Midshires Care Limited

Helping Hands Home Care Head Office

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 10 May 2016 and 3 June 2016. On both days, the inspection was announced. Due to the amount of people this agency supported, the provider was given seven days' notice of our inspection visit to ensure senior management, registered managers, care staff and associated records were available when we visited the agency's office.

Helping Hands is a domiciliary care agency which provides personal care and support to people in their own homes within the local geographical area of Alcester. In the report, this is referred to as the hourly service. Helping Hands also provides a nationwide 'live in' service to support people living in their own homes who may have more complex care needs and therefore, require additional levels of support.

At the time of our inspection visit, the agency supported in excess of 1000 people across the live in service and the hourly service (hourly service calls range from 15 minutes to 10 hours in duration).

This service was last inspected on 22 April 2013, when we found the provider was compliant with the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a registered manager in post. 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. Helping Hands employed several registered managers at this location. Each regional area, North, South, East and Central had a registered manager responsible for the staff and the delivery of care to people using the service, within those regions. Where required, we have split certain sections of our report into these geographic areas to report on our findings.

People felt safe using the service and staff understood how to protect people from abuse and keep people safe. There were procedures to manage identified risks with people's care and for managing people's medicines safely. Checks were carried out on staff during the recruitment process to make sure they were suitable to work with people who used the service.

There were enough staff to deliver the care and support people required and people received care from a consistent staff team. People told us staff were friendly, respectful and caring and had the right skills to provide the care and support they required. Staff received an induction when they started working for the service and completed training to support them in meeting people's needs. Staff felt the training provided them with the right skills and knowledge to support people safely and effectively.

The provider understood the principles of the Mental Capacity Act (MCA), and staff respected people's decisions and gained people's consent before they provided personal care.

Care plans contained relevant information for staff to help them provide the personalised care people

required. People knew how to complain and information about making a complaint was available to them. Staff said they could raise any concerns or issues with the provider and registered manager, knowing they would be listened to and acted on.

There were processes to monitor the quality of the service provided and understand the experiences of people who used the service. This was through regular communication with people and staff, returned surveys, operational board meetings, spot checks on care staff and a programme of other checks and audits.

In the report we have reported the hourly service and live in service separately where we want to make people's experiences of those services reflective of the service they received.

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.

There were procedures to protect people from risk of harm. Care staff understood their responsibility to keep people safe and to report any suspected abuse. There were enough care staff to provide the support people required. There was a safe procedure for managing medicines and a thorough staff recruitment process.

Is the service effective?

Good

The service was effective.

Staff were trained and supervised to ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act 2005 and staff gained people's consent before care was provided. People who required support had enough to eat and drink during the day and had access to healthcare services.

Is the service caring?

Good

The service was caring.

Care staff provided a level of care that ensured people had a good quality of life. People were supported by care staff who they considered kind and caring. Care staff ensured they respected people's privacy and dignity, and promoted their independence. People received care and support from a consistent staff team that understood their individual needs.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and people received a service that was based on their personal preferences. Care staff understood people's individual needs and were kept up to date about changes in people's care. People knew how to make a complaint and the registered managers and senior management dealt promptly with any concerns or complaints they received,

and monitored complaints for any patterns or emerging trends.

Is the service well-led?

Good

Overall, people were satisfied with the service and felt able to contact office staff and speak with a manager if they needed to. Effective leadership and a thorough audit system continually reviewed and improved the quality of service to ensure good standards of care were maintained.

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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 was planned to check 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 reviewed information received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also reviewed information received from members of the public, other healthcare professionals, whistle blowers and people who had raised complaints about the service provided. Before the inspection visits, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR reflected the service provided.

Prior to the office visit, six experts by experience contacted people by telephone to ask them what they thought about the service they received. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service. We spoke with 59 people and 42 relatives of people who used the live in service and we spoke with 13 care staff who provided their care. We spoke with 31 people and six relatives of people who used the hourly service. Speaking with people who received both aspects of the provider's service gave us the opportunity to see the overall quality of service people received from Helping Hands, based on their personal experience.

Prior to our visit we also contacted 60 care staff by email who worked for the agency and provided care to people living in their home. We received 16 responses from those staff. We also received responses from three staff who supported people who received care from the hourly service to ask them for their views on the quality of the care they provided and the support they received from the provider.

The inspection was conducted by three inspectors on 10 May 2016 and one inspector on 3 June 2016.

During our visits at the office, we spoke with four registered managers, a head of live in care, a senior quality assurance manager, a governance and quality advisor and a further 12 care staff who provide care across both aspects of the service. We checked whether staff had been recruited safely and were trained to deliver the care and support people required. On 3 June 2016 we spoke with a chief operations officer, an operations director, a head of live in care and a registered manager.

We looked at a range of records about people's care including eleven care files. We also looked at other records relating to people's care such as medicine records. This was to assess whether the care people needed was being provided. We reviewed records of the checks the registered managers and the provider made to assure themselves people received a quality service. We also looked at personnel files for three members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

Good

Is the service safe?

Our findings

People told us they felt safe. People who received the hourly service said they, or their relatives, felt safe with care staff. People told us they had regular care staff that helped them feel safe and at ease, comments included, "Yes I do feel safe. It's the same people, or I should say, the same person, for both of us." Another told us, "Yes I feel safe with my carers. I am very pleased with them they have been very good from the beginning." People knew what to do if they did not feel safe. One person told us, "Initially I'd talk to the carers (care staff) themselves, and then to the office," another said, "I'd just ring up the office." People receiving the live in service said they had no reason to feel unsafe when supported by care staff, especially when staff spent long periods of time with them, or who stayed with them in their own home. Comments people made were, "Of course I feel safe.", "I have to be hoisted and they [staff] make sure I am safe, they are very good", "I always feel safe. I need help with everything but staff look after me and do things for me."

