Midshires Care Limited

Helping Hands Chipping Sodbury

Inspection report

The Mill Offices
Bowling Hill
Chipping Sodbury
South Gloucestershire
BS37 4AD

Tel: 01454643701
Website: www.helpinghands.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was announced. Forty-eight hours' notice of the inspection was given to ensure that the people we needed to speak with were available. The inspection was undertaken by one inspector.

Helping Hands Chipping Sodbury is one branch of a family run domiciliary care provider. They provide care and support services to people living in their own homes. The service is provided to people who live in the South Gloucestershire area – some of the people were provided with services commissioned by South Gloucestershire Council whilst other people funded their own care and support. At the time of the inspection they were supporting 117 people of which 80 people received a personal care service. The service had 31 care staff.

There was no registered manager in post but the provider had already appointed a manager for the branch and they will apply to the Care Quality Commission to be registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The manager takes up their post on 3 October 2016.

A registered manager from another branch, the head of care and the risk and compliance manager were available during the inspection.

The managers and care staff were knowledgeable about safeguarding issues. They knew the appropriate actions to take if concerns were raised and who any concerns should be reported to. All staff received safeguarding adults training. Robust recruitment procedures were followed to ensure only suitable staff were employed. Appropriate steps were taken to protect people from harm.

As part of the assessment of people any risks to their health and welfare were identified and managed to either reduce or eliminate the risk. The level of support people needed with their medicines was identified in their care plan. Staff received safe medicines administration training to ensure they were competent to undertake the task and their competency was rechecked.

Care staff were well trained and had a training programme to complete. This enabled them to carry out their roles and responsibilities. They received support from the managers, the care coordinator and the field care supervisors. New care staff had an induction training programme to prepare them for their role. Care staff were offered the opportunity to complete additional qualifications in health and social care (formerly called a national vocational qualification).

Staff understood the principles of the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions. Whilst the arrangements for receiving a service were being put in place, people signed their agreement to the plan of care. Care staff ensured that people consented before any care or support was provided each time they visited.

Where people were assessed as needing support with food and drink, care staff would provide the assistance as detailed in their care plan. People were supported to see their GP and other healthcare professionals.

The care staff had good, kind and friendly working relationships with the people they were looking after. Staff ensured people's privacy and dignity was maintained at all times.

The service had good processes in place to assess people's care and support needs and then to plan the delivery of their care. They received the care and support they needed and were looked after in the way they preferred. This was because they were involved in making decisions about how they wanted to be helped. People were encouraged to express their views and opinions and say whether the service was meeting their expectations.

The provider had quality assurance measures in place to monitor the quality and safety of the service. This meant people received the service they expected and it was safe, effective and caring. The service used any feedback from people to make improvements and learned from any complaints, accidents or incidents to prevent further occurrences.

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 were protected from harm, and all staff knew what actions to take if abuse was witnessed, suspected or reported. Any risks to people's health and welfare were well managed.

The recruitment of new staff followed robust procedures and ensured only suitable staff were employed.

The level of support people needed with their medicines formed part of their care plan. Staff were trained to administer medicines safely.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were well trained. Staff were aware of the principles of the Mental Capacity Act 2005 and ensured consent was obtained before providing care and support.

People were supported to have sufficient food and drink where they needed this support. They were supported to contact and see their GP or other healthcare professionals as necessary.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness. They were looked after by care staff who knew them well and had good relationships with them. Staff spoke respectfully about the people they looked after.

People were looked after in the way they wanted and were encouraged to make decisions about things that affected their daily lives.

Is the service responsive?

Good

The service was responsive.

People received the service they expected and was specific to their needs. They were involved in making decisions about their care and support. Care reviews took place so that adjustments could be made when necessary.

People felt able to raise any concerns they may have and felt they would be listened too.

Is the service well-led?

Good

The service was well-led.

People were satisfied about how the service was managed. Staff were committed to providing a service that was safe, effective and compassionate.

Measures were in place to monitor the quality of the service and to capture feedback from people and the staff team.

Helping Hands Chipping Sodbury

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, and to provide a rating for the service under the Care Act 2014.

