Caring Heart and Hands Ltd

Caring Heart and Hands LTD

Inspection report

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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

This inspection took place on 25 May and 1 June 2018, and was announced. This was the service's first comprehensive inspection since it was registered in January 2017.

Caring Heart and Hands LTD 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 adults and younger disabled adults. There were 33 people using the service at the time of the inspection.

Not everyone using Caring Heart and Hands LTD receives 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.

There was a registered manager in post at the time of the inspection. 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.

People told us they felt safe. Staff received training in safeguarding vulnerable adults and were able to describe how they would do so in practice. There were enough staff to meet people's needs, and staff had been recruited safely. People told us staff were generally on time for their care visits.

Medicines were managed safely. Staff were trained in this topic and people told us they received their medicines on time. Guidance for staff on what medicines people required and why they needed them was clear, for example medicines that were 'as and when required' or 'PRN' as this is also known.

Risks to people were appropriately assessed and personalised to reflect how risks presented to each person and what staff needed to do to make sure people were safe. Accidents and incidents were recorded and investigated appropriately. There was a business continuity plan in place to guide staff on how to act in the event of a significant disruption to the service.

Staff were trained in preventing infections and there were large stocks of personal protective equipment available. Spot checks conducted by senior staff ensured this was used during visits.

New staff received a thorough induction which included training the provider considered to be mandatory as well as joining shifts with experienced staff before they were allowed to work with vulnerable people. Staff were supported with supervisions and appraisals which staff we spoke with told us were useful. Staff were able to access training relevant to people's needs if necessary.

People were supported to eat and drink enough to maintain a healthy lifestyle, and people told us the service was proactive in helping them access healthcare professionals when needed.

People and their relatives we spoke with said staff were kind, caring and compassionate. People were supported to maintain their independence, and staff were able to describe how they ensured people's dignity and privacy was maintained.

Care plans were detailed and person centred. People's needs were appropriately assessed before using the service. Care plans were reviewed regularly and in response to changing circumstances.

There was a complaints process in place, and people knew how to raise complaints. People we spoke with were confident they could raise issues and that they would be resolved.

There was a clear vision for the future of the service and both staff and people who used the service were kept informed of this. Staff told us they were confident in the leadership of the service and they felt there was a positive culture.

There were quality assurance processes in place. This included audits and data analysis. Quality assurance processes ensured issues could be identified and tracked until they were resolved in order to drive improvements.

The service engaged with people through newsletters, questionnaires and during spot checks to assess staff practice. The service acted upon feedback it received through action plans.

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 and staff told us there were enough staff to meet people's needs effectively and staff were recruited safely.

Medicines were managed safely by trained staff and guidance for staff was clear.

Risks to people were assessed appropriately and in a person-centred way. Staff received training in preventing infections and compliance with infection prevention measures was monitored through spot checks.

Is the service effective?

Good

The service was effective.

Staff were adequately trained to deliver care and were supported with supervisions, appraisals and spot checks. New staff received a comprehensive induction. Staff were able to access additional training relevant to people's needs.

People were supported to maintain a healthy diet, and staff were proactive in requested health professional support where necessary.

Is the service caring?

Good

The service was caring.

People told us staff were kind, caring and compassionate. It was clear staff knew people well and formed good relationships with them.

Staff were able to describe how they supported people to lead independent lives, and staff told us how they protected people's dignity and privacy.

Is the service responsive?

Good

The service was responsive.

People were assessed appropriately before using the service and care plans provided detailed guidance for staff on how to care for people in a person-centred way.

Complaints were handled appropriately and people told us they were confident they knew how to raise complaints.

Is the service well-led?

Good

The service was well-led.

There was a clear vision for the future direction of the service. People and staff were kept informed of this.

Quality assurance processes were in place and they were sufficiently robust in identifying issues and resolving them.

There was good engagement with people who used the service, ranging from questionnaires to newsletters. Staff were also confident in the leadership of the service and staff meetings were well attended.

Caring Heart and Hands LTD

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.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 25 May 2018 and ended on 1 June 2018. We visited the office location on 25 May 2018 and 1 June 2018 to see the manager and office staff; and to review care records and policies and procedures.

This inspection was conducted by an adult social care inspector. Prior to the inspection we collected and analysed information we held about the service such as statutory notifications and feedback forms. We also gathered feedback from the local authority prior to our inspection which we used to inform our planning.

During the inspection we spoke with six staff, including the registered manager, deputy manager, senior team leaders and carers. We also conducted telephone interviews with three people who used the service and two relatives, to gather their feedback.

We also reviewed records and documents relevant to people's care and the safe operation of the service. For example, we looked at six people's care plans, five staff recruitment files, the service's complaints log and six people's medicines administration records.