All care staff we spoke with had a good understanding of abuse and how to keep people safe. One care staff member told us, "In training I learned PENS to remember, Physical, Emotional, Neglect, and Sexual, as types of abuse." We gave care staff scenarios of abuse and asked what they would do, for example, unexplained bruising on people, financial mis-management and staff attitudes. They understood what constituted abusive behaviour and their responsibilities to report this to the managers. One care worker told us," If I have any concerns I would record it and report it to the managers. The managers would look into it and refer it to social services." Registered managers and the provider understood what was required and knew how to raise any incidents of abuse or potential harm. We found the provider notified us when they made referrals to the local authority safeguarding team where an investigation was required. They kept us informed with the outcome of the referral and any actions they had taken that ensured people remained protected.

The provider's recruitment process consisted of a week long 'recruitment and selection' process. Potential new staff were continually assessed throughout this time and were only employed, at the end of this process. Continual assessment meant they were not guaranteed employment and we were told a number of staff did not gain employment because they did not meet the provider's criteria around behaviours and values. Successful staff had essential employment checks completed, such as reference and criminal record checks, before they started work. Care staff confirmed this. Criminal record checks helps employers make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. The provider operated a thorough recruitment and selection process to recruit staff from outside the United Kingdom. They frequently employed staff from other European countries, holding recruitment fairs as a way of recruiting new workers. Where this was the case, they explained the recruitment process to us that always involved checking staff were of 'good character' and their ability to work in the UK, before their employment process commenced. We were told by one registered manager, "Just because they are on our induction, doesn't mean they are guaranteed a job with Helping Hands. They are continually assessed day and night, to see how they engage and interact with each other, as well as their communication skills and attitudes."

People told us there were enough care staff to provide their care and staff arrived when expected. We found there were enough care staff across both services to care for people safely, and meet their support needs as

identified in their care plans. Very few people experienced late or missed calls. We asked people receiving the hourly service whether their care staff arrived when expected and stayed long enough to do everything that was required before they left. Most people said they did. Comments from people included, "Yes, as near as possible. They come roughly at the time they should," and, "Most of them do come on time. I did have some turn up too early, but this year it's been a bit better." We asked care staff whether there were enough staff to meet people's needs safely. Care staff told us that generally there were enough staff, one member of care staff said, "There are plenty staff and we are all willing to help."

The registered managers confirmed there were enough care staff to allocate all the care calls people required and there was an effective system that allocated care workers to those calls. This system meant it was rare for care calls to go unattended. In addition to care staff, a registered manager and care co-ordinator told us they had also completed the required training that meant they could provide care to people in an emergency, or cover urgent calls. People who received the live in service said care staff arrived when expected and staff received a handover, usually 24 hours before shift change. When care was being provided, start times were not a concern because people told us they received care and support from staff who lived in their own homes. This meant care staff were usually present around 22 hours each day, seven days a week. Typically care staff worked in people's homes for a number of weeks at a time and then a change of staff occurred.

We asked a registered manager how live in staff were matched to people (this was a process to help ensure staff and people were suitable to live together). The registered manager told us people could be involved in selecting the care staff that supported them. This was through reading profiles about staff before they were sent out to their home. In some instances people also chose to speak with prospective care staff. The registered manager explained if people were not happy with the proposed member of care staff, they could and did ask for another choice. The registered manager commented, "We are very good at finding the right staff to support people." They explained their matching process looked at whether the member of staff might fit into the person's lifestyle and home life as well as whether the staff member had the right skills and training to support their health and personal care needs.

People gave us mixed opinions regarding the accuracy of the matching process. We found the majority of people were satisfied. Comments made were, "Yes, it's been really good. When 'breaks are coming up' they match a carer (care staff) to us. This is done in terms of "cultural understanding and language." Some people gave us examples where the matching process did not meet their needs. Comments made were, "They send random carers....there's no rapport and this is huge for me." "Only one choice was ever sent, they send a profile but they just give you one to choose from." "We see the profile of staff before they come, sometimes just one. If they aren't suitable we wait longer to get another one. It feels like you are under pressure to say yes","The profiles don't always match up with the staff. One of the care staff panicked and another didn't adjust to the isolation", "I need drivers and people competent in good communication skills, they struggle recruiting for my needs."

We asked people if they received their care from a consistent staff team. Overall people were pleased with the continuity of care from both aspects of the service, especially early on which established positive and understanding relationships between people and care staff. A minority on the live in service, as the support continued, said the continuity was not what was expected. One person explained how their relative was affected saying, "[Name] feels safe when we know the carers, but we very rarely have the same ones. It's just about stabilising between two carers now, but it's taken a year to get there. There's always been a problem and the impact on [Name] has been huge, it takes them two weeks to adapt to a change."

We asked a registered manager how they ensured care was provided by a consistent team. They told us they

and local care services managers regularly reviewed people's care by visiting them every six to eight weeks. They said part of the review process looked at how staff engaged with people, but to also speak with people to find out if they were happy or to resolve any concerns. They told us in the small minority of cases where people raised a concern about a staff member, attempts were made to find an alternative care staff member. We were told in some cases, it was not always possible to provide a care staff member with a particular skill set at short notice. However plans were in place to improve this, such as working closer with other Helping Hands offices who could supply trained staff within short timescales. Following our inspection visit on 10 May 2016, the provider set up an action plan to improve this area so people had further opportunities and better experiences of receiving a care staff member that matched their profile request.