The last inspection of Helping Hands Chipping Sodbury was completed in April 2014. At that time there were no breaches in regulations. This inspection was undertaken by one adult social care 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.

Prior to the inspection we looked at the information we had about the service. This information included any statutory notifications the service had submitted to CQC. A notification is information about important events which the service is required to send us by law. We also reviewed the previous inspection report and contacted two social care professionals as part of the planning process.

We reviewed the Provider Information Record (PIR) that had been submitted in December 2015. The PIR is information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they planned to make.

We sent domiciliary care agency questionnaires to people who use the staff, relatives, staff and community professionals and have used their feedback as evidence and reported this in the main body of the report. We received 29 (people), six (relatives/friends) and one (community professional) completed forms regarding the service.

During the inspection we spoke with six people who used the service and one relative. We spent time with the senior managers referred to in the summary, spoke with one of the care coordinators and five care staff.

We looked at people's electronic care records, staff recruitment and training records and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints and the safe management of medicines.

Good

Is the service safe?

Our findings

We contacted people who used the service and asked them if they thought the service was safe. They said, "I feel safe and secure with my regular carer", "If my regular carer is away, and they send someone else, I would like to know who I am letting in to my home", "I have asked the office to send those ladies I feel safe with" and, "The staff are very friendly and kind to me. I am not worried at all and I look forward to their visits".

Those people who returned the questionnaires we had sent them prior to our inspection all said they strongly agreed or agreed they felt safe from abuse or harm from the care staff. Relatives or friends who completed the forms also all reported that the person who used the service was safe.

The service had a safeguarding policy and this was reviewed on a yearly basis (due to be reviewed again in September 2016). They also had a copy of the local multi-agency safeguarding adults policy. These gave guidance to the care staff and managers on what to do if they had concerns about a person's welfare, they witnessed bad practice or were told about an event that had happened. The service also had a whistle blowing policy and procedure. This policy protected employees against detrimental treatment as a result of reporting bad practice.

Those managers and care staff we spoke with had a good understanding of safeguarding issues and were aware of the need to alert the local authority of any concerns they had. All care staff completed a safeguarding training programme to ensure they were clear of what processes to take. The new manager will be booked to attend a safeguarding training session for managers with South Gloucestershire Council if they have not already attended this. The new manager will also attend in-house safeguarding training as part of their induction programme. In 2016 three safeguarding concerns had been raised. One was in respect of concerns the care staff had regarding the relationship between a person they supported and their spouse. A second concern was raised because of a single missed visit to a person and the third concern was raised by a community healthcare professional. The service had worked well with the safeguarding investigations and taken the appropriate action to safeguard people and prevent further incidents.

The service used safe recruitment and selection processes in order to employ the right staff. The measures they used protected people from being looked after by unsuitable staff. Relevant checks were carried out before new care staff started work These checks included a Disclosure and Barring Service (DBS) check. A DBS check allowed employers to check whether an applicant had a police record which would prevent them from working with vulnerable people. Written references were obtained from previous employers and validated to ensure they were authentic.

When a new care package was set up an assessment of any risks was carried out. This assessment was either undertaken prior to the service commencing or during the first visit. An environmental risk assessment was undertaken of the person's home to ensure it was a safe place for the care staff to work and also to identify risks for the person. Care staff were expected to report any health and safety concerns they identified when they visited people. This reduced or eliminated the chances of accidents, incidences or

near-misses. There was a process in place to report any accidents or incidents and care staff were expected to follow this. Where people were assisted by the care staff to move and transfer from one place to another their support plan stated the specific equipment to be used and the number of care staff required to undertake the tasks. All risk assessments were reviewed on at least an annual basis.

The service had a business continuity plan in place. This set out emergency contact telephone numbers and the on- call arrangements for senior managers. Because all records relating to the running of the service were maintained electronically, managers were able to access information remotely if need be. The service could be relocated to another nearby branch office if required.

The service only considered providing care and support to new people when they had the capacity to meet the person's needs. At the time of the inspection the staff team consisted of a manager, one care coordinator, two field care supervisors and a team of care staff. The field care supervisors had some office based time but also covered visits out in the community to people being supported. The service had an on-going recruitment process in place.

