Surrey Helping Hands Limited

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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

About the service
Surrey Helping Hands is a domiciliary care agency that provides personal care to people in their own homes in the West Surrey area. People who receive a service include those living with frailty, mobility needs and health conditions including dementia. At the time of our inspection the service provided personal care to 42 people.

People's experience of using this service and what we found
Assessments were not always undertaken to identify risks to people to protect them from harm. The management of medicines required improvement particularly around recording. However, people did say they received their medicines when needed. Accidents and incidents were not always recorded appropriately or analysed.

Quality assurance was not always effective. Where shortfalls had been identified with staff this had not been addressed robustly. Staff were not given travel time in between calls which meant they were not always staying for the full length of the call. However, people, relatives and staff were complimentary of the management team.

People told us that they felt safe with staff and that staff followed good infection control procedures. Staff underwent a robust recruitment process before they started work.

Rating at last inspection
The last rating for this service was Good (published 17 November 2017).

Why we inspected
We received concerns in relation to the missed calls and the safe delivery of medicines. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Surrey Helping Hands Limited on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risks related to the care being provided to people, the management of medicines, incident and accident reporting and the lack of robust provider and management quality assurance at this inspection.

For requirement actions of enforcement which we are able to publish at the time of the report being published. Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Surrey Helping Hands Limited

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
Our inspection was completed by one inspector on site and a second inspector who sought feedback from people by phone.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-
We called and spoke with three people who used the service about their experience of the care provided. We spoke with eight members of staff including the registered manager, office staff and care staff.

We reviewed a range of records. This included five people's care records and multiple medication records. We reviewed a variety of records relating to the management of the service including three staff recruitment files and audits of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We received feedback from a further two people after the inspection.

Requires Improvement

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 Good. At this inspection this key question has deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

- People told us they felt staff understood the risks associated with their care. One person told us, "I have difficulty in doing some things and they make sure I am well supported." Another told us, "She (carer) does a very thorough job and is always very careful with me." A third said, "They put cream on my legs, and they are gentle and make sure it's not sore for me."
- However appropriate assessments of risks were not always undertaken to identify risks to people to protect them from harm. For example, the registered manager told us that one person smoked. There was no risk assessment that related to the risks associated with this. Another person had an assessment in their care plan from the local authority. It stated they were at risk of falls and required a walking aid. However, the risk assessment undertaken by the provider stated they were, "Independent" with walking.
- There were generic 'Risk Management plans' in the care plans. However, for one person the environmental risks had not been assessed and the form had been left blank.
- Where a change had occurred relating to a person's risks this was not always updated in their care plan. For example, staff told us that a person was now cared for in bed and their skin integrity was at high risk of breakdown. The person had developed a pressure sore as a result of this. However, their risk assessment had not been updated to reflect this. Instead it still referred to the person being hoisted into their chair each morning.
- Staff were able to describe what they needed to do if an accident or incident occurred. However, the systems in place did not ensure that accidents and incidents were followed up to reduce further risks.
- During our interviews with staff they made us aware of incidents they had responded to in people's homes. One person had fallen in their home. Whilst staff had responded appropriately, the person's care plan was not updated to reflect this risk in order to put in place measures to reduce the risk of future falls.
- Accidents and incidents were not always recorded centrally or appropriately analysed by the registered manager. We were aware of two separate incidents of falls that been reported to office staff, but accident forms had not been completed for them. There was no formal analysis of incidents to identify and learn from patterns and trends.
- People told us that they received their medicines. One told us, "Staff give me the medication in the morning, and they make sure I have taken it properly." Another told us, "I know what I am having (medicine)and if I ask, they explain and remind me what they are for."
- However, there were insufficient systems in place to ensure the safe recording and administration of medicines. People's medicine administration records (MARs) did not include information around the person's GP, allergy information or how they preferred to take their medicine. The MARs were handwritten but not signed or countersigned to ensure their accuracy.

● Where people required 'as and when' (PRN) medicine there was no guidance for staff on when this needed to be offered to the person. People's MAR did not contain information on how the person needed to take their medicine or what form the medicine was in for example, liquid or tablet.
● There were different codes used including one for prompting and observing a person taking their medicines once they were given. However, it was difficult to decipher what staff had written to determine whether people were refusing or just did not have the medicine on that occasion. We showed this to a member of the office team who reviewed MAR charts. They also had difficulty understanding what had been recorded. This meant they may not follow up on concerns if a person had been regularly refusing their medicine.
● Although staff received online medicine training there was no formal process of assessing their competency to administer medicines safely.

The failure to always manage risks associated with people's care in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse
● People said they felt safe with staff when they visited them in their homes. One person said, "I feel safe. They (staff) are very good." Another told us, "I have a key box by the front door. She (the carer) opens the door and calls out, so I know it's her."
● Staff understood what constituted abuse and what they needed to do if they had a concern that abuse may be taking place. One member of staff said, "It is making sure clients are protected, making sure nobody is taking advantage. I would report it straight away. I would report to the office and take it from there."
● Staff received safeguarding training and there was a whistleblowing policy that staff could access if they needed to.