Staff followed policies and procedures and managed risks associated with people's care. People had an assessment of their care needs completed at the start of the service that identified any potential risks to providing their care and support. For example one person required a hoist to transfer in and out of bed, their relative told us, "He uses a hoist, they [care workers] know how to use it. It's all recorded in the care plan." All care staff knew about individual risks to people's health and wellbeing and how these were to be managed. Records confirmed that risk assessments had been completed and care was planned to take into account and minimise risk. For example, care staff used equipment to support people who needed assistance to move around and undertook checks of people's skin where they were at risk of skin damage. We asked care staff about monitoring people's skin to make sure it remained healthy. One care staff member who supported a person receiving the hourly service told us, "I check when I provide personal care to see if the skin on their bottom is red or sore. Any concerns I would record it, complete a body map to show where the area of concern was and report it to the managers". Another told us, "One person I go to is looked after in bed, we check their skin regularly. Actually the district nurses visited and said they were very happy with our care as there was no redness on [persons] skin at all."

All care staff confirmed they referred to the information in risk assessments and care records to manage risks to people. One member of care staff on the live in service told us about the procedure they used to ensure one person's risks were minimised when they assisted them to move saying, "[Name] has a fear of falling so when we use the standing hoist to help move them I make sure I steady them and give them lots of encouragement. I reassure them by being there."

The provider had an out of hours system when the office was closed. One care staff member told us, "I will phone if I need help or advice, there is always someone on call." Care staff told us this reassured them that someone was always available if they needed support. Most staff said they found the on call system effective, however a small number of care staff did not. These staff said the problem seemed to be around communication of messages, rather than their calls not being received. We saw examples of call logs and saw call entries were made and the actions taken.

We looked at how medicines were managed by the service for people receiving the hourly and live in service. On the hourly service, most people we spoke with administered their own medicines or their relatives helped them with this. Where care staff supported people to manage their medicines it was recorded in their care plan. Care staff told us they had received training to administer medicines safely which included checks on their competence. One care staff member told us, "Medication training is covered in induction training, and updated in refresher training. We are also observed giving medication during direct observations." Competency assessments were covered in direct observations (six monthly) and during appraisals.

Care staff recorded in people's records that medicines had been given and signed a medicine administration record (MAR) sheet to confirm this. MARs were checked by care staff during visits and by managers during spot checks for any gaps or errors. Completed MARs were returned to the office every

month for auditing. These procedures made sure people were given their medicines safely and as prescribed. There were some improvements required regarding the 'as and when' medicines to ensure staff administered consistently. We found eight examples where these types of medicines were not always recorded accurately, so for those people it was difficult to know what they had taken over a period of time. The head of clinical care agreed to review the system and make sure staff recorded consistently to ensure people continued to receive their medicines safely.

Good

Is the service effective?

Our findings

We asked people and their relatives if they thought care workers had received the training needed to meet their needs. People receiving the hourly service were pleased with the care staff who supported them, who they said were skilled and trained to support them effectively. People told us, "Yes my carers are well trained." and "I believe so. to be honest we've had some new ones and old ones (care staff) and they're all alright." Another said, "Yes, on the whole. Obviously new people (care staff) learn but it's a double up call, so we never have two brand new people."

People receiving the live in service gave us mixed opinions. For example, most of the people in the North and West regions told us staff had the skills they needed to support them effectively. Some of the comments we received included; "When the staff come they are very competent","The training is worthy of a mention. I believe they must be given a degree of medical training. I am impressed how much staff understand [Name's] condition, for example, the side effects from the medication and the need to monitor them", "I think they [staff] are very well trained to do their job. They know about Dementia and Parkinson's. They [staff] are very good and patient."

We had some negative feedback from people who received the live in service in the Central and South region. Some of the comments we received were specifically about the moving and handling skills of care staff, and a lack of awareness about dementia care. Comments included, "Some of the care staff have just come out of training. They are not experienced with hoisting", "They have sent carers who've never handled a real live person in their training, just dummies", "There was one carer who didn't know how to use slings (to help with moving me)." "The staff are sometimes nervous about using hoists" ,"They didn't even know how to move [Name] around and change their pad" "They're not well-trained in actually handling people in bed. They don't have lifting or handling knowledge." One relative said, "Instead of speaking calmly to [Name] the carers got anxious, then [Name] got anxious. I don't think they are very well trained in Dementia care." Another relative said, "[Name] has dementia, the carers sometimes ignore their needs." Speaking with the provider about some elements of staff training, they agreed to consider ways they could improve staff knowledge and awareness of certain health conditions. However, the provider confirmed moving and handling transfers were completed by all staff both completing the transfers, as well as being transferred in the equipment.

Care staff told us they completed an induction and training before they supported people. One care worker told us, "When I started I had three days training, we now receive a refresher training day every year. I have gained my NVQ2 with Helping Hands and am waiting to hear when I can start my NVQ3." Care workers said they felt confident and suitably trained to effectively support people, comments included, "I feel I have the correct training to enable me to do my job. I can ask for more training in a specific area if needed", "The training is very intense. It's a full week 8am to 6pm, they [the trainers] cover everything, for example, health and safety, moving and handling and medication." Registered managers told us all staff completed a full induction programme before being able to support people in their own homes. One registered manager said, "Staff can have extra induction or training in specific areas where a need has been identified. For example, staff can have driving lessons if they are unfamiliar with UK roads and driving. Also local

knowledge of their area and amenities are discussed with a local care service manager to orient them."