The service had a medicines policy and this was reviewed every 12 months, next due in December 2016. This stated that care staff had to be trained to administer medicines safely and had to be informed what they could and couldn't do for each person. Care staff were expected to contact the office if they had any concerns about medicine procedures. Because of the measures in place we found that people were protected against the risks associated with medicines.

If a person needed help with taking medicines, an assessment was carried out to determine the level of support required. As a result the provider identified three levels of assistance People were provided with level one general support (prompting or reminding), level two support (actual administration) or level three, (higher level medicines or specialist tasks). The level of support they needed was agreed and the person gave their written consent as part of the overall agreement to care. Care staff received administration of medicines training followed by spot checks (competency assessments) to ensure medicines were administered safely. Care staff we spoke with confirmed that training and competency assessments had been carried out. They completed a medicine administration record after medicines had been given – these were returned to the office on a monthly basis and checked for completeness. Because of the measures in place we found that people were protected against the risks associated with medicines.

Good

Is the service effective?

Our findings

People completed questionnaires prior to our inspection. Of those people who returned a questionnaire, 27 of the 29 said they received care and support from familiar and consistent care staff. Twenty eight said they would recommend the service to another person and 29 said their carers arrived on time. People were also asked about whether they felt the staff were well trained, stayed for the agreed length of time and all the tasks were completed properly. These questions were also met with positive answers. Relatives or friends who completed the questionnaires either agreed or strongly agreed that the service was effective.

People we spoke with during the inspection said, "I have a regular carer and one other. They are fantastic", "I make decisions about where I want to go when we go out shopping", "They will take me to the doctors if I need them to" and, "They do all the things that I ask and I told the boss that I needed help with".

Those care staff we spoke with talked about the people they supported and were knowledgeable about their individual preferences and daily routines. One member of staff said, "I mainly go to the same people but if I had never been to a person before I would look at their care plan to find out what I have to do". From speaking with the staff it was evident that people were generally looked after by staff who were familiar with their needs. One community care professional told us that over the summer time the service had experienced some difficulty in maintained consistency of care staff holiday period.

People were supported by care staff who were appropriately trained and able to fulfil their role. The induction training programme incorporated interactive three day classroom based training, shadowing with an experienced member of staff and a series of online training modules. For new-to-care employees the induction programme met the Care Certificate. The Care Certificate was introduced for all health and social care providers on 1 April 2015 and consists of 15 modules to complete. All modules were expected to be completed within the first three months of employment.

There was a programme of on-going training for all care staff to complete and update after specified periods of time. Some training had to be repeated on a yearly basis, others every two or three years. Examples of training included moving and handling, health & safety, basic food hygiene, administration of medicines, abuse awareness and basic infection control. The service maintained an electronic training record for each member of staff. Care staff were offered the opportunity to undertake level two health and social care qualifications after six months working for the service. They complete QCF level two training, formerly called a National Vocational Qualification (NVQ)).

Care staff were well supported and could contact the office or the on-call person at any time. The on-call was shared by the field care supervisors. Each member of care staff had a minimum of two formal supervision sessions per year plus two 'spot checks' of their work and an annual appraisal. The spot checks of work performance looked at how staff interacted with people, how they worked to the care plan and how they completed the required records. The appraisals were used to discuss work performance and any training and development needs. Regular staff meetings were scheduled on a monthly basis but operational pressures meant these were sometimes held on a quarterly basis. The last team meeting was

held on 17 August 2016. Minutes of the meetings were sent to those care staff who could not attend and this was confirmed by those care staff we met.

During the assessment and setting up of a service, people signed their agreement to the care plan and the service delivery arrangements. A person's ability to give consent was also assessed as part of this process. Care staff gained people's consent before starting to provide care and support. They respected people's rights to be independent and to make their own choices but had an understanding of the need for people to consent to being cared for or supported with tasks. Mental Capacity Act 2005 (MCA) training was covered as part of the mandatory training programme for all staff. The MCA sets out what must be done to make sure the human rights of people who lacked mental capacity to make decisions were protected.

