Ginger Homecare Limited

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Inspection report

7 Clifton Parade, Bristol Avenue
Farington
Leyland
Lancashire
PR25 4YU

Tel: 01772463097
Website: www.gingerhomecare.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
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 announced inspection took place on 5, 7 and 12 September 2017. We last inspected Ginger Homecare in January 2016. At the inspection in January 2016 we rated the service as 'Good' overall and for all the individual domains of 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well-led'.

Ginger Homecare Limited is a privately owned domiciliary care agency providing practical and personal care to people living in the local community. The agency operates from an office base in Farrington, Lancashire.

At the time of our inspection there were approximately 120 people receiving a service from the agency which equated to approximately 1000 hours per week. The vast majority of people using the service had their hours commissioned by the Local Authority.

The Registered Manager was present during the inspection of the registered premises and was cooperative throughout the inspection process. 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. The Deputy Manager was also present throughout the inspection and was also cooperative. Both had worked at the agency for over 20 years.

People who received a service from Ginger Homecare told us they felt safe when staff from the agency visited them in their own home.

People we spoke with told us they were supported well to take their medicines on time by a competent staff team. We did however see some examples within care plans were people's current needs were not reflected in this area and we have made a recommendation about this.

People's needs were risk assessed prior to receiving a service from the agency. As with medicines management risk assessments, we found some examples where people's current needs, were not consistent with the information within their care plan. We have made a recommendation about this.

People told us the staff that came to provide care and support were well presented and wore personal protective equipment (PPE) when assisting them with personal care. Staff confirmed with us that they had enough PPE to carry out their duties effectively.

We spoke with staff and asked them if they were supported to carry out their role effectively. All the staff we spoke with told us they felt supported by management and peers.

We saw evidence that staff received a thorough induction when they first started work with the agency and that they received a variety of training once they were established. Staff also received three monthly supervisions and an annual appraisal.

We found some conflicting information with regards to how people gave their consent. The agency had introduced a new system and paperwork to resolve this issue prior to the inspection process finishing.

People we spoke with told us they were happy with the care and support they received and that staff were caring and considerate in their approach. People and relatives we spoke with raised no issues with respect to dignity, privacy or confidentiality.

Improvements had been made to care plans in terms of the detail within them and how they related to individuals. This had been an issue raised at the previous inspection. Whilst some work was still needed, to ensure care plans were fully reflective of people and their current needs, we could see that a lot of work had gone into this aspect of the service. People told us they were involved in the review of their care if they wished to be.

The agency had an up to date complaints policy in place and we saw that complaints were responded to and investigated in line with their published procedures. People we spoke with told us they knew how to raise complaints.

People, relatives and staff we spoke with talked positively about the management of the service and told us they considered it to have a positive culture. People we spoke with were able to tell us who the registered manager of the service was and that she was approachable.

Staff we spoke with were knowledgeable about adult safeguarding procedures and how to recognise and report potential issues in this area. However, there were several examples of potential safeguarding issues that should have been notified to the Care Quality Commission which had not been. We have made a recommendation about this.

The agency had several quality monitoring and auditing tools in place including external checks on their processes and systems via an external agency. We saw evidence to show that issues raised were dealt with and also were a catalyst to make changes to the service to make improvements.

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.

People told us they felt safe when receiving care and support from Ginger Homecare.

Staff were able to explain the agency's safeguarding processes and received training in this area.

People told us they received their medicines on time however some medicines risk assessments were not reflective of people's current needs in this area.

The agency had effective recruitment processes in place.

Is the service effective?

Good

The service was Effective.

People told us that staff were competent and professional in their approach and appearance.

We saw evidence to show staff were trained, supervised and supported to carry out their role effectively.

Staff understood the principles of the Mental Capacity Act. We did however find some conflicting information with how people's consent was gained and recorded although this was resolved by the time our inspection was completed.

Is the service caring?

Good

The service was Caring.

People and relatives told us staff were kind, compassionate and attentive to their needs.

Staff were aware of the need to protect people's dignity and privacy and spoke well in this area.

People were given information abut the agency prior to, or at the beginning of their service starting.

Is the service responsive?

Good

The service was Responsive.

Care plans had been improved since our previous inspection to include more person centred information and detail. This was an on-going process.

The agency had an effective complaints process in place that was adhered to in practice.

People were assisted to access the community if this formed part of their assessed service.

Is the service well-led?

Good

The service was Well-Led.