Staffing and recruitment
● People and relatives told us that the calls had not been missed and if staff were running late, they would be contacted by a member of staff at the office. One person told us, "Oh yes, they arrive when they say and if she (carer) is going to be late, she will let me know." Another told us, "I get told who is due to attend and I know who to expect."
● A member of the office staff told us in the event of sickness or absence from work this would be covered by r either a member of the bank staff or trained care staff from the office. There had not been any missed calls at the service.
● Staff fed back that there were sufficient numbers of staff to cover the calls. Comments included, "I think there is enough staff as work is a bit slower" and, "I don't have pressure put on me to do extra calls."
● The provider operated effective and safe recruitment practices when employing new staff. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Preventing and controlling infection
● People and relatives told us that staff adhered to good infection control. One person said, "They come in wearing their masks and gloves and always wash their hands."
● Staff understood what they needed to do to ensure that people were protected from the risk of infection spreading. One member of staff told us, "I did the online (Infection Prevention Control) training. We use a lot more PPE (Personal Protective Equipment). We were given information from the office." Another said, "When I arrive, I would put gloves and apron on before I go in. I wear foot covers, visor, apron, mask and arm covers and dispose of them all in a bag."

● Staff were provided with adequate stocks of PPE and were able to get additional from the office if needed. Staff also did weekly COVID-19 tests to and provided the results to the office to record.

Requires Improvement

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 remained Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- At the previous inspection we recommended the provider put systems in place to monitor when staff had arrived at calls. Staff were now texting to a dedicated mobile to say they had arrived. which was being monitored by the registered manager. However, there was a lack of systems in place to monitor whether staff were staying for the duration of the call. We identified instances where staff had not stayed for the full length of the call. The registered manager told us they were introducing an electronic system so that staff would scan to say when they had arrived at a call and when they had left. However, this had been raised as a concern at the previous inspection and still had not been addressed.
- Audits of care were not always consistent and did not always identify shortfalls. For example, there was no formal recording of care plans to ensure they had the most accurate information around people's up to date risks. Audits of medicines were not always effective in ensuring that where shortfalls were identified these were addressed.
- Staff told us that they were not given travel times between calls. They said that this, at times, resulted in them either starting calls early or leaving a call when their tasks had been completed.
- People fed back they were not always informed who their carer would be. One told us, "Usually at the weekend I am not told who is coming and I don't know who to expect. I don't always feel mentally prepared or relaxed. I would appreciate this as an improvement." Another told us, "I know what time they are due to come but I am never sure of who will be coming." The registered manager told us they would not routinely tell a person if their carer was not the usual member of staff. They told us they would address this.

As quality checks were not robust this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- However, people and relatives were complimentary about the leadership at the service. One person told us, "They have a team and they are always polite."
- Staff fed back that they felt the management team were supportive. Comments included, "(The registered manager) is great and the girls. I get on alright with them", "I personally cannot fault them. They are very good and fair" and, "Its family orientated. Nothing to improve. If you have a problem its sorted."
- People and their families had contacted the service to express their thanks for the care that had been delivered. Comments included, "Please would you pass on my thanks. I could not have managed without them (carers)", "They are always willing to help with any problems that occur" and, "Carers are friendly and

understanding."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● People fed back that they were able to speak to their carer about how they felt about their care and anything they wanted to improve upon. One person said, "We always talk about my care and what other bits I could think about. I know if I need to change something or do something differently then this would be respected." Another told us, "I talk to my carer about anything and if something needs changing then she sorts this for me, and I trust her." A third said, "It's always two way and they are happy to adapt to me each day depending on what I need."

● Annual surveys were sent to people and the families to ask them about the quality of care. We saw from the most recent survey that the majority of comments were positive. The only concern raised was around people not always being contacted when the carer was going to be late. The registered manager told us they would now ensure that people were contacted if this happened and people we spoke with confirmed this.

● Staff morale was good, and staff told us they that felt valued. Comments from them included, "They ask me questions and listen to me." Another said, "If I have any concerns they will act."

● Although meetings had not taken place during the COVID-19 pandemic staff told us they were regularly contacted on a staff telephone chat group. They were also sent regular memos from the service to keep them updated of any changes. However, the provider was looking to start meetings again either face to face or via a video call.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events including incidents and safeguarding concerns.

● Records showed that people and their families had been contacted when things had gone wrong.

● The provider and registered manager worked with external organisations that regularly supported the service. Where a concern about a person was identified the provider and staff would contact health and social care professionals. One member of staff told us they had noticed a sore develop on a person's skin. They told us they had contacted the district nurse who was now regularly visiting the person. We confirmed this from the person's records.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that risks associated with people's care and medicines were managed in a safe way.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there was robust quality assurance processes in place.