Good

Is the service safe?

Our findings

All of the people and their relatives we spoke with told us they felt safe. There were safeguarding policies and procedures in place, and staff knew how to identify and refer potential safeguarding matters they witnessed. One member of staff said, "It could be noticing unexplained bruises, missing money or medicines. I would go to the team leader with it, or if it was accusing the team leader I'd go to the manager. If it was higher than that I would go to CQC." The registered manager made safeguarding alerts to the local authority when required. During our inspection we observed a meeting with care staff about a potential safeguarding issue and this was raised with the local authority appropriately.

There were enough staff to meet people's needs. Rotas we reviewed evidenced that there were enough staff to conduct visits. People and their relatives told us staff were on time, or if they were not on time they would notify them in advance, for example in bad traffic or weather conditions. One relative told us how staff had made their visits by walking despite particularly bad snow conditions that made roads unusable. One staff member said, "We aren't pressurised by time. We still get to have a chat and time one to one. There are enough staff definitely."

Staff were recruited safely. We reviewed staff files and found records of applications, interview notes, and proof of identification. This included photographic ID such as passports and driving licenses, as well as a valid Disclosure and Barring Service (DBS) check. The DBS is a national agency which helps employers make safer recruitment choices by carrying out criminal records checks and checks of a list of people who are barred from working with children and vulnerable adults.

Medicines were managed safely. Staff received training in medicines management and their competency was evaluated before they were permitted to administer medicines. Competencies were evaluated every three years or in response to a change in circumstances, for example poor performance in audits or observations made during a spot check. Spot checks on staff member's practice were conducted regularly by senior staff and part of the spot check included observing the staff member during medicines administration.

Medicines prescribed to be given 'as required' (known also as PRN) were recorded appropriately with the necessary level of detail to guide staff about when they were required in PRN protocol documents. For example, a PRN protocol about a skin cream to be applied as and when required told staff the reason why it was needed, the maximum dose in a 24-hour period and where the cream was to be applied. There was also a topical medicines administration record (TMAR) in place with a body map to show the exact area where the cream needed to be applied.

Staff understood how to record and dispose of refused medicines or those that were no longer required. One member of staff said, "I administer medicines, recorded a refusal of pregabalin by one person, took it to the chemist and filled out a disposal form."

Other documents were in place relevant to medicines management. For example, in one person's care plan

there was a letter from the GP authorising staff to administer homely remedies and another letter confirming that staff were to crush a person's medicine before giving it to them.

Risks to people were assessed appropriately and with use of tools recommended by nationally recognised guidelines such as the malnutrition universal scoring tool and waterlow skin assessment tool. For example, a choking risk assessment identified how the risk was presented, and what actions staff needed to take to prevent harm. This meant using a spoon for delivering fluids, adding prescribed thickeners to drinks and keeping small objects out of reach of the person. Accidents and incidents were investigated appropriately. We saw examples where lessons had been learned and where appropriate disciplinary action had taken place in line with the service's disciplinary policy wherever this was necessary if staff had been found to be at fault in some way.

Staff received training in preventing infection. People we spoke with told us staff used disposable gloves and aprons when delivering personal care. There was a large stock of personal protective equipment available in the office.

There was a business continuity plan in place which provided guidance for staff in the event of significant disruptions to the service, for example a severe weather event, or terrorist attack.

Good

Is the service effective?

Our findings

People and their relatives told us staff were well-trained to perform their roles. One relative we spoke with said, "Yes, the company are very hot on training."

New staff received a 12-week induction which included 'shadowing' of experienced staff. One member of staff said, "Training is good. We do shadow shifts. We aren't left alone until the registered manager is confident in us. We get good support." Staff also received training the provider considered to be mandatory. This included safeguarding vulnerable adults, basic first aid, and infection prevention and control. Staff compliance with training was monitored using a training matrix and regular reminders were sent out to ensure staff were on track to refresh training modules in a timely way.

The service also provided staff with specialised training relevant to the needs of the people they were looking after. For example, we saw the registered manager had booked staff who were caring for someone with Parkinson's disease on additional training in that subject. One team leader we spoke with said, "Training is really good, I didn't know anything about care before I came here, health and safety, medicines and those sorts of things." Another member of staff said, "I've recently done training in Parkinson's disease. They are looking at getting a nurse in to provide further training on things like dressings so we can support district nurses and in end of life care."

Staff were supported with regular supervisions every six weeks and annual appraisals. Staff said they felt these were good and were an opportunity for them to let senior staff know their training needs and to discuss personal development. One member of staff said, "We get regular supervisions and appraisals. It's useful, we can discuss problems. If I said I wasn't confident with medicines, they'd get me on training." Another member of staff said, "They ask how you feel, if you have concerns, you get feedback on your performance. At my last one I spoke about the staff rota and cover for leave." The service also conducted spot checks on staff practice during visits to make sure staff were following guidelines such as wearing personal protective equipment. This also included asking the person receiving care their opinion of the staff member.

