Midshires Care Limited

Helping Hands St Albans

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service on 28 May 2016 in response to concerns received at the Care Quality Commission in relation to people's safety and the overall management of the service. We undertook this inspection to check if people were being kept safe, risk assessments were being completed and reviewed and staff knew how to keep people safe. This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Helping Hands St Albans on our website at www.cqc.org.uk.

At the previous inspection on 30 October 2015 we found that the provider was meeting the regulations the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. However at this inspection we found Improvements were required in the two key areas we assessed. We also found breaches in two of the regulations.
Helping Hands St Albans provides personal care and support to up to 80 people living in their own homes including daily visits and a live in service.
There was a new manager in post who was not currently registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

We found that there were some processes in place and risks to people's safety and well-being had been assessed and were kept under annual review. However staff had not always followed the appropriate guidance provided and had undertaken tasks for which they had not been trained and this had caused harm to a person who used the service. We found that actions had been put in place to address the issues of concern and the staff concerned were not working at the service at the time of our inspection. The manager was being supported by the provider and was also working with the local authority to identify priorities and to make improvements to the safety of people who used the service. This included undertaking observed practice, spot checks and individual supervisions to review staff training and development needs. We found that some actions had been taken to start addressing these concerns and mitigate the immediate risks to people but further work was needed to help ensure people's safety and well-being was maintained.

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 consistently safe.

Potential risks to people's health were not always identified and managed safely and effectively.

People were not consistently supported to take their medicines safely by staff.

Safe and effective recruitment practices were followed to ensure staff were suited to work in a care environment.

Sufficient numbers of suitable staff were available to meet people's needs at all times.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems that were in place were ineffective in identifying and managing risks and in the overall monitoring of the services.

People and their relatives and staff gave mixed feedback regarding how the service operated.

The manager had not informed the CQC of significant events in a timely way which meant we could not check that appropriate action had been taken.

Helping Hands St Albans

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 was to check the safety and overall management of the service due to information of concern that had been received by the Care Quality Commission.

This inspection was carried out on the 26 May 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed information we held about the service and requested feedback from local authority commissioning teams and other partner agencies who had knowledge of the service.

During the inspection we spoke with four people who used the service, two relatives and four staff members. We also spoke with a care coordinator and the manager of the service. We looked at care records relating to three people who used the service, reviewed three staff recruitment files along with training records. We looked at other documentation relating to the safety and welfare of people who used the service and quality monitoring processes and audits. We obtained feedback from the local authority and commissioning teams.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 30 October 2015 we found that the provider was meeting the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding people from harm or abuse and risk management. However, at our inspection on 28 May 2016 we found that people were not always protected from the risk of harm as staff had not always followed instructions detailed in care plans and risk assessments. One person had been injured as a result when a staff member cut the person's nails without training and contrary to the instructions in the person's care plan. Staff actions had resulted in the person sustaining cuts to three of their fingers. A risk assessment had not been completed in respect of the nail cutting task.

We found this person's risk assessment relating to skin viability documented that they had fragile skin which was susceptible to skin tears and that they had previously had a pressure ulcer. However there were no instructions for staff to follow on how to reduce the associated risks. Despite having risks identified in multiple areas and requiring the assistance of two care staff for all moving and handling the overall risk level was recorded as low which did not reflect the current level of risk accurately.
Although the manager had subsequently taken action to address the above concerns this person's safety and well-being had been put at risk.

People's care plans included assessments for such areas as moving and handling, the risk of falls, and the administration of medicines. However, we noted that risk assessments were only reviewed annually and we found that people's needs had changed during that time but the changes were not always communicated to the managers by care staff. In addition the risk assessments were in a tick list format with little individualised information to provide guidance for staff to maximise people's safety or independence. For example, a risk assessment stated that a person was at risk of their skin breaking down and that staff were to monitor this. However it did not state the frequency, what was to be monitored, what the risk was or how it could be reduced or removed. This meant that risks to people's safety were not effectively assessed or managed.

