Caring Hands (Domiciliary Care) Ltd

Caring Hands

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Caring Hands is a domiciliary care service providing personal care and support to people in their own homes. They were providing a service to 75 people at the time of inspection; 73 of whom were receiving 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.

People's experience of using this service and what we found
People's current care needs and risks were not always assessed or recorded accurately which exposed them to the risk of harm. Medicine records were not completed accurately and audits did not identify gaps in medicine administration. People's health conditions were not assessed to mitigate the risks associated with Covid-19.

There were not always enough care staff to meet the needs of people and staff had not received regular training to provide care and support safely. However, people felt safe with the care they received and care staff understood people's needs well.

We found significant concerns about the management of the service. Their systems were either not in place or not effective to assess, monitor, and improve the quality and safety of the service. The systems had failed to ensure risks were properly assessed, documented and mitigated. The provider had failed to ensure care staff had guidance in place to provide safe care and treatment to people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection
The last rating for this service was Good (published 7 April 2018).

Why we inspected
The inspection was prompted in part due to concerns received about safe staffing. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective 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, Effective 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.

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 people's safe care and treatment, managing risks to people's safety; staffing and governance and oversight of the service at this inspection.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Caring Hands

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
The inspection team consisted of an inspector and 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 homes.

The service did not have a manager registered with the Care Quality Commission; however, the service had a manager who had applied to register for this position. This means the provider is 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 48 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, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 of this information to plan our inspection.

During the inspection
We spoke with six people and one relative about their experience of care provided. We spoke with seven members of staff, including the manager, two office managers, a coordinator and three healthcare assistants. We reviewed a range of records. This included five people's care records and multiple medicines records. We looked at two staff files in relation to recruitment. We also looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at healthcare service correspondence, quality assurance records and the providers policies and procedures. We spoke with the local authority.

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 now 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; Using medicines safely; Learning lessons when things go wrong

● People's mobility and risks relating to manual handling were not accurately documented to provide guidance for staff to support them safely. For example, two people required hoist equipment to support them safely. However, their care plans and risk assessments did not include complete information provided by an Occupational Therapist for care staff to follow. This increased the risk of harm occurring.

● People's skin integrity risks were not always fully assessed and care plans did not direct staff to monitor the condition of people's skin. For example, four people were at risk of skin deterioration due to their healthcare needs. Their risk assessments and care plans did not provide current or detailed information for care staff to follow to reduce further risk of skin deterioration. They were not updated to identify changes in people's health which increased the risk of harm occurring.

● People's continence needs were not always assessed with plans in place to reduce risks. For example, three people required support with their continence needs. Their care plans had specific sections to include continence needs and risks, however these were not completed for care staff to follow which increased the risk of harm occurring.

● Medicine administration records (MAR) were not always completed accurately or had "as required" protocols in place to evidence medicines were administered safely. For example, two people had significant gaps in their MAR's where no administration outcomes were entered. This meant we could not be assured people were receiving their medicines as prescribed which increased risk to their health. Three people required medicines to be administered "as required." However, there were no "as required" medicine protocols. This meant staff did not have information to know when people required their medicine administering. We found two people were prescribed medicine to manage pain, however their MAR did not clearly document the dosage of medicine required to avoid errors which increased the risk of harm occurring.

● Medicine risk assessments did not detail people's current prescribed medicines. This meant staff did not have information about specific risks each medicine may have or how staff were to manage these risks. Not recording specific prescribed medicines does not meet national guidance and increases risk of errors in administration and harm to people.

● Staff had not received manual handling and medicines management refresher training. We found most staff had not completed the training updates required for a period of between 14 to 18 months and no competency checks were completed. Therefore, we could not be assured staff had the knowledge and skills to deliver this care safely.

● Although risk management systems were not always in place, we found when people received care from staff who knew them well, they did have an understanding of their needs. However, the risk of harm was not

mitigated by the provider to ensure that any staff member could provide this care safely.

We found the provider had failed to ensure people's needs and risks were comprehensively assessed and recorded accurately. Guidance and training was not in place for staff to follow to keep people safe and people were exposed to the risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our feedback following the inspection and told us new care documentation would be implemented to improve the quality and accuracy of information relating to people's needs and risks. The manager told us training would resume once an appropriate training instructor had been sourced. We found no evidence people had been harmed due to the failings identified above, however the risk of harm was present due to these failings.