People, staff and relatives spoke positively about the culture of the service and the management team.

A range of quality audits and checks were in place that contributed to service improvements.

The management team met at regular intervals throughout the year to discuss issues and plan for the future.

Ginger Homecare Limited

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.

This inspection took place on 5, 7 and 12 September 2017. We gave the service 24 hours' notice of the inspection to ensure the registered manager and other key members of staff would be available to support the inspection.

Prior to the inspection we reviewed the Provider Information Return (PIR) which had been sent to the provider for completion. The PIR 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. This was completed in detail and we asked for further updates on this information when we inspected the service.

The inspection team consisted of one adult social care 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. The expert by experience made phone calls to people and relatives on the 7 September to talk with them about their experience of the service. The lead inspector visited the registered office on the 5 and 12 September to look at records, which included four care plans, four staff files, quality audits, team meeting notes and other associated documents.

We spoke with a range of people about the service, this included five people who received a service, five relatives, eight members of staff, including the registered and deputy manager and commissioners of the service.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with who received care from Ginger Homecare told us that they felt safe. Comments included, "Yes, very safe", "Yes I do", "Oh yeah" and "Yes completely." Relatives we spoke with also told us they felt comfortable with regards to the safety of their loved ones when receiving care and support from the agency.

We spoke with staff about the agency's safeguarding procedures. They were all aware of the safeguarding policy and how to report any potential allegations of abuse or concerns raised and were aware of the procedures to follow when we spoke with them. They were also able to tell us who they would report issues to outside of the agency if they felt that appropriate action was not being taken and displayed good knowledge of local safeguarding protocols. Staff confirmed that they received training in this area and we saw evidence of this via the agency's training matrix and within the staff files we reviewed.

We checked on the support staff gave to people who needed help to take their medicines. People and relatives we spoke with had no concerns with how staff helped them or their loved ones to take their medication. The staff training matrix showed that staff who had responsibility for administering medication had received appropriate training. Staff we spoke with told us, they were confident in administering medication and they had sufficient training and support to do so. Medication Administration Records (MARS) were brought into the office monthly and these were checked and audited for any recording or administration errors.

We saw that care plans contained medication risk assessments which covered the ordering, labelling and the storage of medicines. The assessment also identified any issues around administration or each person's capacity to remember to take their medicines if staff did not assist them to do so. However, we did see two examples were people's risk assessments with regards to their medicines needed updating to reflect their needs or current issues. One issue was referred to above in that the person had been refusing and stockpiling their medicines, this was not reflected within their risk assessment, which meant staff who were not familiar with this person may not be aware of the issues. Another person's risk assessment stated that they self- medicated however carers assisted them to take medicines out of boxes as the person was unable to complete this task. This is considered as administration of medicine therefore the person's risk assessment was incorrect in stating they self- administered their medicines.

We recommend that the service reviews all people's risk assessments with regards to medicines management to ensure that they are reflective of any current issues and that risk assessments regarding people who are classed as self-medicating are accurate.

We reviewed risk assessments for other areas of assessed needs in addition to medicines management. This included load management, meal preparation and people's environment. In general risk assessments were reflective of people's needs and current circumstances. However, we did find some information that was contradictory. For example, one person was assessed as being at low risk within their meal preparation risk assessment, yet the information within the assessment stated that they needed their food cut into

manageable pieces and needed assistance with eating and drinking. Another person had been initially classed as at risk of falls, however their current risk assessment indicated that they were at low risk as they had not fallen for a while. There was no rationale other than the person had not fallen for a period of time to indicate they were no longer at a high risk of falling. We discussed this issue with the registered manager and it also became apparent that the person now only needed one person to transfer as opposed to two people as indicated within their risk assessment. Whilst this perhaps evidenced that the risk of falling had reduced it also evidenced that the information within the risk assessment was dated.

Although four of the six care plans we reviewed were accurate, as with medicines risk assessments we recommend that all people's risk assessments were reviewed to ensure they were in line with current need to ensure that staff have an up to date picture of risks to individuals and how to best manage them.

We looked at staffing levels within the service to ensure that there was enough staff employed to provide the assessed care people required. None of the people or relatives we spoke with raised concerns regarding staffing levels, although two relatives did say the consistency of care staff coming to their home could at times be an area for improvement. No one we spoke with had an issue about the timeliness or length of visits. We discussed staffing levels with the registered and deputy manager who informed us that whilst recruitment was an ongoing exercise, systems were in place to cover both planned and unplanned staff absence.

We looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. Prospective employees were asked to undertake checks prior to employment to help ensure they were not a risk to vulnerable people. We reviewed recruitment records of four staff members and found that robust recruitment procedures had been followed including Disclosure and Barring Services (DBS) checks, application forms being completed, candidates attending an interview and suitable references being sought prior to staff beginning work.

We asked staff if they had access to the appropriate personal protective equipment (PPE). Staff confirmed that they did and that they could pick up additional supplies from the office. There was a suitable policy and procedure in place related to infection control measures. People and relatives we spoke with raised no concerns with regard to the appearance of staff or their practice in this area.

The service had an accidents and incidents book kept at the registered office. There had been no accidents or incidents within the 12 month period prior to our inspection.

The service had a whistleblowing policy in place for staff if they felt they were unable to raise concerns with their line manager. There were no recorded whistleblowing incidents for the service for the 12 month period prior to our inspection.

Good

Is the service effective?

Our findings

People we spoke with told us that the staff that came to their homes to support them were competent, professional and knowledgeable about their needs. One person told us, "They know what I require, I am very satisfied. I don't think there are any bad things I could tell you about them or the service." Another person said, "They (staff) are very good at their job. They are very compliant with my wishes, keep my place nice and tidy and are very good company for me as well." Relatives we spoke with told us similar with one relative saying, "They all do what they should do. I couldn't care for [name] any more or do anything right for [name]. There are no problems with any of them (staff)."

We spoke with staff and asked them if they were supported to carry out their role effectively. All the staff we spoke with told us they felt supported through formal mechanisms such as supervision and training and also they felt able to approach both management and peers with any issues they had. Throughout the inspection we saw that staff came into the office in between visits to discuss issues, for an informal chat or to pick up personal protective equipment. One member of staff we spoke with told us, "We come into the office regularly for training, usually about six of us at a time and the training providers are really good. I have done moving and handling, safeguarding, food hygiene and a number of other things I can't remember off the top of my head." Another member of staff said, "I'm more than happy with the way things are run here and the support I get. They are on the ball with showing you what to do and we are always coming in for training." We received very similar responses from all the staff we spoke with.

As well as staff telling us that they received the support they needed we saw evidence within staff files that staff received regular supervisions and an annual appraisal. We saw that new staff received a 12 week induction which included completing 'The Care Certificate'. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with the non-regulated workforce in mind, the Care Certificate gives everyone the confidence that these workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Within the office the staff training matrix was on display which showed that regular training was provided to staff across a range of areas which included; safeguarding, moving and handling, infection control, food hygiene, health and safety and medication management. We also found certificates on staff files when we reviewed a sample of them. The service had a training and development plan in place that detailed training for new recruits and existing staff. This included minimum targets for supervision, appraisals, expected training and also encouraged staff to attend specialist training in areas such as catheter care, peg feeding and incontinence. This would be dependent on the needs of the people staff visited.

Where people received support in their own home, applications to deprive a person of their liberty must be made to the Court of Protection. We checked whether the service was working within the principles of the the Mental Capacity Act 2005 (MCA). The 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. We checked whether the service was working within the principles of the MCA.

We found some conflicting information with regards to how people gave their consent. For example one person had signed several parts of their care plan, such as signing to understand the agency's complaints policy and service user guide. However a relative had signed the care contract. This person was deemed to have capacity therefore there was no reason they should not have signed their own care contract unless this was their wish. We found another example where one person had signed to state they had understood the agency's complaints procedure and safeguarding procedure but a relative had signed to give consent for their medication to be managed by the service.

We discussed these issues with the registered manager and deputy manager. It was evident that they, and the staff we spoke with, knew people well and that some care plans needed to be updated to reflect each person's ability to give consent. By the time we returned to give feedback following our inspection each care plan we discussed had been reviewed and people's capacity was reflected accurately via a new consent form that had been introduced. This included information and explanations for people who were unable or unwilling to sign consent documentation.

Staff we spoke with had a reasonable understanding of the MCA and confirmed they had received training in this area which we also saw evidence of. When discussing with staff how they gained consent from people prior to them giving assistance they were able to do this well. People who received care and support spoke positively about how staff communicated with them, whether that was care or office staff.