The induction training included the Care Certificate. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. One care staff member supporting people on the hourly service said, "I completed lots of training when I started and I have regular training to keep my skills up to date." Another care staff member on the same service told us about the training they completed, "The dementia training was very good, they run a course most months for staff about this. Actually we are always updating our training; we have regular moving and handling and medication refreshers. It's good as things do change; especially how we should move people." Care staff completed training and had the skills to provide the care and support people required. The provider supported staff to maintain their skills and obtain nationally recognised qualifications in care to improve their practice.

Staff on the live in service told us their local care services manager planned frequent updates to their training to ensure they were kept up to date with the latest guidance on how people should be cared for effectively. Care staff also received training in specific clinical conditions, or how to use specific equipment, which was tailored to the needs of the people they supported. One care staff member told us about their training on how to administer medicines and food through a specialist tube called a 'PEG' saying, "I had this training because I care for someone who needs to use a PEG. I have been trained properly to use this equipment and signed off as being competent." The head of clinical care said, "People are involved in training staff if they have specialist needs. For example, staff go out and learn how to apply their training in the person's home." We were told their competency and effectiveness was monitored before they were allowed to do this on their own.

All care staff told us their knowledge and learning was monitored through supervision meetings with their local care services manager and unannounced 'observation checks' on their practice. The registered manager (hourly service) told us that during observation checks senior staff looked to see if care staff worked to procedures and training. Records confirmed care staff were observed working in people's homes to ensure they had put their learning into practice. Care staff on the live in service told us they were supported using a system of meetings with a manager to check on their performance and offer them support with their personal development. Staff told us regular meetings with a manager provided an opportunity for them to discuss personal development and training requirements. One care staff member said, "I have meetings with my manager. We receive our supplies like gloves and things, the local care services manager has been very supportive." Regular meetings enabled the local care services manager to monitor the performance of staff, and discuss performance issues. These managers undertook regular observations on 'live in' staff's performance to ensure standards of care were met. This was confirmed by care staff and people we spoke with. One person said, "Yes. They [manager] come and watch the staff working."

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. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way 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. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered managers (hourly and live in service) we spoke with understood their responsibilities under the Act. They told us there was no one using this service at the time of our inspection that lacked capacity to make their own decisions about how they lived their daily lives. We were told some

people did lack capacity to make certain complex decisions, for example how they managed their finances, but they all had somebody who could support them to make these decisions in their best interest.

All care staff we spoke with had completed training in MCA and knew they could only provide care and support to people who had given their consent. We asked care staff what the MCA meant, they told us, "It's about people's right to make their own decisions." Another said, "All the people I visit have capacity to make decisions, but I still get their consent before I do anything." People confirmed care workers gained their consent before providing care and support, one person receiving the hourly service told us, "They always ask me before they do anything for me even though they do the same things each day. They are lovely girls." Care staff said everyone they supported could make everyday decisions themselves, or lived with a relative who could support them with this.

For the hourly service, most people told us that they or their relative provided all their meals and drinks. People who were reliant on care staff (hourly and live in) to assist with meal preparation told us choice was given whenever possible and drinks were offered where needed. One person told us, "I have really good carers they do all my meals I couldn't manage without them. I have what I want to eat, I tend to have my cooked meal at lunch time it's usually just a microwave meal but they always ask me what I want and then cook it for me. It's served nicely." Another told us, "They ask me in a morning what I want for my dinner and they get it out of the freezer before they leave. They never leave without getting me a drink." One live in care staff member who came from another country to work for the agency said, "During the induction training there was a cooking lesson showing the British way of serving, meal times and some practice in cooking typical meals."

No one we spoke with on the hourly service was dependent on their care worker to provide all their food and drinks. One person required their nutrition to be administered through a percutaneous endoscopic gastroscopy (PEG) tube. A PEG is a way of introducing food substitute, fluids and medicines directly into the stomach. A risk assessment had been completed and there were clear detailed instructions for staff to follow about how to manage the PEG. There was also information for staff about maintaining and checking the PEG regularly. Care staff we spoke with knew how to administer food through the tube and said they had received training so they could do this safely. Care staff told us about people who required their food prepared in certain ways to maintain their health and keep them safe. For example we were told two people required soft or pureed food as they had difficulty swallowing. Care staff knew how to monitor and manage people's nutrition and hydration if this was required to make sure people's nutritional needs were maintained.

Live in care staff assisted people to prepare food and supported them with eating their meal if this was required. For example, the service also offered support to people with a PEG, or people who were on a 'soft diet'. We asked people whether the food prepared for them met their preference. One person said, "It's well-cooked." Another person told us, "I usually get two choices of meal as [name of carer] will cook theirs too so we can eat together. I have what I like." Most of the people we spoke with told us they could choose what they wanted to eat each day. Comments included, "They do involve me in choosing what I like, they ask how I like my veg" and "We do it together and choose what we'll have", "We seem to do the food between us. They cook a roast one day, cold the next." People told us they were supported to do their shopping, if this was part of their care package. One person confirmed this saying, "The carer goes shopping for me and makes my morning tea...they are always lovely to me."

People receiving the hourly service managed their own health care appointments or family supported them to do this. Care staff said they helped people manage their health and well-being if this was part of their care plan. Care staff said they would telephone a GP and district nurse if they needed to but would usually ask

the family to do this. Records confirmed the service involved other health professionals with people's care when required including district nurses, speech and language therapists and GPs. People were supported to manage their health conditions were needed and had access to health professionals when required.