Staffing and recruitment

● People were not always receiving consistent care due to a shortage of staff. The manager told us the service was continually seeking to recruit new staff, however this had not been successful which impacted on the consistency of people's care. For example, the manager told us people who required care from two members of staff sometimes had to be supported by one member of staff and a family member to provide the care needed.

● People we spoke with gave mixed feedback regarding the consistency of their care call times. For example, one person told us, "I am happy with the times if they stick to them but of late, they have been getting out of sync. They are supposed to be 7.30 am but one day it was after 9am so you can't tell for sure. I think they are very short staffed, and they don't always ring to let you know so you are unsure what is happening." Another person told us, "I get regular carers and they will tell me who is due next, so I know who is coming."

We found the provider had failed to ensure there were sufficient numbers of suitably qualified staff in order to consistently meet people's care needs and call times. This was a breach of Regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they have been unable to recruit new staff and explained they have mitigated the risk by not providing new complex packages of care. We will request an action plan from the provider to explain how they will ensure the service has sufficient staff to meet people's needs and care call times.

● Staff were not always recruited or employed safely. Employment checks were completed including employment history, references and proof of identity. Disclosure and Baring Service (DBS) checks had been completed however, an unscheduled DBS check was not requested following concerns of serious misconduct of a member of staff. The Disclosure and Barring Service helps employers make safer recruitment and employment decisions.

We recommend the provider follows national guidance and update their policy for undertaking proper assessment and in taking action to mitigate potential risks posed by staff towards vulnerable people.

Preventing and controlling infection

● We were somewhat assured the provider had effective infection control procedures in place. However, people and staff did not have Covid-19 risk assessments in place to detail their individual health needs and risks.

● The provider had infection prevention and control policies in place, however the policies were not updated to include advice and guidance associated with the management Covid-19.

We recommend the provider refers to current guidance on the assessment and management of associated Covid-19 risks and take action to update their practice.

● People gave us positive feedback regarding the use of personal protective equipment (PPE) by care staff. For example, one person told us, "They (carers) are all very kind and respectful and throughout the whole pandemic they have worn masks as well as gloves and aprons."

Systems and processes to safeguard people from the risk of abuse

● People felt safe with the care and support they were provided and knew how to raise concerns. For example, one person told us, "They are all very good, they don't rush me and will tell me to take my time and be safe. Having them here makes me feel safe."

● Staff had completed safeguarding training. Staff we spoke with understood their safeguarding responsibilities and knew how to raise concerns.

● The provider had appropriate policies and systems in place to raise safeguarding concerns.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
● Staff did not always complete training, receive supervision or attend team meetings to ensure they had the knowledge, skills and experience to provide care safely.
● Where staff had received training, a significant proportion of staff had not received supervision or spot checks by the provider to ensure learning was retained and care was provided competently. Some staff told us they had not received a spot check or supervision in over 12 months which was confirmed when reviewing staff records.
● At the time of inspection, the trainer within the service had stepped down from this role and there was no other qualified trainer within the service to ensure staff received the training they required. The provider had failed to source training from an external training provider to meet this shortfall. In addition, there were no facilities available for staff to receive face-to-face training as the training room was being used as a storage room.
● Some staff told us they had not attended a team meeting in over two years which affected communication. One staff member said, "I think we should have a space to share and vent our concerns." Another staff member told us, "To be honest I don't see anybody because we work on our own now, but we are told by the office if anything changes." The manager confirmed team meetings had been postponed since the beginning of the Covid-19 pandemic, however the provider had failed to consider alternative methods, including smaller or virtual meetings.

We found the provider had failed to ensure staff were suitably trained and competent to provide care and support safely and did not provide staff with enough opportunities to obtain information, develop learning or share concerns. This placed people and staff at risk of harm. This was a breach of Regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager responded to our feedback and told us new trainers for the service were in the process of obtaining their qualifications to ensure training could be delivered to staff. The manager told us spot checks, supervisions and team meetings were in the process of restarting.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to eat and drink enough to maintain a balanced diet.
● People's needs and choices were not always fully assessed or documented. For example, one person required a diabetic diet to be prepared by staff. No dietary requirements, preferences or choices were entered into the person's care plan or risk assessment for staff to follow. However, daily care records

