

Here to Care Limited

Here2Care (Dartford)

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

About the service

Here2Care (Dartford) is a domiciliary care agency providing personal care and support to people in their own homes in Dartford, Gravesend and surrounding areas. Here2Care (Dartford) also provide support to people living in Extra Care Housing. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of inspection there were 187 people using the service, of which, 175 people received support with personal care. This included twenty people living in an Extra Care Housing, including older people, people who live with dementia and people with a physical disability.

People's experience of using this service and what we found

Feedback from people and relatives was positive. People told us they, "Felt safe and had good relationships with the staff that visit them." One relative told us, "I have had no worries at all during the Covid-19 pandemic that my [relative] has not been safe." And, "My [relative] is never rushed and the [staff] are all so kind to him."

People were protected from the risk of abuse, with staff able to recognise the signs and different types and knew what actions to take to keep people safe. Concerns were raised when needed with guidance in place to manage this effectively. People were supported with their medicines as prescribed and staff competency was checked to ensure they knew how to complete this safely. There were adequate numbers of staff to ensure people's needs were met and the provider had safe recruitment procedures in place. There was clear oversight of accident and incidents, when these had occurred, action was taken to reduce any risk of reoccurrence. Staff ensured risks of infection to people were minimised.

Feedback from staff and people was actively sought and analysed. There was a clear and open culture of learning from past mistakes and concerns.

Quality monitoring systems had improved and where issues were identified they were acted upon. The service is using a new electronic call monitoring system to reduce the risk of any missed or severely delayed care visits. The service worked in partnership with other agencies to provide good outcomes for people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was Requires Improvement (published 7 February 2020) and there were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected

We carried out an announced inspection of this service on 5 November 2020. At last inspection there were three breaches of regulation in relation to Safe care and treatment (Regulation 12) Staffing (Regulation 18) and Good Governance (Regulation 17) The provider completed an action plan after the last inspection to show what they would do and by when they would improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Requires Improvement to Good. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Here2Care (Dartford) on our website at www.cqc.org.uk

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Details are in our safe findings below.

Good ●

Is the service well-led?

The service was well-led.

Details are in our well-Led findings below.

Good ●

Here2Care (Dartford)

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

Two inspectors carried out this inspection with an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. This service also provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service did not have a manager registered with the CQC. However, a new manager was in process of registering. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection site visit took place on 5 November 2020. We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection. Inspection activity started on 5 November 2020 and was completed on 10 November 2020.

What we did before the inspection

We reviewed information we had received about the service. We received positive feedback from the local

authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection

We spoke with six members of staff including the manager, survey coordinator, client services support manager, care advisor and two care staff. We spoke with 10 people and six relatives on the telephone to gain their views of the quality of the service. We reviewed a range of records. This included six people's care records and medication records. We looked at three staff files in relation to recruitment. We also looked at a variety of records relating to the management of the service including compliments and complaints, electronic call monitoring system audits and spot checks of care staff.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now Good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. Risk assessments were not updated and there were not always risk management plans in place. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- People's care and support needs were assessed and regularly reviewed. There was guidance in place to enable staff to manage risks safely. Any new issues identified were actioned by the manager. This was so any emerging risks were actioned in a timely manner.
- Improvements had been made in the management of risk. For example, staff understood when people were at risk of skin breakdown or developing pressure sores. Where there were concerns these were reported and acted upon appropriately.
- People we spoke with stated they felt safe with the care staff. People's relatives told us they felt confident that their family member(s) were being kept safe at all times.
- Staff we spoke with were able to describe the risks to people and what they did to keep people safe. For example, how to manage anyone at risk of choking. Staff sought medical professional support when this was needed.

Staffing and recruitment

At our last inspection the provider had failed to ensure staff were effectively deployed. There was not robust oversight in the deployment of staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

- There were enough staff to deliver care to the people using the service.
- The majority of feedback was that people received calls at the time they were expected. People said they had not had any calls missed. One person told us, "I couldn't be happier with anything. I am never rushed, and the [staff] have plenty of time to do everything I need." Another person told us, "My calls are usually on

time and if they are going to be late, I always get a call to tell me."

- Following the last inspection there had been improvements. There was an electronic call monitoring system in place. Office staff were employed to have continued oversight of this, ensuring calls were completed on time. The electronic call monitoring system was also used to communicate changes to people's care in 'real-time' to staff. This helped staff respond to changes to people's needs promptly.
- Recruitment practices made sure the right staff were recruited to keep people safe. Checks on new staff include obtaining an applicant's full employment history, references, and a Disclosure and Barring Service (DBS) check. The DBS assist employers to complete safe recruitment and helps prevent unsuitable staff from working with people who require care and support.