Equally, people receiving the live in service were supported to access support from other healthcare professionals. Staff we spoke with told us they often spoke with visiting district nurses or GP and would carry out any agreed treatment as required. One member of staff explained, "If the district nurse needs me to do something specific or [Name's] treatment changes we will update the care records so I know exactly what to do." Another member of staff said, "[Name] has recently been diagnosed with a medical condition, I was with them at the time. I spoke to the multidisciplinary team to see how to help them cope with their stress levels. We work together to make sure they get the best care." A member of staff in the North region told us how they worked with professionals to support people with their equipment needs saying, "We have just taken receipt of a new hoist following our discussions with the person's district nurse and Occupational Therapist (OT). I was concerned that (Name's) skin was very delicate and the hoist they had was getting old. The fabric wasn't covering the frame properly I was concerned it would damage their skin. I spoke to the DN and the OT and we agreed to get a new hoist. It has been delivered and I am waiting for them to come and check my skills with it now." This showed the provider worked in partnership with other professionals for the benefit of the people they supported.

Good

Is the service caring?

Our findings

People told us all care staff across the hourly and live in service were kind and caring, comments included, "Oh yes, they're lovely girls." "They are caring, very much so and they are very thoughtful." "The majority are caring. You get the odd one or two who rush or have to go quickly", "I've one who's very attached to me, it's lovely" and "I feel I am getting quality and compassion." A relative told us, "The ones that come very regularly are like part of the family, the way they talk to all of us. They treat [family member] really nicely, and have a laugh with her." We asked people if care staff treated them with respect, people said they did. One person told us, "I really like my girls; they make my day, I look forward to them coming each day. Of course I have my favourites but they are all good."

All care staff made sure people's privacy and dignity was respected. One comment that reflected what a lot of people told us was, "The carer (staff member) always discusses with us what would like, we couldn't be looked after better, we are very satisfied." Care staff we spoke with told us how they upheld people's privacy and dignity, "I make sure I treat people how I would like to be treated myself" ,"I make sure their bottom half or top half is covered while I'm washing them" and, "I make sure curtains or doors are closed when people use the bathroom." Another said, "You need to remember you are in someone else's home and treat this with respect." The registered managers told us it was part of the observed supervision process by them and the local care service managers to observe how care staff spoke to people, to ensure they were polite and treated people respectfully.

With the occasional exception, people told us they had regular care workers (hourly service) who they knew and trusted, comments included, "I have the same people. They're more than carers; they are friends," and, "Yes usually it's the same person, but sometimes we have a different one when she is off, but I don't really mind." Another said, "I call them my angels. I have had the same carers since I started having care about two years ago, they are great more like friends nothing is too much trouble at all." Some people receiving the live in service had some concerns around continuity, however they all said care staff treated them how they wanted to be treated. We looked at the call schedules (hourly service) for four people who used the service and three care workers. These showed people were allocated regular care workers where possible. The registered manager and care co-ordinators told us they tried to make sure people were supported by the same team of staff, a co-ordinator said, "Where possible people have regular care staff who they can get to know and build up trust." Care staff we spoke with had a good understanding of the people they visited because they supported the same people regularly and knew people's likes and preferences. Care staff (hourly service) said they had time to talk to people as they didn't have to rush. Most of the comments from people confirmed this, "Oh yes, we always have a chat", "They do chat when they're helping me"," She'll help me in the shower, get dressed, and she sits and talks to me till her times up."

People and relatives receiving the live in service, said care staff were kind, caring and used a variety of communication techniques to build up caring relationships and to encourage conversation. Some of the staff were from other countries and for some, this could present challenges. People told us of positive examples when care staff used their different cultural experiences and life histories to better inform people about who they were. For example, one relative said, "Everyone (care staff) brings something different. One

(staff member) brought film slides and did a film show." They told us about another staff member who, "Was setting up a new home. She was Romanian and things are cheaper there so, she bought things and showed them to [relative]. They said, "She showed him pictures of her new home." We were given other examples where care staff were into arts and crafts and crochet, so, "They showed [relative] bits and pieces." They told us their family member had experienced speech difficulties and one of the care staff, "Helped [person] to use an iPad to help communicate. As they're younger they're more in tune with iPads and 'help [person]. They even get on YouTube and show [person] old films and music." They told us their relative enjoyed this.

We asked if people were supported to maintain their independence, people told us they were. Comments from people using the hourly service included, "Yes. I do as much for myself as I can." Relatives said, "She does try to do as much as she can." Care staff told us they had enough time allocated for calls to encourage people to do things for themselves where possible. One care staff member said, "You do have to be aware of the time but we do try and encourage people to do as much as they can for themselves." People using the live in service were equally complementary about the staff who supported them to maintain their independence. For example, one care staff member explained how they supported one person. They told us they made sure the person was encouraged to do what they could themselves, and the staff member only supported them with tasks they could not manage. One person receiving support told us, "My carer tries to help me be independent." Another person said "I can do quite a lot of myself but it is good to know (name of carer) is by my side, they help and support me to do things for myself." A relative told us, "They help [Name] do an online shop. It takes a bit of time doing it, but it's important to them to make choices and to retain a sense of independence."

Most people or their relatives said they were involved in making decisions about their care and were able to ask care staff for what they wanted. People said, "I can make my own decisions." "Yes. I know what I want and I tell them." A relative told us, "They always ask her if there's anything else they can do." People said they had been involved and consulted when their care was put in place, at the start of the service and when care reviews were completed.

Good

Is the service responsive?