demonstrated staff understood the person's needs and prepared meals after offering different choices.
● The provider had a policy in place for reviewing people's needs and choices. However, review of people's care was not consistently completed within the minimum stated time frame of 12 months to ensure people's care was meeting their current needs. There was no evidence found to indicate people had unmet care needs, however the risk of this occurring was increased.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to access healthcare services; however, this was not always documented within their care plans. For example, one person had developed pressure sores and required treatment and support from District Nurses. The service made the necessary referral to access treatment and recorded the advice given; however, the person's care plans and risk assessments were not updated to include their change in need. Regular care staff knew what support the person required, however this information was not readily available to any new or agency staff who may be required to support the person. This meant people were at risk of not receiving effective and timely care.
● We observed communication books were in place to document any concerns staff had regarding people's health and the actions taken to seek appropriate care and treatment. The book included which professionals had attended to the person and the advice and treatment provided.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● People were asked to consent to their care, and this was recorded in their care files.
● People we spoke with told us they were supported to make their own decisions. One person told us, "I can't fault the carers in any way, they are the best crew I've ever had. They work around me and always ask if there is anything else they can do. I choose what I want to eat and if I want to go to bed."

Inadequate

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The providers governance and quality assurance processes failed to provide oversight in the quality and completeness of people's care assessments, risk assessments and care plans. Care plans lacked guidance for staff to follow in order to provide safe care and treatment. Risks were particularly increased for people with complex care needs, including manual handling, hoist transfers, diabetes management, continence care and pressure care. Auditing systems and processes were not effective in identifying these failings nor were audits identifying the lack of consistency throughout care records. This increased the risk of harm occurring.
- The provider failed to ensure people's medicine records were complete, recorded accurately or medicines administered safely. Medicine risk assessments did not detail people's current prescribed medicines. Auditing of MAR records was ineffective and did not always identify errors or follow through with actions where errors had been identified.
- The provider had failed to identify MAR charts were not formatted in a way to meet best practice guidelines. The guidelines advise care workers must record the support given to a person for each individual medicine on every occasion. The MAR charts used by the service did not contain sections or spaces to allow carers to enter full medicine administration outcomes.
- The provider had failed to ensure staff received safety related refresher training for manual handling and medicines management. Most staff were overdue this training for a period between 14 to 18 months. The provider had not attempted to obtain training from any internal or external source to meet staff's training needs.
- The provider failed to maintain oversight of staff member's learning and support needs and did not ensure staff were competent to provide care safely. Staff supervision, competency observations and spots checks were not consistently completed. The manager told us no face-to-face supervision and team meetings had not been completed since March 2020 due to the Covid-19 pandemic in order to reduce risk of potential transmission of infection between staff. However, no alternative forms of completing formal staff supervision and team meetings had been considered.
- The provider failed to ensure the service deployed enough staff to ensure people received consistent care. Recruitment drives were ineffective in increasing the amount of staff required at the service. The manager told us positions were advertised on a recruitment website, through social media and by word of mouth, however no advertisements were found following review of the recruitment website.

● The provider had failed to ensure risks associated with staff misconduct were assessed robustly and measures taken to reduce or remove risks.

We found managerial and governance systems and processes had not been established or operated effectively to keep people safe. This placed people at risk of significant harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our feedback and told us the failings would be responded to in full. We found no evidence people had been harmed due to the failings identified above, however the risk of harm was present due to these failings.

● There was no registered manager in post at the time of inspection. The manager of the service had applied to us for registered status; however, their application was rejected due to being incomplete.
● The service had sent out questionnaires to people to obtain their views and experiences of care provided and analysed the results which were markedly positive. However, there was mixed feedback from people we spoke with. For example, a relative told us, "We do get an annual questionnaire to complete but I am not sure how effective it is to fill it in. I do think they could communicate better, particularly with what is going on for example there's been a change of manager, but they've not really introduced themselves properly. I think sometimes they leave the carers out in the dark which is not helpful."

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
● The manager and provider did not always understand their legal requirements. We found there were systems in place to record, investigate and feedback on any incidents, accidents or complaints. However, there were no recent accidents, incidents or complaints on file at the time of inspection despite the CQC being made aware of an active complaint made to the service. Due to the failings described above, we could not be assured the systems in place were effective in their purpose.

Working in partnership with others
● People were supported to access external care and support from health and social care professionals. A staff member told us a person had a fall but was not injured, however referred to the person's GP for extra support around falls risks.

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 failed to ensure people's needs and risks were comprehensively assessed and recorded accurately. Guidance and training was not in place for staff to follow to keep people safe and people were exposed to the risk of harm.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Managerial and governance systems and processes had not been established or operated effectively to keep people safe.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably qualified staff in order to consistently meet people's care needs and call times. The provider had failed to ensure staff were suitably trained and competent to provide care and support safely and did not provide staff with enough opportunities to obtain information, develop learning or share concerns.