses signs and symbols to support the spoken word to help people with learning disabilities and/or communication difficulties.

People continued to be given essential information about what the agency offered. A relative said, "The agency gave us a useful guide before we started using them so we knew what to expect from them." The registered manager told us people were provided with a brochure called a 'Home handbook' that included

information about the services they provided and the standard of care they could expect to receive. The registered manager also told us if any person planning to use the service was not able to understand this information they could provide it in different formats to meet their needs for example audio, large prints, different languages or through interpreters. We saw two examples of easy to understand pictorial care plans the agency had specifically developed for children. However, the service user guide for children and young people is not available in an easy to read version. We discussed this with the registered manager who agreed to develop more child-friendly versions of this guide.

Care staff were familiar with the needs and preferences of the people they supported. People told us they received consistently good care from their 'regular' care staff who were familiar with their needs, daily routines and preferences. A relative told us, "We've got a good team of carers who've been with us for a while so they know my [family members] likes and doesn't like." Staff we spoke with were able to tell us about the people they regularly supported and describe what these individuals liked to eat and drink, activities they enjoyed, significant people in their lives and what their health care needs were. It was clear from comments we received from two care staff they were both aware of the religious dietary requirements of the people they supported and knew they were not allowed to bring any pork products in these individual homes whilst they were on duty.

The service continued to support people to be as independent as possible. Several relatives gave us examples of care staff actively encouraging their family members to continue dressing themselves, brushing their teeth or using standing frames, or in one case an exercise bike, to help people maintain their independent living skills. One care staff gave us a good example of how they were teaching a young child to use a fork to eat their meals. Care plans reflected this approach and included detailed information about people's dependency levels and more specifically what they could do for themselves and what help they needed with tasks they couldn't undertake independently.

Good

Is the service responsive?

Our findings

People continued to receive personalised care which was responsive to their needs. People told us a nurse from the agency had visited them at home to complete their care needs assessment before any home care support had been provided. People also said they had been involved in developing their package of care with the agency and had been given a copy of their care plan. These plans were written in a person centred way that focussed on the care needs, abilities and preferences of the individual. They also included detailed information about how people preferred care staff to deliver their personal care and who was important to them, such as close family members and friends.

People remained involved in making decisions about the home care service they received. People told us the agency had asked them for their preferences in relation to the gender, age, culture/spoken language and shared interests of their 'regular' care staff. The registered manager told us they always took peoples preferences into account and where possible tried to meet them. Care staff gave us examples of how they had been matched with people they regularly supported who spoke the same language. The registered manager also told us about a case when ten different care staff had been tried before the person receiving a service agreed they had found the right team of care staff who shared their interests to support them.

Care plans reminded care staff to continually offer people opportunities to make informed choices about how they lived their daily lives. For example, several care plans made it clear care staff should always hold up and show people a selection of garments to enable them to choose what they wore each day. One care staff told us, "I encourage the person I always look after to choose the outfit they want to wear each morning by showing them at least three or four different garments for them to pick from."

Peoples care plans were routinely reviewed. People said they were involved in reviewing the package of care they received. This was done bi-annually or sooner if there had been a change in people's needs or choices. Where changes were required, care plans were updated promptly and information about this was shared with all care staff. This meant care staff continually had access to up to date information about how people's needs should be met.

People continued to participate in activities of their choosing both in their home and the local community. Care plans were clear what activities people enjoyed doing. For example, several care plans mentioned people liked talking with their care staff, doing arts and crafts, listening to a specific radio station that played the type of music they enjoyed, watching a particular soap opera on television, spending time in a sensory room, visiting a local park, shopping and attending school.

Several care staff told us some of the people they regularly supported were at risk of becoming socially isolated at home, so helping these individuals to pursue meaningful activities in their local communities was a useful way to reduce this risk, such as going shopping or visiting local parks. Care staff being matched with people who spoke the same language or shared a culture also helped reduced the risk of people becoming socially isolated due to language barriers and cultural differences.

People were encouraged to maintain relationships with those that mattered to them. The agency had a relationships and sexuality policy. Staff told us they were trained to support people they supported with their personal relationship needs, which included advice on understanding the specific issues that lesbian, gay, bisexual and transgender (LGBT) people using the service might face. Care plans contained a section on sexuality which people could complete if they chose. Two care staff gave us good examples of occasions when they had needed to be flexible and change their shift times at short notice when people had requested to have some alone time with their partners. One care staff said, "You have to respect a person's right to have a love life, whether their gay or straight, and to always be sensitive to their relationship needs and wishes."

The service had suitable arrangements in place to respond to people's concerns and complaints. People and their relatives told us they knew how to make a complaint if they were not happy with the service provided. People confirmed they had been given a copy of the agency's complaints procedure, which was included in their Home care guide. Most people we spoke with who had raised a concern about the agency said they had found the complaints process easy to use. They also said they were listened to and their concerns investigated. Records showed when a concern or complaint had been received the agency had conducted a timely investigation, provided appropriate feedback to the person making the complaint and offered an apology where this was appropriate when people experienced poor quality care from the service. Several people gave us examples of prompt action the agency had taken to replace care workers they did not feel they got along with particularly well.