The service had an MCA policy and a Deprivation of Liberty Safeguards (DoLS) policy. Both were kept under review by the senior quality assurance manager and next due in 2017. DoLS legislation does not apply to this service because care staff are providing care and support to people in their own homes and their liberty is not being restricted.

The level of support each person required to eat and drink was determined in their assessment of the support they needed. Where support was to be provided this would be detailed in their care plan. People were provided with support to prepare their meals and drinks and supported to eat their meals where necessary. Any risks associated with eating and drinking, for example poor dietary intake, dehydration or choking was made clear in the plan with details on how to reduce or eliminate that risk. Care staff were expected to report any concerns they had about people's eating and drinking to the care coordinator or healthcare professionals.

People were registered with their own local GP. Care staff may support them to make appointments and arrange for repeat prescriptions as part of their care package. Where health and social care professionals were also involved in the person's community support, the care staff worked alongside them to make sure people were well looked after. Examples included working with community based occupational therapists, physiotherapists and district nurses.

Good

Is the service caring?

Our findings

People said, "(Named member of staff) is very good", "They sit with me a lot and we have a coffee together" and, "I don't want to lose (named member of staff), she is like a friend to me". The majority of people (28 out of 29) who returned the questionnaires we had sent them prior to our inspection said they were introduced to the care staff before they provided care and support. All of them said they were treated with respect and dignity and the care staff were kind and caring. Six relatives or friends strongly agreed or agreed their relative/friend was treated with dignity and respect but three disagreed that care staff were introduced before they provided care and support.

From those care staff we spoke with it was evident they had positive working relationships with the people they supported. We asked the care staff if they would recommend the service to a family member or a friend and we received positive responses each time. One member of staff said, "I think of all the lady's I help as my grandparents and help them as if they were". Care staff were knowledgeable about people preferences and the things they liked. Care staff were expected to treat people as individuals and be respectful at all times.

On the whole people were looked after by the same care staff or the least number of staff as possible. A social care professional told us the service had difficulty in achieving this in the previous couple of months because of staff leave arrangements. This was discussed with the managers during the inspection who stated this summer had been particularly difficult but this had been resolved now. By arranging to place the same care staff with the same people being supported meant they could get to know the person well and would know if they were unwell.

People were involved in the assessment process and had a say in how they wanted to be looked after. They were asked by what name they preferred to be called, what was most important to them and who was most important to their care plan – their circle of support. People were asked what they wanted to achieve from their support package. This was invariably recorded as a wish to remain in their own home with the support they needed. Each person received care and support based upon their specific identified needs.

Good

Is the service responsive?

Our findings

People received the service that was agreed upon when the service was first set up or had been agreed when their care service was reviewed. They said, "Someone came around and asked me what I wanted and we had a little chat at the start", "I have not had a problem with them (Helping Hands). Almost all of them are good but my regular carer she helps me with anything and everything I need" and, "I would talk to my carer if I was unhappy and I have the number for the office if I need to talk to someone else".

Those people who returned the CQC questionnaires were asked whether they were involved in making decisions about their care and support needs, whether they knew how to make a complaint and whether the service responded appropriately to their complaints. Not all respondents said they were involved in decision making (89%). Only 63% knew how to make a complaint and 69% felt the service had responded to any complaints or concerns well. Half of the relatives or friends who responded also did not feel complaints or concerns were responded to well but, they all agreed or strongly agreed the service kept in contact with them and informed them of any changes.

People's care and support needs were assessed by the branch manager or the care coordinator. Where South Gloucestershire Council arranged the provision of the support package for people the service would obtain a copy of the community assessment and other information that was relevant to the person's support package. A care plan and a timetable of support was written and copies of these were kept both in the office (electronically) and also in the person's own home. The care staff were provided with clear instructions of the tasks they were expected to complete each time they visited.

All packages of support were reviewed after a three month period unless needed beforehand. There was then an annual review scheduled which can be brought forward if necessary. This review programme was amended if a person's care and support needs changed and the support provided needed adjustment. This meant people would be provided with the support they needed to remain in their own homes where this was possible.