We asked people who were supported with their nutritional and hydration needs if they were happy with this aspect of their care. No issues were cited within this area. Care plans we reviewed reflected peoples assessed support needs.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy with the care and support they received and that staff were caring and considerate in their approach. One person told us, "All I can say is that their friendliness and willingness to help are the best." Another person said, "Brilliant support, there is nothing I could complain about." Relatives we spoke with also had no issues with the staff that provided care and support to their loved ones. One relative told us, "The key thing I like about Ginger Homecare is that carers take the time to have a chat with [Name]. This is really important for people with dementia. It's not just about tick boxes. All the carers I have met seem pretty good to me."

People and relatives we spoke with told us they were, or had the opportunity to be involved in the design and review of the care they or their loved ones received. One person told us, "They (staff) come and talk it through with you, the care plan. About twice a year I think." Another person said, "Yes, yes I am involved, very much so." We were told similar by relatives we spoke with. We saw evidence within people's care plans that they were involved in care planning design and on-going reviews although how this was recorded was not always consistent.

We contacted the Local Authority who commissioned the majority of the services. We received positive information in terms of communication and the quality of the service provided. No issues were raised in terms of the service provided by Ginger Homecare.

When speaking with staff about dignity and confidentiality they were able to talk through specific examples, such as the delivery of personal care, and how this was done in a dignified and professional manner. People and relatives we spoke with raised no issues with respect to dignity, privacy or confidentiality.

The agency provided end of life care to people although this was not a specialist area. Only staff who wished to and felt confident in doing so provided end of life care to people. The registered manager informed us that some staff had received training and that going forward this would be an area that formal training would be accessed on a more regular basis for those staff who felt this was an area they wished to become involved with.

There was no-one at the service using a formal advocate at the time of our inspection. An advocate is an independent person, who will act on behalf of those needing support to make decisions. The registered manager told us that they were aware of local agencies who could provide such support and that people would be directed if needed, to such agencies.

We saw evidence that people were given enough information about the service. This included each person receiving a service user guide as their service began. The guide contained a description of the agency and its history, aims and objectives. It also contained information with regards to how to contact the agency including raising concerns and making a formal complaint. The registered manager told us that people were given a thorough explanation of the service during the initial assessment visit. People we spoke with said they had enough information about the agency and that communication was good.

Good

Is the service responsive?

Our findings

We reviewed six people's care plans in detail. At our previous inspection we had made a recommendation with regards to the lack of detail within people's care plans and the lack of a person centred approach as care plans were task orientated in places. We saw at this inspection that a lot of work had been done looking at people's preferences and ensuring that information was centred around individuals. We saw some good examples of how care plans gave good explanations of how care staff were to assist people without compromising people's independence.

One example we saw was when helping one person to get dressed. Their care plan clearly stated that staff were only to offer help if requested as the person wished to remain independent as long as possible. Another example was for one person who had limited ability in terms of holding a cup or glass. Their care plan included a suggestion that staff supplied drinks with a straw so the person could independently drink without staff assistance once their drink was presented to them.

Some of the care plans we reviewed were not as detailed. There were some genuine reasons for this including the lack of ability or willingness for some people and families to engage with the service. The registered manager did tell us that some care plans also needed to be reviewed to ensure that they were fully reflective of the needs of people. However, we saw that good progress had been made since our previous inspection and that there were a number of care plans that could be used as good examples in terms of the type and quality of information within them.

We asked people if they were aware of their care plan and if they were given the opportunity to be part of reviews. All the people we spoke with told us they were aware of their care plan and some people told us they were involved in reviews. Other people told us they were not bothered or were not interested in actively being involved with care plan reviews but knew they could be if they wished to be involved.

People we spoke with knew how to raise concerns including making a formal complaint if they felt this was needed. The service user's guide contained information on how to raise concerns within the service and externally to the Local Authority or Local Government Ombudsman. When asking people and their relatives if they knew how to raise concerns or complaints we received responses such as; "Yes, I would ring and speak to someone in the office." "Oh yeah, definitely", "I have their address and telephone number and have rang in the past." And "Yes, I have the managers number and have always managed to get hold of her if needed, not that I have ever made a complaint."

The service had received five formal complaints in the 12 month period prior to our inspection. There was a complaints log book in the office which contained details of each complaint. Each complaint was given a reference number, was dated and actions taken to resolve and prevent future occurrences were noted. The person responsible for dealing with the complaint was also recorded. All five complaints had been resolved within the given timescales of the agency's complaints policy.

