

Hedgerow Homecare Ltd

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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 13 October 2016 and was announced. The provider was given 48 hours' notice of this inspection to ensure that the registered manager would be available to support it with this process.

Hedgerow Homecare Ltd is a small domiciliary care agency that provides personal care and support to older people in their own home in and around North London. The service works with people living with dementia, people with sensory and physical impairments as well as supporting people with palliative care. At the time of the inspection there were seven people using the service.

This inspection was the first inspection of the service since it was registered with the CQC in August 2015.

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.

People and relatives that we spoke with were complimentary of the service that they received. They also commented that care staff were aware of their individual needs and requirements and how these were to be met.

We saw suitable and safe arrangements in place in relation to the administration and recording of medicines. However, we noted for one person that there were gaps in recording on the Medicine Administration Record (MAR) for one month which would confirm whether a person has received their medicines. The registered manager explained that they had only recently begun providing support with medicines administration and had not identified this issue. The registered manager confirmed that they would put systems in place to ensure that MAR's were checked on a regular basis to ensure if any gaps were identified that there was a reason explaining why.

Procedures relating to safeguarding people from harm were in place and care staff understood what to do and who to report to if people were at risk of harm. A number of other policies and procedures were available to ensure people's safety which included risk assessments that considered people's individual potential risks, robust recruitment process and mental capacity assessments.

People were supported to make their own choices and decisions where possible. The care staff team demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and how this was to be applied when supporting people. Care staff were able to demonstrate the ways in which they obtained consent from people. They understood the need to respect a person's choice and decision where they had the capacity to do so.

The provider ensured that care staff were equipped with the skills and knowledge needed to deliver good

care. A number of methods were used to deliver training which included face to face training, competency assessments as well as on the job shadowing alongside experienced care staff.

People had individualised care plans which had been written from the perspective of the person requiring care. Care plans were person centred, detailed and provided information to enable care staff to appropriately support people. We saw that care plans were regularly reviewed and updated as and when required.

Care staff received regular supervision and support. Care staff told us that they enjoyed working for the agency and felt well supported by the registered manager. Care staff were yet to receive an appraisal as none of them had fully completed a year of employment.

The registered manager was yet to hold care staff meetings due to the lack of available appropriate premises to do so. However, care staff told us that they were appropriately supported and told us that were in regular contact with the registered manager who regularly contacted them by telephone, visited them at people's homes to carry out observations and received regular information exchange emails.

The registered manager tried to ensure that people received continuity of care. Each person receiving care had a regular and consistent member of care staff allocated to their package of care. This promoted good working relationships between care staff and people who used the service.

People and relatives told us that they were treated with respect and dignity. We were told that although staff were present to support people they also encouraged and promoted people to build their independent living skills.

People and relatives knew who the registered manager was and felt able to raise concerns or issues relating to the care and support that they received. They also felt assured that any concerns or issues raised would be appropriately addressed by the registered manager.

A number of quality assurance systems were in place to monitor the quality of the service being provided and to identify any issues or concerns thus allowing the provider to learn and improve the quality of service provision. These included spot checks, regular telephone monitoring, feedback questionnaires.

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. Care staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

Risk assessments ensured people were kept safe and were detailed and specific to the person's individual needs and requirements.

People were supported to have their medicines safely.

Robust recruitment processes were adhered to, to ensure that only suitable staff were recruited.

Is the service effective?

Good 

The service was effective. Care staff received regular training to effectively carry out their role. Care staff were regularly supported in their role through regular supervisions.

The registered manager and the care staff demonstrated a good understanding of the principles of the Mental Capacity Act 2005 (MCA).

People told us and care plans confirmed that they had consented to the care that they received. Where people were unable to consent to their care, appropriate processes had been followed whereby relatives consented to care and support on behalf of the person.

Where people required support with their nutrition and hydration, their dietary preferences, likes and dislikes had been recorded in their care plan.

People had access to health and social care professionals and were supported in this area by the care staff supporting them, where required.

Is the service caring?

Good 

The service was caring. People were supported by care staff who knew about and understood their needs.

The service provided positive and effective palliative care to people. Care staff were provided with specific training in this area and were well briefed and supported by the registered manager when caring for people who were nearing the end of their life.

People and relatives told us that care staff were caring and treated them with respect and dignity.

Care plans were detailed and person centred. People were supported to make informed decisions about the care that they received.

Is the service responsive?

Good ●

The service was responsive. People's care was person centred and planned in response to their needs. People were actively engaged in making decisions about their care.

The service had not received any formal complaints since they had begun providing care and support. Where small issues and concerns were raised, we saw that the registered manager had systems in place to ensure that these were dealt with and recorded effectively.

People and relatives were encouraged to provide feedback about the quality of the service that they had received.

Is the service well-led?

Good ●

The service was well-led. People and relatives knew the registered manager and were able to raise any concerns or issues at any time.

A number of quality assurance systems were in place which assessed the standard of care provision with a view to learning and making improvements.

There was an open and transparent culture within the service where good practice was identified and encouraged.

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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.'

This inspection took place on 13 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to support us with the inspection process.