When people were nearing the end of their life, they received compassionate and supportive care from the agency. Care plans contained a section that people could complete if they wanted to record their wishes during illness or death. We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in some of the care plans. Records showed all care staff had completed their end of life care training. Managers told us they worked closely with various community based palliative care professionals, including local hospices, when people they supported were nearing the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not always well-led. We received mixed feedback from people and their relatives about the way care staffs shifts were coordinated. Specifically, people expressed concerns about the high rates of staff turnover they had experienced in the past year, which some people felt had resulted in them receiving inconsistent support from care staff they did not know and who were not familiar with their complex health care needs, daily routines and preferences. Many people also said they were concerned about poor communication with the agency, which resulted in them not always being notified in a timely way about any changes to shift rotas. This meant they did not always know who which care staff would be turning up and what knowledge, skills and experience they had of meeting their needs and preferences.

Typical feedback included, "Our regular care workers are wonderful, but I just wish the office would let us know when they were going to change them…I'm constantly having to teach new staff how to look after my [family member] properly", "My regular carers are very good at their job, but the emergency cover ones often don't have a clue and rarely know what my routines are or what I like doing " and "My carer went sick recently and I've had a different carer every day since, which means you have to retrain them all the time. Our main problem is a lack of information coming from the office. No one there ever seems to know what's going on."

We also received mixed comments from health care professionals with two out of four we contacted expressing concerns about their clients new care staff. One community professional told us, "We have had recent concerns raised by my client's family in relation to new carers being sent that don't fully know their [family members] needs." Another professional said, "I have been concerned that carers who have been sent to cover my client's shifts were not competent to meet that particular child's needs."

In addition, although community health care professionals we contacted told us they worked closely with HFH reviewing joint working arrangements and sharing best practice, most also felt communication with this agency could be significantly improved. One professional said, "I have found communication slow with HFH, having emailed to ask how to address these concerns but have had no response as yet", while another commented, "Rotas are not being sent to us or my clients in advance and communication is poor with HFH."

We discussed the aforementioned issues with the registered manager who confirmed approximately a third of the agency's workforce, including many of the care coordinators who arranged care staffs shifts, had left the organisation in the past 12 months. The registered manager acknowledged this high rate of staff turnover had invariably had a negative impact on the continuity of care some people experienced. The registered manager also acknowledged internal communication between the office based staff and people receiving a home care service, as well as external communication with community health care professionals representing various continuing care teams and CCGs had been identified as an issue recently, which the organisation was trying to address as a matter of urgency.

The registered manager told us after listening to care staff who had expressed concerns about their zero hour's contracts and as a consequence they have agreed to introduce new fixed hour contracts for care staff

in January 2018, which it is hoped will help improve staff retention. In addition, the registered manager said they planned to improve the agencies internal and external communication by creating new senior coordinators posts in 2018 whose new role and responsibilities would include overseeing and communicating with smaller groups of people and their care staff in specific geographical areas. Progress made by the provider to introduce new staff contracts and senior coordinator positions to improve staff retention and communication within and outside the agency will be assessed at their next inspection.

The provider had effective systems in place to regularly assess and monitor the quality of service that people received. Regular audits were undertaken by managers and nurses to routinely monitor and assess safeguarding incidents, accidents, near misses and complaints, medicines management, care planning and risk assessing, and staff recruitment, training and supervision. For example, nurses continued to carry out bi-annual spot checks on care staff during their shifts to directly observe their working practises and ensure they remained competent to effectively perform their duties. Care staff confirmed nurses routinely arrived when they were on shift to check they had turned up on time, were wearing their uniforms and identification badges, managed medicines safely and completed all of the tasks they were supposed to.

The provider had also established an effective integrated governance committee (IGC) which consisted of four subcommittees, including an operational quality, clinical governance, information governance and health and safety committees, which regular fed into the ICG. Records showed if any issues were identified as part of the audits described above these would be discussed at the aforementioned committee meetings and an action plan developed to address them. Managers told us the agency had learnt a number of valuable lessons in the past 12 months, which they had now addressed, as a result of these on-going audits. For example, care staff had recently been reminded through individual and group meetings and newsletters about the importance of appropriately maintaining accurate medicines records, after a number of spot checks had revealed some care staff were not always following the correct medicines recording procedures. We identified no concerns with the way care staff maintained medicines records, which indicated care staff followed the provider's medicines recording protocols and administered people's medicines as prescribed.

The provider promoted an open and inclusive culture which welcomed and took into account the views and suggestions of people using the service and their relatives. The agency used a range of methods to gather people's views which included visiting people at home at least bi-annually and using annual satisfaction surveys. .

The provider valued and listened to the views of staff. Staff spoke favourably about their employer and said they liked working for HFH and found the managers and nurses approachable and supportive. Staff had regular opportunities to contribute their ideas and suggestions to the management of the agency through the newly re-launched monthly staff newsletter, quarterly staff meetings and forums, various team building sessions and annual satisfaction surveys. Records of this contact showed discussions regularly took place which kept staff up to date about people's care and support and developments within the agency. The registered manager gave us an example of action they had taken in response to feedback given by staff which included the creation of a care worker of the month award, nominated by people using the service and care staff. The provider also has designated staff representatives who regularly meet with senior managers to give feedback about care staffs suggestions and/or concerns.

The agency worked closely with various health and social care professionals. The registered manager informed us they had a good working relationship with various commissioners and nurses representing a range of NHS Trusts, local authorities, continuing health care teams and CCGs. They regularly liaised with these health and social care bodies and professionals to seek advice, discuss issues, review joint working practices and share best practice, as well as learn from their near misses and mistakes. The registered

manager gave us a good example of how the agency had sought advice from Muscular Dystrophy groups to improve the standard of care they provided people diagnosed with this condition.