Our findings

People receiving both aspects of the service told us their support needs had been discussed and agreed with them when the service started and that their regular care workers knew their likes and preferences. Comments included, "Yes, they know what I like," and "I've used them for 10 years, they know us well." One relative of a person receiving the live in service described to us where responsive action from care staff had been important. They said, "[Name] had a fall. The carers took prompt action to call out the paramedics. If there are any situations like this, proper care is given." Care staff told us they had regular people so they got to know how people liked their care provided, in a way that was personal to them. One care staff member told us, "We have regular customers so we are able to identify any changes quickly, for example if people are unwell and we will let the family know."

Hourly care staff we spoke with, had a good understanding of people's care and support needs. They told us there was information in care plans about how people liked to receive their care and to inform them what to do on each call. We were told, "We have time to read care plans and we have regular clients so you get to know what they need and what they like." Care staff told us if people's needs changed they referred the changes in care to local care services managers so plans could be updated. They said plans were reviewed and updated quickly so they continued to have the required information to meet people's needs. The managers used a digital pen system to record information in people's homes. This allowed the information to remain in the home for care staff to access. The written information was transferred to their computer system and saved to the person's care file for office staff to access. This meant the office records and records in people's home were the same, so all Helping Hands staff had access to the latest information.

Live in service care staff told us they read care records at the start of each stay in a person's home. The care records included information from the previous member of care staff as a 'handover', which updated them with any information they needed. Care staff also attended people's home for a verbal handover at the start of their working contract in the person's home. One person said, "There's a handover and they make notes of what needs to be done." A relative told us, "They [care staff] come the day before if it's a new one, they learn how they like to be moved. They work alongside the existing carer as a handover." One member of care staff told us about the handover procedures saying, "I have had a 24 hour hand over and also a two hour handover depending on the needs of the individual. Prior to the new staff member taking over from me, there is a form which must be completed detailing all relevant information."

Staff explained the daily records supported them to provide responsive care for people because the information kept them up to date with any changes to people's health. Most of the people we spoke with confirmed that the daily records each person had in their home were kept up to date by staff. One person said, "They fill in the records every day."

Hourly care staff told us they had regular clients who had scheduled call times. They said they had enough time allocated to carry out the care and support required. Care staff who worked in the evenings told us they found it difficult to complete some of their calls on time as they were only allocated 15 minutes to complete the call. They told us, "We can't get things done in the time, it's not the office's fault its social services that's

all the time they will allow. We do report it back to the office and they do try to get more time allocated."

We looked at the 'hourly' call schedules for the people whose care we reviewed. Calls had been allocated to a regular team of care staff and scheduled in line with people's care plans. Call schedules showed care staff were allocated five minute travel time between calls to support them to arrive at people's homes at the arranged times. Care staff told us if there was an unexplained delay for example, traffic hold ups, they may arrive later than expected. Care staff said they either phoned the person or asked the office to let people know they were running late. Care staff who worked in more rural areas told us, that five minute travelling time between calls was not always sufficient to allow them to get to people at the agreed time, due to traffic holdups and distances.The provider evaluated call times from their call monitoring system to ensure time lost travelling was kept to a minimium.

We looked at four care records for people receiving the hourly service. Care plans provided care workers with detailed information about the person's individual preferences and how they wanted to receive their care and support. There were clear instructions for staff about how to provide the care people required. For example; how staff should support people with personal care or use equipment to assist people to move around. Records of calls completed by staff confirmed these instructions had been followed.

People told us they had reviews of their care. Comments from people included, "The manager comes and we go over my file about twice a year", "We have reviews regularly", and "I'm supposed to have one review a year, but it seems to be longer than that since I had one." Plans we viewed had been reviewed and updated as needed and had been signed by people or their relative which showed they had been involved in planning their care. One person told us, "I have a care plan. I know everything in it and I'm happy with it." People receiving the live in service had the same experience. They and their relatives told us they were involved in planning and agreeing their own care. Care records we reviewed confirmed this. People told us all their likes and dislikes were discussed so their plan of care reflected what they wanted. We saw records detailed people's likes and dislikes and their support needs and differed from person to person meaning people's individual needs were listened to and supported. A relative told us about the care planning process saying, "At the start we had an assessment interview by one of the managers so they knew exactly what care [Name] needed."

Care reviews were undertaken monthly by staff. This system helped to ensure people's care records reflected their current support needs. Reviews also took place each year with the person and their representatives to ensure people continued to be involved in making decisions about their care and support needs. One person confirmed this saying, "Yes. There's usually (at least) a review every year."

The provider had a written complaints policy, which was contained in the service user guide which each person had in their home. People who used the service and their relatives, told us they knew how to make a complaint if they needed to, by contacting the managers in the office. Several people said they had contacted the office to raise concerns and these had been resolved to their satisfaction. People told us, "I've complained the odd time, it was nothing bad, and yes it does get sorted out," and "Concerns, I've had none, but I would say if I was not happy. I'd report it and they would put it right." Care staff knew how to support people if they wanted to complain, we were told, "I would refer any concerns or complaints to the office so they could sort it out." The registered manager told us, "We take all complaints seriously as it's a way of putting things right and improving what we do. I tell the team to be honest, open and transparent. If it's our fault we need to accept it and apologise and make sure it doesn't happen again."

Good

Is the service well-led?