Using medicines safely

At our last inspection it was found that medicines were not safely managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- People received their medicines as prescribed. The service had improved since last inspection, by employing a 'care mentor' who had oversight for the management of medicines. The care mentor investigated any medicine errors and completed medicine audits, allowing mistakes to be identified and actions to be taken to keep people safe.
- Medication Administration Records (MARs) were complete and accurate. There was information on what people's medicines were for and how they wanted to be supported to take them.
- Medical advice was sought if there were any medicines errors and appropriate actions taken to minimise any reoccurrence.
- Staff had completed mandatory medicines training and their competency was checked regularly. The manager told us that staff received specific medicines training for any person using the service who had individual medicine needs. For example, staff were trained by health professionals to enable a person to remain at home and avoid visits to hospital for these medicines.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. People told us they felt very safe with the care staff. Relatives said they were confident their family members were always kept safe.
- Staff continued to recognise the signs of potential harm or abuse to people and raised concerns when needed. Concerns were raised to the manager and local authority appropriately.
- Staff had a proactive approach in reporting concerns so immediate action could be taken to keep people safe. Staff kept in contact with the person they reported the concern to, to ensure they were addressed, and the person being kept free from harm.
- Staff knew how to follow the service's whistle blowing policy and how to contact CQC if they did not feel they were being listened to.

Preventing and controlling infection

- People were protected from the risk of the spread of infection.
- Personal protective equipment (PPE) was provided to staff by the provider to ensure staff were protecting themselves and people using the service from infection.
- Staff had completed mandatory infection control training, and this had been updated to reflect the current COVID-19 guidelines. Staff training was delivered via video conferencing to ensure staff receive the

most up to date guidance as well as maintaining recommended social distancing.

- The service had completed random 'spot checks' on staff delivering care and support to ensure staff were following updated COVID-19 guidelines and wearing correct PPE.

Learning lessons when things go wrong

- The manager was open and honest about learning from past mistakes, complaints, incidents, accidents and other significant events.
- There was clear oversight of accidents and incidents. Action was taken quickly to address any shortfalls. For example, when a person's medicine was given incorrectly, the GP and pharmacy were contacted promptly and medical advice acted on. Staff had completed refresher training on medicines to ensure they had the skills and knowledge to do so competently.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff were clear about their roles, and understood the importance of quality, performance, risks and regulatory requirements to ensure people received safe care.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- At the last inspection quality monitoring systems had not been fully effective in highlighting shortfalls in service provision. The provider had followed their action plan and made improvements with regards to the management of risks, deployment of staff and oversight of the service. For example, changes had been made to peoples' care plans. Potential risks to people had been clearly assessed together with actions for staff to take to help keep people safe.
- The manager was active in all aspects of running the service. They knew staff and people who used the service well. A relative of a person using the service told us, "I do think it's well managed. We have regular carers and if anyone is off, we get a call from the office to let us know."
- Staff were motivated and had confidence in the management team. There were clear management and reporting structures in place and staff understood their roles and responsibilities
- The manager understood their responsibility to notify CQC about any events or incidents such as abuse, serious injuries and deaths in line with regulatory requirements and ensured that their rating was appropriately displayed in the service and on their website.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The manager understood the need to be open and honest and these values had been cascaded down and were understood by the staff team. Staff knew people's individual care needs, likes and dislikes in order to be able to provide personalised care.
 - People said they would recommend the service. One person told us, "I would recommend them as everyone is so nice and they all know what is going on, on a daily basis."
- A person's relative told us, "We had a couple of problems at the start with who was coming and at what time, but I rang the office and they couldn't have been more helpful."

- Complaints had been investigated and actions taken, and apologies offered when things had not gone as well as they could have done.
- The service had a duty of candour policy which outlined how they should respond where things had gone wrong. Where things had gone wrong action was taken appropriately.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were contacted every three months to review the support they received and to feedback on anything they feel should be improved or changed. Feedback was mainly positive. People were able to contact the office staff at any time to raise concerns or to give feedback.
- One person told us, "I receive a wonderful service; the [staff] are all so kind and they seem to really care about me."
- Staff were involved and engaged in the running of the service with regular supervisions to gain their views and suggestions on improvements or changes. Staff told us their views were listened to and acted upon.
- People told us that telephone contact with the service had increased through the pandemic. People were happy about this and told us it made them feel as though the service really cares about their wellbeing.

Continuous learning and improving care

- Since the last inspection, the manager had implemented a programme of audits and checks on records in relation to the care that people received, to help improve the quality of the service provided.
- The manager had good oversight and knowledge of how the service was operating. The management team understood the importance of communicating effectively and improving people's care outcomes by keeping up with best practice and developments. The manager networked with other providers through local authority forums to share learning and keep up to date.
- The manager kept up to date with legislation and changes in practices through training and accessing relevant articles and websites.

Working in partnership with others

- The service worked in partnership with health care professionals such as occupational therapists. One professional fed back to the service that care staff had "worked fantastically with [person's name]. They had worked really well together to ensure all tasks were completed efficiently."
- Strong links had been developed and maintained with local authority case workers, district nurses and specialist services such as hospice care. For example, the service had worked jointly with health professionals to assist a person to remain at home rather than be admitted to hospital.