Midshires Care Limited

Helping Hands Chester

Inspection report

43a Hoole Road
Chester
Cheshire
CH2 3NH

Tel: 01244439335
Website: www.helpinghands.co.uk

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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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This comprehensive inspection took place between the 18 and the 25 October 2018. It was the first inspection of this service and was announced.

Helping Hands Chester is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older and younger adults some of whom were disabled and some of whom were living with dementia and other age-related conditions.

Not everyone using Helping Hands Chester receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection 42 people were receiving 'personal care' and 20 care staff were employed.

The service did not have a registered manager. 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. A new manager had been employed and was working one day a week. This manager was due to start working at the service full time in January 2019. In the interim the area manager was responsible for the day to day management of the service.

The provider had not ensured their systems for reviewing, monitoring and assessing the quality of the service had always been implemented effectively. Therefore, gaps in records and the fact that some people had experienced missed and late calls had not been identified.

People received their medicines on time. However, the information available to staff about people's medicines was not robust. Therefore, there was a risk that staff would not have the guidance they needed to ensure people received their medicines safely. Risks to people's health and safety had been assessed and action taken to minimise them but people's assessments and care plans had not always been updated and reviewed to reflect changes in their needs. Information was stored securely on password protected computers or in locked cupboards but information had not always been shared securely.

People's spoke highly of the caring nature of staff who they referred to as being patient and kind. However, some people felt the number of different staff that visited them had a negative impact on the continuity of their care.

The provider had an action plan in place to address shortfalls in the quality of the service people were receiving and had sent a letter of apology to everyone who used the service. They were also in the process of reviewing each person's care plan and arranging face to face meetings with people who had raised concerns about the lack of continuity of care or had experienced missed and late calls.

People were supported by staff who had the skills, knowledge and experience required to support people with their care and support needs. Staff knew the people they supported on a regular basis well and were aware of their personal preferences, likes and dislikes. Care plans were in place detailing how people wished to be supported and people and or their representatives were involved in making decisions about their care.

People were supported with their healthcare needs and staff liaised with their GP and other health care professionals as required.

People's privacy and dignity was respected. Staff had a firm understanding of respecting people within their own home and providing them with choice and control. People said the service met their needs and encouraged them to be as independent as possible.

People confirmed they felt safe with the staff. Systems were in place to protect people from abuse and harm and staff acted on any concerns they had. When concerns had been identified these had been passed to the local authority for them to consider under local safeguarding protocols. However, the provider acknowledged that the timings of these referrals needed to improve.

Staff worked in accordance with the principles of the MCA and sought people's consent before delivering care.

We found one area where the provider was not meeting the requirements of the law you can read what action we have 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.

Risks to people's health and safety had not always been kept under review and the procedures for safeguarding people from abuse had not always been followed promptly.

People received their medicines safely but the information available to staff about people's medicines was not robust.

People were supported by staff that had a good understanding of infection control

There were sufficient numbers of safely recruited and suitably qualified staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People's care needs had been assessed and planned for.

People were supported by trained staff.

People were supported to access food and drink of their choice in their homes and assisted where needed to access healthcare services.

Staff gained peoples consent and worked within the principles of the Mental Capacity Act (MCA).

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by kind and caring staff who promoted and protected their dignity but the number of different staff supporting them impacted on their continuity of care.

Information about people had not always been shared securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always have access to up to date accurate information about people's current care needs.

There were processes in place for the management of complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The providers systems for monitoring the quality of the service people received had not been implemented effectively.

The provider was aware of their responsibilities for informing the CQC of notifiable events.

The provider worked with other organisations to keep up to date with current good practice guidelines.

Helping Hands Chester

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place between the 18 and 25 of October 2018. It was completed by one adult social care inspector and was announced. We gave the service one days' notice of the inspection site visit because it is small and we needed to be sure somebody would be in the office.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

The provider had completed 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 any improvements they plan to make. We used all of this information to plan how the inspection should be conducted.

We visited the office location on 18 October 2018 and spoke with the area manager, the providers' head of care for the north, the manager, a member of the providers quality assurance team and two care staff. We reviewed nine people's care records, three staff recruitment records and quality assurance documentation, accident and incident records and policies and procedures.