As well as formal review meetings the field care supervisors completed spot checks and visited people whilst a member of staff was supporting them. These visits had a dual purpose, they were able to assess the member of staffs work performance, the interaction with the person and assess the person's view on how things were going. Telephone quality monitoring calls were made by the quality assurance manager during their review of how the service was performing. These measures ensured people were able to feedback their views about the service they received and make any suggestions.

People were provided with information about the service and this was placed in the service information folder placed in their home. Although some people had told us they did not know how to raise any concerns or complaints, information regarding the procedure was placed in these folders. The service had received five complaints since the beginning of the year. We looked at how two of the complaints were handled and found they had been responded to appropriately. Issues raised in one of the complaints had been discussed at the staff meeting held in August 2016. This evidenced that complaints were taken seriously.

Good

Is the service well-led?

Our findings

People said, "I have been phoned by the manager a few times. She is lovely and asks me how things are", "I get to speak to the office when I need them", "I filled out a survey" and, "Everything runs well, I get the service I expect". One person told us they had never been let down by the service, no visits had been missed and time keeping was generally good.

Those people who returned the CQC questionnaires were asked if they knew who to contact in the service, whether they had been asked for their views about the service and, if they had received information from the service that was clear and easy to understand. Eighty-six % of respondents agreed or strongly agreed they would know who to speak to in the service and had information but only half said they had been asked what they thought about the service provided. All of the relatives/friends knew who to contact in the office.

Helping Hands Chipping Sodbury was one of 20 branches of a family run domiciliary care business, based through England. The manager who will be joining the service in October had experience of running a small domiciliary care service but will be supported by the other nearby branch managers and the head of care.

There was a staffing structure in place, with the different posts having responsibility for elements of the service. The team was led by a manager, currently a manager from another branch and other senior managers were overseeing the service. The care coordinator was responsible for organising the staff rotas, staff supervisions and the call monitoring system which ensures all planned calls were filled. The field care supervisors worked alongside care staff, completed the spot checks and covered shifts.

In the evenings and at weekends there was an on-call system for care staff who needed support and advice if they were dealing with a difficult situation. Staff said the arrangements worked well. The on-call cover was provided by the field care supervisors and they had access to an on-call manager if they needed advice.

The service had a clear vision and a set of core values that all staff were expected to work within. These were to focus on the people being supported, to provide an excellent service every time, to listen and understand people's views and to improve people's lives. The aim of the service was to provide well led, effective support, in a caring and responsive manner which enabled people to remain safely in their own homes. From speaking with the three managers who were present during the inspection and care staff it was evident these values were shared by all.

The provider used a variety of different ways to assess the quality and safety of the service. These ensured the service was meeting it's aims and purpose. All policies and procedures were kept under review by the provider and updated where necessary. An annual survey was undertaken to gather the views and satisfaction rates of people being supported and the care staff. This resulted in a, "You said….We did" report. The customer survey is sent out at the end of September/beginning of October each year and will be closed in the middle of October for analysis of the results. The 2015 survey showed satisfaction rates between 84-100% for people using the service and 85-99% for staff.

Care plans were regularly reviewed with people and any other relevant representatives to ensure they continued to receive a service that met their specific needs. This ensured people received a person centred service. Staff supervisions, spot checks of their work performance, and collation of feedback from people using the service and their relatives was used to identify any areas where improvements could be made. Any complaints, accidents or incidents and safeguarding alerts were recorded and reported upon. Any complaints, accidents or incidents were analysed to look for trends. This enabled the service to make any improvements and prevent similar reoccurrences. A quality assurance manager visited the branch and completed an audit looking at people's records (care plans and risk assessment), staff records (recruitment and training) and any events that had occurred. As a result of these audits the service was rated green, amber or red. Where improvements were identified an action plan was devised and then monitored to ensure remedial actions were made. The frequency of the quality assurance manager's audit were dependent upon the outcome of the audit.

We have not received any notifications since our last inspection. The managers were aware when notifications had to be sent in to CQC. These notifications would tell us about any events that had happened in the service. We use this information to monitor the service and to check how any events had been handled.