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 and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was working under the principles of the MCA. Care plans contained documents relevant to people's capacity such as court of protection orders, and mental capacity assessments carried out by other agencies. The service understood its role and responsibilities. One member of staff said, "It's their choice to make decisions even if they haven't got capacity for certain things, you can't say you can't change your hair colour because you don't have capacity for something else. People can make their own decisions." Another staff member said,

"Everyone has capacity, don't assume they don't unless the registered manager has done an assessment. Some people you might not think they have capacity unless you know them and how they communicate, but they do."

The service ensured consent forms were signed by people or their representatives. This included care plans, consent to share information with third parties where necessary such as the CQC and also consent for photographs to be taken for the purpose of identification and as a record of activities.

The service supported people to eat and drink enough to maintain a balanced diet. Nutritional care plans contained detailed guidance for staff. One person's nutritional care plan instructed staff: '[Name] has all flood blended, they need to take their time, encouraged them gently to swallow.' Care plans for visits included what food people liked. One person's care plan read, '[Name] Likes rice pudding and chocolate mousse for desert. Give them a choice, and ask them if they want more'. Care notes included details of what people had to eat.

People and their relatives told us staff were attentive to their health needs and always raised issues they found to be escalated to health professionals. Care plans contained a detailed record of health professional visits and their outcomes such as physiotherapist and speech and language therapy team visits which had resulted in changes to diet and mobility. This then informed changes to the care plan. One staff member said, "The keyworker contacted the district nurse and the speech and language team after a person's weight dropped, we got them to gain a stone with prescribed food supplements."

The service had a catalogue of electronic devices and forwarded information about them to people where they felt this may improve people's lives. For example, we saw a person with a dementia related condition had purchased a device which delivered a pre-recorded message to help them remember daily tasks and information on the advice of staff. The service also used a secure messaging service monitored by an administrator to allow staff to instantly provide updates to one another regarding people's needs, for example their emotional state and any healthcare needs that had developed during their care visits. A newsletter sent by the service included gadgets the service had available for demonstration, including the recording device, special clocks and fidget blankets.

Good

Is the service caring?

Our findings

All people and their relatives we spoke with said staff were kind, caring and compassionate. One person described staff as, "Like family". One comment the service received said, "I wanted to say what a lovely afternoon mum had. Staff looked at photos with them and she was in such good spirits. She really likes staff, she is very well looked after."

Staff actively promoted people's independence. One member of staff said, "A person I look after has poor mobility and cannot get out of bed without help. We give them a choice of their clothes, where they want to sit in their home, we try to give them control over food and let them have choice. It's the same with washing. We step in and let them say I need help or prompt them carefully." Care plans also reflected this and instructed staff to offer people choice. The service kept a photobook of staff with people who they supported going out on trips or having their lunch outside in good weather, which indicated that people were supported to maintain independence over their lives.

Staff we spoke with gave detailed information about people they cared for such as their personalities, likes, dislikes and hobbies. It was clear that staff had good relationships with the people they cared for. One staff member said, "The person grew up here. Used to work in a pub. I took them there and they were really happy with that. I have got to know their husband, daughter and grandson. Their favourite food is fish and chips. They love telly. I do their nails and hair."

Rotas evidenced and people we spoke with confirmed that they received care from a regular team of staff they were familiar with. One relative we spoke with told us that when their loved one did not 'gel' with a member of staff because of a difference in personality, the service was accommodating and sent a different member of staff to attend instead. In care plans we reviewed, people had a named member of staff as a key worker.

Staff promoted people's privacy and dignity when delivering care. People we spoke with told us staff were also sensitive to this. One member of staff said, "When assisting someone with personal care or getting them changed we close doors and shut curtains. We put a towel around the bottom half when washing the top half and vice versa. We always ask permission before doing things."

The service provided training in equality & diversity, and where possible sought to match people with protected characteristics to staff who shared or best understood their needs. People's spiritual, cultural and sexual preferences were recorded if they wanted this recorded.

The service understood the role of advocates. Advocates are people who help vulnerable people make important decisions about their lives and support them to have their voices heard. We saw evidence that advocates were included in people's care plans and at relevant meetings.

Good

Is the service responsive?

Our findings

People were assessed by senior staff before using the service. This included recording information about their medical history, personal and professional contacts, and other relevant information such as their mobility and communication needs.