Following the visit to the office the provider sent us a range of additional information relating to the management of the service including a series of action plans they had implemented, copies of staff meeting minutes and a copy of a letter of apology that had been sent to people who used the service.

Between the 19 October and 25 October, we spoke with 8 people who used the service, five people's relatives or representatives and five members of staff over the phone.

Requires Improvement

Is the service safe?

Our findings

People told us they received their medicines when they needed them. One person commented "They get my medicines out for me and prepare them but I take them myself. They record when I've taken them". Staff who administered medicines had been appropriately trained and medication administration records (MAR) had been completed. However, records about medicines were not all up to date and accurate. Some people's care plans stated that family members managed and administered the person's medicines but the MAR and daily records showed that staff were administering them. People's care plans did not always accurately reflect the medicines that people had been prescribed or provide information about what conditions they were prescribed to treat. One person's medicine had been prescribed 'as required' (PRN) basis but the MAR did not reflect this. We also saw that the balance of medicines in stock or brought forward from the previous month had not always been entered onto the MAR.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an action plan in place to make sure everyone's care plans would be reviewed and updated so they accurately reflected the medicines each person was taking and the support they needed to do this. They had also scheduled all staff to attend medication administration refresher training over the coming weeks.

Despite the shortfalls in records about medicines, staff demonstrated a clear understanding of their roles and responsibility in the safe handling of medicines. For example, one staff member told us when they noticed a person had not been administered their morning medicines they sought advice from a medical professional, recorded and followed the advice they had been given and reported the omission to the office. Another staff member told us they had informed their line manager that a person they visited had been prescribed new medication. Following this the person their relative and a manager had reviewed and updated the care plan to reflect the changes.

People felt safe with the care workers and said that they always stayed for the agreed length of time. One person confirmed care workers arrived on time and commented "If they're a bit late they tag it on at the end so I always get the full time". One person's relative told us "We've not had any problems with timings, maybe five minutes here and there; the traffic can be a problem around here, but nothing to complain about. Overall, we are very happy with them".

Despite the positive feedback most people told us there had been occasions when calls had not taken place as planned because care workers had been running late. In addition, three people, had experienced missed calls which they had not always been given notice of. On most of these occasions people had a family member or other carer who had provided the care or assisted as the 'second' carer. One person had not had anyone to help them but told us they had managed by themselves. The provider had an action plan in place to address this issue however it is an area of practice that needs to improve and be sustained.
Following the inspection, the provider wrote to us to confirm they had consulted with staff about the travel

time allocated between calls and check that their duty rotas matched people's preferences. They also told us a system to monitor calls throughout the day had been implemented and that there had been no further missed or late calls.

There were usually sufficient staff to make sure people received their care calls. A senior member of the management team explained they had arrangements in place to use staff from other branches to cover calls when regular staff were not available to make the call. People and their relatives confirmed this.

There was a range of risk assessments in place to determine risks to people's health and safety including those associated with moving and handling, pressure area care and the environment. When risks had been identified steps had been taken to reduce them. Care workers who visited people on a regular basis were aware of the changes in people's needs and could describe the steps they took to make sure they delivered care safely. People and their relatives told us care workers visiting them for the first time always checked with them what their needs were and that they felt staff delivered care safely.

Staff had access to the equipment they needed to follow safe working practices for example, hoists to transfer people. There were processes in place to ensure staff checked to make sure the equipment they used was safe and had been routinely maintained.

Staff were aware of how to identify, report and escalate suspected abuse. They confirmed they received safeguarding training and knew who they should report any safeguarding concerns to. However, we saw that there had been a two-day delay in one safeguarding concern being reported to management who in turn had not reported the concern to the local authority until four days later. This is an area of practice that needs to improve to ensure that all concerns are reported and can be addressed quickly to protect people.

Staff had completed training in infection control and had access to supplies of personal protective equipment (PPE) such as disposable gloves and aprons. Staff were also supplied with a uniform, identity badge, a work mobile and out of hours emergency contact numbers. Accidents and incidents had been recorded and action taken to minimise the risk of reoccurrence. Management had oversight of accident and incidents and monitored for themes and trends.