Our findings

The majority of people we spoke with across both services provided were happy with the service they received. Comments included, "I'm happy, yes. If I wasn't they would hear about it. You've got to speak up for yourself," and, "I am very happy with Helping Hands I wouldn't be in my own home without their help, I am sure I would be in a care home." A relative told us, "No company is perfect. We have problems when carers have days off or holidays but on the whole, day to day we are happy with the service my [relative name] receives." The majority of people also said they found visiting managers approachable. Comments included, "Yes certainly the supervisor is very good and they are all very polite. [Manager's name] is very good and prompt to help out. A relative confirmed this by saying, "We are in the London area. The local manager is pretty good about any concerns that I raise."

People we spoke with told us they were able to contact the office if they needed to speak with someone. "Yes, I can ring the office, I've got their numbers" and, "Yes, there is always someone available in the office if I need them." We asked people if they thought the service was well managed. Most people said they did, comments included, "Yes I do. I've met the managers and I'm very confident in them," "It seems to be managed okay," and "Sometimes it is, sometimes it is not. You know when the managers' change as it messes things up. At the moment, it is well managed."

A limited number of people receiving the live in service told us they were not always pleased with the responses to complaints or issues they had raised. Before our inspection visits, we reviewed the information we received from people and found examples of complaints that had been sent to us and Helping Hands, where people were not satisfied that their complaints had been handled correctly. We found when we spoke with the provider, investigations were held and if responses were not received, duplicates were sent out to those people. Some comments people made to us when preparing for this inspection were, "They are not so good at communication…that has been appalling", "Their carers are first class, their managers are very good but their office staff are constantly changing so they are not well organised" and "Its good at the moment but it's been very hit and miss in the past."

We looked at how the provider learnt from complaints. The provider's complaints system recorded complaints for the live in service and hourly service separately so they could identify the areas of the service where people had raised a complaint. Complaints were discussed at monthly operational meetings and we were told analysis of complaints was taken and if there was any shared learning, this was cascaded by senior management to staff. The chief operations officer and the operations director said part of the provider's complaints handling system was, if the person was not satisfied, individual complaints were passed to them to deal with directly and they managed and monitored them through to satisfactory conclusion. The operations director said where people's complaints were not always resolved, those people were signposted to seek support with their complaint, from the Local Government Ombudsman We had knowledge of some of the recent complaints and we were told a thorough investigation of staff and processes were reviewed. Where staff were deemed negligent, the provider had taken the necessary action, such as further observations of practice, additional training, or consideration of continued employment.

The provider had systems to seek people's feedback about the quality of the service they received For example, local care services managers visited people using the live in service and asked them their thoughts on the quality of service, if they had concerns, or if they had ideas for improvements. The provider issued quality surveys to people and staff and analysed these comments into 'You said, we did'. We saw the latest survey results which were positive from people receiving the service. For example, 96% of people said they were treated with respect. The provider set to improve this by increasing the time local care services managers spent with people and observing the staff delivering care. 96% of people felt safe using the service and 91% felt they were supported by staff to maintain their independence.

Part of the provider's quality assurance systems, included regular meetings to discuss ways to drive continuous improvement. Regular 'Operation Team' meetings were held which included operational and non-operational staff such as heads of live in care, team leaders for care services, head of home care, senior quality assurance managers and registered managers. We saw a copy of the minutes from the last meeting dated 26 April 2016. We were told all business areas were discussed, which meant senior management had up to date knowledge and awareness of how the business was performing and how some actions or decisions, impacted others. Areas for discussion included care delivery, staffing, finances, quality assurance and sales and marketing. Recent minutes identified a number actions for review and improvement. For example, internal monitoring of staff by observations was discontinued in favour of assessing competency. A review of on-call systems and call schedules was planned to improve efficiency. Discussions were held about people's clinical care needs and how these would be identified and handed over to clinical nurses, without affecting, but improving the delivery of service people received. We were told previous action points were reviewed at each meeting to monitor and progress planned improvements.

We spoke with a 'Head of live in care' manager. They explained to us how they ensured the local care services managers and care staff they were responsible for, worked and delivered the standards of care expected. They said, "I do a dip sample, so I check four care plans, of different managers. I check they are person centred and have the right risk assessments." They said they had found some instances where care plans were not in place. For example, new care packages did not always have detailed care plans in place at the start of delivery, so improvements were made to ensure care plans were written and put in place so staff had information to provide consistent care. They said they had supervision meetings with the local care services managers and these discussions helped them identify any positive or negative situations, so early intervention could be taken. They told us these supervisions helped them be assured care staff were being supported and if there were issues being raised, they could escalate them to see if there were common issues across the business, or issues related to a specific area.

A local care services manager told us they 'felt involved' because they had regular conference call meetings which they found helpful. They said these meetings helped them reflect on how they and their team did things and as a result, improvements were identified. For example, they told us about one meeting where they discussed a person who was at risk of choking and as a result, identified some staff were unsure what action to take if a person had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation). They said they held a training session with their team and discussed what DNACPR meant regarding people's choice and to test staff's understanding about the importance of this. They said if there was an issue they needed staff to know about quickly, they sent an email called 'e-shots'. They said this was a useful way to communicate important information consistently and quickly. Staff also had electronic access to internal guidance, policies and updates which provided them with access to information about the support networks, training and information they needed to know.