People were assisted to access the community if this formed part of their assessed service. People were

assisted to access the community for a variety of reasons such as shopping, socialising and were offered assistance with banking and financial matters.

Good

Is the service well-led?

Our findings

People and relatives we spoke with talked positively about the management of the service, the staff and the care and support they or their loved ones received. We asked people and relatives if they knew who the registered manager of the service was and the vast majority of people did. Those who did not told us they had the information written within their or their loved ones care plan or within other documentation.

We asked people about the culture of the service and if they would recommend the service to others based on their own experiences. Everyone we spoke with told us they felt there was a positive culture within the agency and that they would recommend it to others. One person told us, "Definitely." Another person said, "Yes, I would very much so." And another person said, "Oh yes, I have done in the past." Relatives we spoke with also said they would have no hesitation in recommending the service to other people who needed assistance.

No notifications regarding safeguarding incidents had been received into the Care Quality Commission (CQC) for the 12 month period prior to our inspection. It was however apparent that there had been some potential safeguarding issues which, whilst they had been alerted to and/or discussed with the Local Authority they had not been notified to the CQC. We discussed this with the registered manager and reinforced that the Local Authority policy sets a higher threshold than making an alert to the CQC, which means that every potential safeguarding issue needed to be reviewed in line with CQC guidance for making a safeguarding notification. For example one person had been found to be having issues with their medication. They had at times not been taking their medication as prescribed, secreting their medication and stockpiling it. The agency's daily records showed that on a number of occasions this person had refused to take their medication. This had been discussed with the Local Authority safeguarding team however this should have been notified to the CQC in line with published guidance and was not.

We recommend that the agency's safeguarding procedures are reviewed to ensure that all notifiable safeguarding incidents are reported to the CQC in line with published guidance.

We spoke with staff to get their opinion on the leadership and culture within the organisation. Again the responses we received were very positive. One member of staff told us, "I can ask the office anything I want, I feel very supported and able to ask questions so I think the culture is good." Another member of staff said, "I'm really happy with the support I get. I love the job and the people here (within the office) are part of the reason for that although the biggest reason is the people I help, they make the job what it is."

We could see that there were a range of quality audits and monitoring in place to measure the effectiveness of the service. This included sending out surveys to people and families. The latest annual survey was sent out in July 2017. From 108 surveys sent there was a response rate of 43%. The results of the survey were positive and any negative comments were collated and an action plan had been formed. As most of the surveys were anonymous to encourage people to return them and be as honest as possible it was difficult to address specific issues raised although they were only a small amount of issues. For example 2% of respondents had said that they had raised issues with the consistency of carers coming into their home.

However they also said they were happy with the agency. As a result the agency had improved communication with people when their regular carer(s) were not available. There were other examples of the agency making slight adjustments to how they operated in light of feedback.

A staff survey was also sent out in July 2017. From 42 staff surveys sent out there was a 70% return rate. As with the service user questionnaire the theme was a positive one. There was a couple of comments from staff wanting additional training using hoists as people's needs had increased. Staff we spoke with told us that this training had taken place as a result of such comments and we saw further evidence to show this.

We could see that quality checks took place via spot checks for staff. This included eight key questions such as does the carer arrive on time and stay for the correct amount of time. There were also questions around respect and dignity and do staff know which procedures to follow as well as asking people if they felt they were listened to.

The agency had recently successfully completed its reaccreditation with ISO9000 earlier in the year. ISO9000 is a series of standards, developed and published by the International Organisation for Standardisation (ISO), that define, establish, and maintain an effective quality assurance system for manufacturing and service industries.

A business plan was in place for 2015-18 which clearly laid out the structure of the business, staff roles and responsibilities and the potential challenges facing the agency within that time frame including sustainability, staffing requirements and external relationships.

We saw that management review meetings were held between the director, registered manager and deputy manager. The last meeting had taken place on 23 May 2017. Discussions included commissioning issues, minutes from the previous meeting and the latest ISO and CQC inspections. There was also a review of existing policies, the organisations statement of purpose, service user guide, surveys, training and auditing processes.

The service was seen to be displaying their latest Care Quality Commission (CQC) rating within the registered premises. We saw the website also contained a link to the latest CQC report. However we discussed the need for the link to be made more obvious to people and to check the ratings display guidance published by the CQC. There were no registration issues other than the issues referred to with the safe domain in terms of ensuring that all reportable issues were notified to the CQC in line with published guidance.