Recruitment practices were safe and checks were carried out to make sure staff were able to work with people who needed care and support. An internal recruitment department managed all new staff's recruitment processes, such as the documentation required, references, Disclose and Baring Service (DBS) background check, identity and health checks. Potential staff completed a pre-screening questionnaire prior to being invited for a formal interview.

Good

Is the service effective?

Our findings

People were supported by staff who had been appropriately trained. New staff received an induction to the service which included shadowing experienced staff and completing training before they worked unsupervised. Staff new to care also completed the Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered by staff 'new to care'. Staff had completed had a range of training that included topics such as medication, safeguarding, equality and diversity, fire safety, food safety, mental capacity, moving and handling, dementia and mental health.

There were processes in place for staff to receive regular supervision with their line manager and for an annual appraisal of their performance. Supervision provides staff and their manager with a formal opportunity to discuss their performance, any concerns they have and to plan future training needs. A senior member of the management team explained they had identified gaps for some staff where there were records of the supervision meetings had not been maintained and had scheduled dates for these staff to receive supervision over the next two weeks.

Each person's needs had been assessed prior to care being delivered. Assessments had been undertaken and care plans developed to identify people's health and support needs in conjunction with the person and where appropriate, their relatives. One person told us, "I've got a care plan. It's in a folder where they keep the records they write in. I haven't bothered looking in it but they read it every time". The plans were developed outlining how people's needs were to be met. They detailed task based activities such as assistance with personal care and the support people required. They also included details of people's mental health and information about how people who were living with dementia were affected by their condition.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People were supported to make day to day decisions, such as what they wanted to eat or wear. Staff told us they explained the person's care to them and gained their consent before carrying out any care and support and all the people and relatives that spoken with confirmed that this was the case. One person told us, "They always ask me what I want them to do and how I like things done". Staff told us that people chose how they would like to be cared for; they explained they always asked permission before starting a task and would never make anyone do anything they did not want to do. Staff told us and we saw that care plans included details of whether a person had capacity to make their own decisions. Where people had a representative, who could legally act on their behalf, evidence of this had been obtained for example copies of Power of Attorney documents were held on file.

Where needed, staff provided people with help to access support from health care professionals for example by informing relatives or contacting the persons GP. Staff said they would always notify the manager of any advice given and record this in the daily records. One staff member told us they had been present when one person had been visited by a health care professional and described to us the advice they had been given. They explained the person had been given exercises to do and that they encouraged and helped them to do these. Another staff member described the advice a person had been given by a visiting district nurse and confirmed to us that they made sure they followed this advice.

People's dietary requirements were catered for with the persons full knowledge and involvement. Dietary information was available in their care plan, documentation included information on diabetic needs or intolerances to certain foods. Daily records completed by staff informed what they had provided at meal times. One person told us, "I usually have ready meals, they always ask me what I want and prepare it for me". Another person told us "They make me a sandwich and drinks. They usually know what I like but they always ask first".

Requires Improvement

Is the service caring?

Our findings

Without exception people and their relatives spoke highly of the caring nature of staff describing them as "Very caring", "Very polite" "Understanding" and "Patient". One person told us, "I can't fault them they are wonderful". Another person commented "They are lovely girls; they do everything as I like it". A relative told us "We'd be lost without them. Great service so far".

Despite the positive feedback about staff, people felt the service was not always caring. This was because the number of different staff delivering their care was having a negative impact on the continuity of their care. Some people told us the continuity of care had been good when they first started using the service but over recent months this had deteriorated. They told us they had been visited by different care workers most weeks, some of whom had travelled from other branches to cover the call and never visited them again. Whilst these people were happy the call had taken place they said they would prefer to be visited by care workers they knew so they did not have to keep explaining where things were and how they liked their care to be delivered. People said they had raised their concerns with the office staff but had not seen any improvement. One relative explained it took time for their loved one to build relationships with staff and trust them enough to allow them to assist them, for example to stand. They said they also felt embarrassed to be supported with their personal care when it was provided by staff they had not met before. Although the provider had an action plan to address this issue and was meeting with each person to gain their views, it is an area of practice that needs to improve and be sustained.