The care plan for a further person stated that care staff should check the person had taken their medicines. However we found that although the person had frequently not taken their medicines in line with the prescriber's instructions this was not always reported to the manager to enable them to take appropriate remedial action. This meant that the person was at risk of deterioration in their health and wellbeing because they had not received their prescribed medicines on several occasions. The person did have capacity to make decisions but sometimes made the decision not to take their medicines. We reported our concerns to the local safeguarding authority for investigation.

A further person had been left without their agreed and planned support on at least two occasions and therefore had not been assisted to take their medicines. Additionally the person was assessed as being forgetful and needed encouragement to eat and to drink regularly. This lack of support had put the person at risk of harm. However the person was supported by a family member on both occasions and therefore the risk of harm was mitigated. The incidents were under investigation and the person concerned was no longer receiving support from this service. In addition the provider had introduced a call monitoring system which

alerts office staff if a care called was missed or the care worker has not arrived at the expected time. This was being tested at the time of our inspection.

We found that this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the provider had not ensured that assessments of the risks to people's health and welfare were carried out, mitigated and reviewed when it was required or ensured that medicines were well managed.

The manager told us they were undergoing their induction so were not yet fully aware of their responsibilities to report safeguarding concerns. We also noted that the safeguarding concerns had been reported to CQC by concerned staff rather than by the management of the service. Staff were aware of their responsibilities to safeguard people from abuse and avoidable harm and the staff we spoke with were able to describe what constituted abuse and said that they would escalate any concerns they had. At the time of this inspection there were safeguarding concerns that were being reviewed by the local authority safeguarding team.

Requires Improvement

Is the service well-led?

Our findings

We found that improvements were required to the overall management of the service. The manager had only been in post for two months and had told us they had not yet completed their management induction, but were getting systems and processes in place to help make sure the service was operating effectively. We had received information of concern about the manager's approach and ability to address the concerns raised both in a timely and appropriate way.
Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had not informed the CQC of significant events in a timely way which meant we could not check that appropriate action had been taken.

This was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009 the provider had not notified CQC of events that should have been reported.

People and their relatives told us the care staff were lovely however they felt that the office and management could not always get things right. People and their relatives were aware there was a new manager as they said they had seen recent communication from them. However they did not recall being contacted to inform them of the change in management. Staff told us that they found the office coordinator helpful and approachable and that they felt the new manager had a 'vision' for the service but as it was early days they had not yet seen some of the benefits of any proposed improvements.

There were some systems in place to audit various aspects of the care delivery at the service. These included spot checks, observed practice and individual one to one meetings with staff. However these checks had not been happening regularly and the manager told us they had plans to make these more regular and effective as some of the documents seen did not demonstrate how things were monitored or followed up.

The manager provided us with information which demonstrated that audits were being introduced to check daily care records which included checking that tasks had been completed in accordance with the care plan. In addition the manager had put an action improvement plan together showing the areas of improvement that they were focusing on. This included a review of at least four care plans each month and making them more personalised Other documentation was being reviewed including DNAR (do not attempt resuscitation) this was to make sure these had been reviewed and that staff knew peoples wishes.

Field care supervisor's responsibilities were being reviewed to enable them to review and update care plans and risk assessments when required for example if a change was identified as part of an observation visit they will be required to update the care plans and risk assessments. To audit MAR charts (medication administration records) and put remedial actions in place where these were found to be below the required standards. The introduction of a monthly newsletter for care staff was being introduced and would include information about regulations changes in practice and the sharing of good practice. There will be a monthly branch audit of systems and processes and where any continued shortfalls are identified an 'improvement notice' will be issued giving specific requirements and timescales for improvements to be achieved.

Feedback from staff indicated that meetings were not always happening routinely but more in response to issues that had happened. We saw that although there was a complaints process in place and we were provided with records it was not possible to assess how complaints were concluded or any potential learning outcomes as the records seen were more of a diary entry than a reflection of an end to end process.