Care plans were detailed and provided clear guidance for staff on how to meet people's needs. This included personalised information such as how to enter the property and what the person liked to eat. One person's care plan summary instructed staff to knock on the side door, provide breakfast of porridge and thickened drinks before a shower, then to help the person with a stretching exercise. The exercise guide consisted of photos taken of a member of staff and the person (with their consent) going through the exercise step by step as a visual guide.

Care plans were reviewed every three months, or in response to a change in need. One person's care plan was reviewed in November 2017 and then again in December 2017 due to a deterioration in their health. The service held a six-monthly meeting with people and senior staff to gain feedback on care and make changes to the care plan as well. One relative we spoke with told us "The senior staff and manager came for a meeting and we discussed if anything needed changing." At one meeting we saw that people discussed timekeeping, training and communication from the service, and forwarded these as actions. We saw they had been addressed by the service.

There was a complaints process in place, and people and their relatives told us they knew how to make complaints. One relative we spoke with said they had raised an issue with the attitude of a member of staff some years ago and this issue had been resolved satisfactorily. The service provided people with blank copies of complaints forms and contact details to forward their complaints. Complaints responses we reviewed were responded to in a timely way, and most complaint responses were in an appropriate tone. One complaint we reviewed contained informal language and was not professional in tone. When we raised this with the registered manager they provided some context to the complaint, and they accepted that they would ensure all future complaints were responded to professionally as was the case with other complaint responses we reviewed.

The service understood it's role to support healthcare professionals in the event that a person was approaching the end of their life. People's wishes were recorded in their care plans and staff told us they always attended the funerals of people they cared for. We reviewed cards and letters of thanks from relatives of people who had passed away expressing gratitude for the levels of care provided. The registered manager's vision for the service was that staff would be given further specialised training in end of life care so they could take a more active role in supporting healthcare professionals, to this end the service had recently recruited a registered nurse to provide training.

Staff supported people to access the community and take part in social activities as much as they wanted. We spoke to one person who was supported to access a day centre regularly and they told us that staff were mindful of this when helping them get ready. We saw evidence of one instance where a person wanted to go

on holiday to a seaside resort, and a staff member, with support of the service and appropriate risk assessments in place, facilitated this.

Good

Is the service well-led?

Our findings

People we spoke with were aware of the management team of the service and felt they were approachable with any needs or issues they wanted to raise. People said they were kept up to date on the vision of the service for the future, for example, one person we spoke with told us they were aware of planned changes to the structure of the leadership team which included the deputy manager taking on a more senior role. At the time of the inspection the registered manager was supported by a deputy manager, senior team leaders and administrative staff.

The registered manager had a clear vision for the service which included further training for staff on providing more complex care, to this end they had recently recruited a nurse to provide more specialised training.

We reviewed quality monitoring arrangements at the service and found these to be adequately robust. This included audits of medicines administration records, care plans and care notes. We saw that where staff had made minor errors in the recording of medicines administration this was followed up with supervisions and if necessary extra training for staff. The deputy manager collated and analysed data on a monthly basis in order to present regular reports to the registered manager on the performance of the service. For example, in relation to compliance with mandatory training, where certain modules fell below the expected target, there was mitigating evidence and actions planned as a result, for example because the training provider was unable to accommodate a large number of staff for a particular course it was noted that the service would book staff based on highest need on the next available course. The service also used an external quality assurance assessor to give feedback on the service's performance annually.

There was good engagement with people who used the service. The provider sent a monthly newsletter to people which included any updates or news regarding the service, new staff who had been recruited and some puzzles for people to complete. One person we spoke with described it as 'basic' but that it was good and provided them with information about the future direction of the service. The provider also sent an annual survey and conducted regular visits to people using the service such as care plan reviews and spot checks where people were also asked questions about how the service was performing and if they were happy with the service. At the last survey, 30 questionnaires were sent and 26 returned. Comments around communication led to the development of the newsletter. Other comments were generally positive.

Staff we spoke with were positive about the leadership and culture of the service. Staff felt the registered manager was approachable. One member of staff said, "I'm confident in the leadership, I can tell the registered manager what I think. It is like a big family, we can all talk. I'm not a manager but they are still interested in my views."

There were regular staff meetings which were well attended. One member of staff said, "We have regular staff meetings, everyone comes when they can. We have minutes sent round if not. We get told about new service users and what's happened." The provider also sent out a staff survey annually to gather views from staff about how the service was performing and if there were any issues they wanted to raise about working

for the service. At the last staff survey in 2017 there were 26 responses. Actions from the survey were to review and improve staff rotas, and get training for staff who needed it. We saw these actions were recorded as completed.

The registered manager understood their legal obligation to submit statutory notifications to the Commission in line with the Care Quality Commission (Registration) Regulations 2009.