A member of the senior management team acknowledged that there had been an issue at the service with the management and oversight of staff duty rota. They sent us a copy of a letter of apology that had been written to everyone who used the service. They also sent us evidence to show that all staff had been asked to submit a form detailing their hours of availability and confirming they were undertaking a full review of people's care needs and staff duty rotas. To reduce the number of different staff visiting some people, their care packages had been given to another branch of Helping Hands that could provide better continuity of staff.
Following the inspection, the provider told us specific carers had been allocated to complete calls to individuals. They sent us evidence to show that the impact of this was that the number of different carers visiting people had reduced.

People's private information had not always been shared confidentially. People's care plans were stored in people's homes and on a password protected computer in the office. However, care staff told us that they also been using their mobile phones to share information about people's needs. This method of communicating and sharing information about people was not secure and had not been agreed and approved by the provider. A senior member of the management team told us they had stopped staff communicating and sharing information in this way as soon as they found out about it and told us they had raised the issue with the Information Communication Office (ICO) to establish whether there had been a breach of the General Data Protection Regulation (GDPR). Whilst it is recognised the provider has taken appropriate action to prevent this happening again it is an area of practice that needs to be improved and sustained.

People told us they were always treated with dignity and respect by staff. Staff had a good knowledge of the people they were providing care and support for on a regular basis and could describe to us people's personality, likes and dislikes. Staff told us how they protected people's privacy when delivering care for example by covering people with towels and making sure curtains were shut.

People told us that in their opinion the staff helped them in any way possible with some going above and beyond what was expected of them. Staff told us they enjoyed their work. One commented "I love my job. I love caring for people and doing the little things that make a difference to their day". Another staff member told us "I've not done care before and didn't know if I'd like it but it's the best thing I've ever done. I love it and love my customers".

People told us they were aware of the records kept at their homes and had agreed for the care plans and assessments to be in place. The service had a service user guide in place that gave people a good range of general information regarding the service that was provided including equal opportunities, promoting independence and their health and well-being. There was also information about support to access advocacy services and the providers philosophy of care, principles and values.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to peoples changing needs. People's care plans had not always been reviewed and information updated to reflect changes that had taken place. For example, one person's care plans stated they were continent but the daily records showed staff were supporting the person to use continence aids. It was evident from another person's daily records that the person's dementia had advanced since they started using the service but their care plan had not been updated to reflect this.

The above evidence further demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider wrote to us to confirm that every person whose care plan had been identified as needing a review, was now up to date. They also told us they had a plan in place to ensure all care plan reviews would take place when due or as soon as a change in care needs was identified.

Most people's care plans were up to date and reflected their physical, mental, emotional and social needs, personal history, individual preferences, interests and aspirations. For example, they detailed people's previous job roles, their family members and their contact details, how people liked to spend their time, whether they preferred a bath or a shower, and how they liked their care to be delivered. People, their relatives and representatives confirmed they had been visited on occasions by managers to discuss their care, ask if they remained satisfied and whether they would like any changes made.

People were supported to remain independent. In one care plan it detailed how staff assisted a person to take a shower clearly stated what the person could do for themselves and how best to support the person. For example, 'Put the shower gel in my left hand'. In another care plan it described how the person wanted to be supported and that the person needed 'a lot of encouragement'. A relative commented that staff always encouraged their loved one to do as much as they could for themselves.

The provider had a clear written complaints policy and this was included in the information pack given to people when they started using the service. Most people told us they knew who to complain and those that didn't told us they would ring the office if they wanted to complain. There was a complaints log in place and this confirmed that the complaints that had been recorded had been responded to appropriately.

Care staff that visited people on a regular basis knew them well and were responsive to their changing needs. Thee staff told us they would report any changes in their condition to their line manager to request a review of the persons care needs and in some cases, they would also inform the person's family. Staff told us that they felt they could support people with the time that was allowed for each call. If they felt there was not enough time they would raise this concern with their line manager to request a review of the person's care or suggest an additional call.

People's communication needs had been assessed and planned for. Each person's care plan included details of how they communicated. Relatives of people who were not able to speak to us commented that

care staff communicated well with their loved ones. One care staff told us they supported one person who was unable to speak but explained they had got to know them well and could understand from their eye movements and expression what they wanted and how they were feeling. Another member of staff told us they had written out the office contact details in large writing for a person with a sight impairment. The provider had processes in place to provide information to people in formats accessible to them upon request however none of the people we spoke with had requested this be provided.