Most care staff said they enjoyed working for the agency and that it was managed well. Comments included, "I love my job, it's so rewarding." We asked care staff if there was anything that could be improved. We were

told overall the service worked well but the information provided before they made a call to a new client could be improved. They said although there was a care plan in the new person's home, it would be helpful to know a little about the person and what the call entailed before the call, so they felt better prepared before they met the person. We fed this back to the registered managers who said they would look into this. We also received similar concerns from care staff (South region) in the live in service. They told us improvements could be made regarding communication between management and office staff. Some staff said despite the methods of communication, at times, they felt isolated which sometimes impacted on their overall wellbeing. For example, during this inspection we spoke with a staff member who told us they felt isolated and not supported by their line manager. A typical comment was, "It's not been very well run round here and I've had no support and cannot get decisions, I've not seen anyone for four months since starting. The main difficulties are pay structures, such as getting half pay when the people we care for go into hospital" and "Once you are out of the training room and in a placement that is more or less where all the support ends. Over a period of six years I had worked with several managers and out of them only a few have provided the support that the company promises to provide. Once you are in a placement you are pretty much on your own and reliant on your own common sense and knowledge. If there is a problem there is usually no support from either the manager or the office staff. They pretty much expect you to sort it on your own." Some staff told us they felt they should have meetings within the first week or two to address any initial concerns or fears they may have.

We discussed these comments and others with senior management and they were disappointed to hear this, however they welcomed the feedback and agreed to look at ways for staff to feel more engaged. A head of live in care told us, in their region (Central) they were confident local care services managers visited new staff and made sure staff were settled and if not, staff knew who to contact, such as a head of live in, office staff or senior management.

A registered manager covering the South region told us they recently used a 'buddy system' for staff. They explained this meant new or existing staff, if close by, could meet up for a coffee or lunch to reduce feelings of isolation and a lack of support. They told us this worked well and could be rolled out across other regions. A small number of live in staff raised issues regarding contracted hours and the length of time 'on shift'. A typical comment we received was, "In a live in care contract with the customer it is stated that a live in carer is only expected to provide nine hours of service. But this whole clause is there just to avoid any legal problem. When they first take on a customer for live in care they never explain this clause clearly to the customer. So when a carer is sent to a live in placement most often the customer thinks that the carer is there to provide care 24/7. No human being can operate for 24/7 without proper breaks and sleep at night."

We discussed care hours and staff breaks with the operations director and the chief operations officer. They showed us how each care package was calculated on 'an average hours' basis and a review was regularly completed to ensure averaged daily hours did not exceed nine hours. We saw an example of the calculation and the review which gave an average of six point three hours per day. The operations director said they were aware of the working time regulations and the hours and breaks staff were legally required to take. They said Her Majesty Revenue and Customs (HMRC) had recently reviewed the business and no issues were found. We were told they took staff working conditions seriously and did not encourage staff to work above legal limits.

The provider invited staff feedback as part of their governance checks, such as supervision meetings, observation checks, yearly appraisals and they supported staff with on-going training and personal development. A majority of staff told us they felt well supported by the management team. Care workers said they had team meetings where they could raise any concerns and share their views and opinions. They also had regular supervision meetings to make sure they understood their role and observations of their

practice to make sure they carried out their role safely. We were told, "We have regular spot checks; they check to make sure you have your ID badge, are wearing your uniform and use disposable gloves and aprons. They look at the records I have completed and talk to the customer about the call. They also give you feedback about your practice."

The provider had an effective system that trained all staff within each role and monitored their training and induction through a series of meetings and observations. A local care services manager said, "No matter who you are in this organisation, everyone goes through the induction, from care staff, even the CEO has done it." They said this was important because, "If a carer was to phone up in tears, you are equipped to help. We are big (organisation) but we have the staff with the skills, that's the beauty of it" Training and further development programmes supported staff at all levels. For example, care staff were supported on NVQ development and there was a bespoke internal management programme that aligned with level 5 qualification of the Health and Social Care diploma, targeted for local care service managers called 'Operational Excellence in Social Care for leadership and management'.

Care staff knew who to report concerns to and were aware of the provider's whistle blowing procedure. One care staff member told us, "There is a whistleblowing hotline where we can raise any concerns anonymously. I've never had to use this." They were confident about reporting any concerns or poor practice to the managers. One care staff member said, "If I had any queries or concerns I would contact the office and let them know, there is always someone available by phone."

The provider's staff survey results in some areas fell below the providers expectations, supporting some of the concerns staff shared with us. For example, 52% of people felt office staff gave them important information and 70% staff said their care manager was accessible. These scores reflected some of the concerns staff raised with us regarding communication and feeling involved. The senior quality assurance manager told us improvements in how the office staff and regional staff communicated was being made, such as one to one supervision meetings with their line manager and weekly emails that informed staff what was going on within the wider organisation and their local geographical area.

The provider had a system of 'exit interviews' that were held (where staff agreed) so the provider could speak with staff to find out why they did not want to continue working for Helping Hands, and if there were areas for improving working conditions. We saw a sample of exit interviews and staff were complimentary about working for the agency. Comments staff made at these interviews were, "I was sad to leave", "The training is excellent", "I like the manager who was approachable, just not enough hours." We were told these were reviewed to see if there were trends that could be investigated further.

A head of clinical care was responsible for 35 people who had been assessed as higher dependency based on their clinical health needs. They told us they completed regular quality checks that made sure these people received safe and effective care from staff, who were trained to meet their needs. For example, the head of clinical care regularly checked care plans, risk assessments and staff competency to administer medicines safely. They told us they checked medicines administration records (MAR) and did medicines audits to ensure they had been stored, administered and recorded safely. They told us they did an observed practice of staff which assured them staff were competent to support people to meet their care needs.

The provider met the requirements of the regulations such as, having a registered manager in post and they understood their legal responsibility for submitting statutory notifications to the CQC, such as incidents that affected the service or people. The provider submitted their PIR before the required deadline and we found what they said, was a true reflection of what we found.