People told us that care staff completed a daily record at each visit. We saw these daily records were detailed and described the care that had been given and how the person was feeling. Staff knew how to obtain help or advice if they needed it and one member of staff told us, "Someone is always on the end of the phone, we have an out of office hour's number to call for assistance".

A senior member of the management team told us they were not providing anyone with end of life care but that they would work with the relevant healthcare professionals to provide the right level of care should the need arise. They also explained the provider employed a range of healthcare professionals whose area of expertise included end of life care that they could go to for advice and could provide staff training. Where people had expressed a preference for whether they wanted to be resuscitated in the event of a heart attack a Do Not Attempt Resuscitation Record (DNARR) had been obtained and stored within the persons care plan.

Requires Improvement

Is the service well-led?

Our findings

People who had been using the service for more than a year told us the service used to be very reliable but that things had deteriorated over the last six months. One person told us "It used to be fantastic and I recommended it to many people but I wouldn't now". Another person said, "The girls are great no complaints there but the organisational side has been a bit chaotic".

The providers system for monitoring the quality of the service had not always been effective in identifying areas that needed to improve. Therefore, prompt action had not been taken to address people's concerns about the lack of continuity of care, care plans being out of date, missed and late calls, the frequency that some staff had received supervision and the inappropriate sharing of peoples private and confidential information.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A senior member of the management team told us the registered manager no longer worked at the service and had left their employment at the beginning of October 2018 but a new manager had been appointed. The new manager had previously worked at the service as a care co-ordinator and had a good understanding of the service and of people's needs. They told us they were currently working one day a week and would start full time in January 2018. In the interim the area manager was overseeing the day to day management of the service with support of the office staff. The providers' head of care for the north was also overseeing the service and supporting the area manager.

A member of the senior management team acknowledged that there had been an issue with the management and oversight of the service. They explained they had been aware of some of the concerns through customer and staff satisfaction surveys and their own quality assurance monitoring systems but had not been aware of all the shortfalls, some of which had only just come to light. They told us the provider had a system for checking that people received a good standard of care and staff followed the providers policies and procedures. However, they had identified that some of the checks that should have taken place hadn't. For example, dates had been inputted onto the providers system indicating that people's care plans had been reviewed and updated and for when staff had received supervision but these had not always taken place. They told us that it was company policy that people's daily records and MAR were to be brought back to the office and checked every month but that these checks had not always taken place and the checks that had taken place had not always been robust. Therefore, issues such as late and missed calls had not always been identified and flagged to senior management so they could take corrective action.

Following the inspection, the provider sent us a series of action plans detailing the action they had taken and were planning to take to ensure people were receiving safe effective care that was responsive to their needs. These included a full audit of all daily records and cross checking them with the care plan to identify any anomalies, meeting with each person who received a service to review their care and a review of the staff duty rotas. They had also held a staff meeting at which they had apologised to staff and invited them to

raise any concerns they had. They told us the shortfalls identified at the service had been passed to the executive team and the organisation would take learning from the gaps they had identified in their own systems. The provider told us all actions on their action plan had been completed by the end of November 2018.

The provider had systems in place for managers to get together to learn from each other and share good practice by way of meetings and corporate events. Although over the last six months staff meetings had not always taken place regularly, a new schedule of meetings had been implemented and two meetings had taken place. Staff told us they felt reassured by the information shared with them at these meetings and the changes planned. One staff member told us "I'm more confident now that things are going to get back on track". Another staff member tod us "I love my job and do believe they are listening".

The area manager was aware of the duty of candour and was in the process of setting up face to face meetings with each person that had raised concerns about their care or had experienced any missed or late calls. They were also aware of their responsibilities to inform the CQC of notifiable events by way of statutory notifications the majority of which had been submitted without delay.

The provider worked in partnership with other organisations to produce information for people who used the service and staff covering subjects such as supporting people living with dementia, acquired brain injuries, strokes, nutrition and hydration. The provider also had a team of clinical specialist on whom managers could go to for advice and who could provide staff with specialist training such as end of life care should the need arise.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems they had in place for the monitoring the quality of the service were effective in identifying shortfalls in records and driving improvement.