The inspection team consisted of one inspector and an expert by experience. On the day of the inspection the expert by experience carried out telephone interviews with people using the service and their relatives. 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 spoke with one person and three relatives.

Before the inspection we looked at the information that we had received about the service from health and social care professionals, notifications that we had received as well as the provider information return (PIR) that the provider had sent to the Care Quality Commission (CQC). A 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.

During the inspection we spoke with the registered manager, the nominated individual and one member of the care staff team. We reviewed a range of records about people's care and how the service was managed. These included care plans for seven people, eight care staff files, medicine administration records, staff training records, quality surveys and a range of policies and procedures.

After the inspection we conducted telephone interviews with a further three care staff.

Is the service safe?

Our findings

People and their relatives told us that they felt safe with the care staff that supported them. When asked if people felt safe, one person told us, "Yes they [care staff] are lovely. I am happy, I have one special one [care staff] and she is fantastic." Relatives said, "I think so" and "Yes they discussed it all with us the main thing is risk of falling. But they try and keep the area clear and support her whenever she walks."

The providers safeguarding policy contained relevant information about the different types of abuse and the actions to take if abuse was suspected. Also contained within the policy were flow charts which outlined the processes to follow if and when reporting abuse. Attached with the policy were the local authority contact details as well as their protocol for safeguarding adults. This was also displayed in the registered office from where the service operated.

The registered manager and care staff that we spoke with were able to explain how they would keep people safe and understood how to report any concerns or suspicions of abuse. Care staff were able to explain the different types of abuse and how to recognise signs of abuse. Care staff received safeguarding training as part of their induction session which they attended prior to providing care and support. Certificates were available on each care staff file confirming their attendance. One of the care staff told us, "I would report it to [name of registered manager]." Another care staff explained, "I would call [name of registered manager] straight away, no if's or but's."

The service had not received any safeguarding concerns since it had begun providing a regulated activity. However, the registered manager understood their responsibilities in relation to reporting any concerns. We saw a record of when the service had made a referral to a local authority where some concerns of alleged abused had been noted. The registered manager had been pro-active in communicating with the local authority or the Care Quality Commission (CQC) as required.

Care staff understood the meaning of the term 'whistleblowing' and to whom this must be reported to including external agencies such as the police or the local authority.

The service carried out individual risk assessments to assess the risks associated with people's care and support needs. These gave information and guidance to care staff on how to reduce and mitigate risks that had been identified ensuring that people were kept safe from harm. Areas that were assessed included environmental risks and risks associated with health and safety. In addition, individual risks that were assessed included the risk of falling, the risk of developing a pressure sore, moving and handling and assessing psychological factors such as aggression, agitation and comprehension. Risk assessments were reviewed on a regular basis and were updated as and when required.

As part of the information and guidance provided in risk assessments, this included information about any equipment that was in use to support people with their moving and handling. This guidance provided directions on how to use the specific equipment such as slide sheets and hoists.

Medicines were administered in people's homes for some people who required this support. Care staff that supported people with medicines received medicine administration training which included a competency assessment once the training was completed. The service had only recently begun providing support with medicine administration to two people receiving a service. All processes around the overall administration of medicines were noted to be safe and the service ensured that they followed their medicine policy at all times.

We saw a medicine risk assessment was completed for the people who required support with medicine administration. This included information on the names of the medicines that need administering, when they were to be administered, any side effects, where the medicines were to be located and how they were to be stored.

However, we looked at the one completed medicine administration record (MAR) for the last month that had been returned to the office. We noted there to be several omissions on the record where care staff had not signed to confirm that people had received their medicines. The registered manager had not checked this one record and therefore was not aware of these omissions. The registered manager confirmed that this was an area that they would address. An audit system would be put in place for the future to ensure that care staff were recording correctly and people were receiving their medicines when required.

We looked at eight care staff files which contained the appropriate documents confirming that safe recruitment checks had been undertaken. These included a criminal records check, proof of identity and obtaining suitable references. In relation to criminal records checks, the registered manager explained that any new care staff with a recent criminal record check completed through another provider and within the last 12 months would be accepted. Hedgerow Homecare Ltd would then require the staff member to undertake a new criminal records check within a year of being in employment.

People were allocated a regular and consistent team of care staff where possible. The registered manager explained that this only changed where care staff were on annual leave or had taken sick leave. Regular care staff enabled people to experience continuity of care. One person when asked if the carers had been matched to meet their needs told us, "Yes, she [care staff] knows me inside out know."

People and relatives confirmed that there was enough staff available and that generally they were always on time when arriving for their visit. One person, when asked about timekeeping told us, "Yes most of the time. I don't mind if they are 10 or 15 minutes late." Relatives told us, "Yes almost always. I think a couple of minutes late every now and again but nothing to worry about" and "I don't think they have been late yet."

Is the service effective?

Our findings

People and relatives told us that they found the care workers to be trained and experienced. One person told us, "I feel that some of them know the ropes, she knows what she has to do." Relatives comments included, "Yes they know her really well and know exactly how to take care of her" and "I think so."

Care staff files contained records confirming that each of the care staff had received a comprehensive induction prior to commencing work with the agency. The induction covered areas such as record keeping, care planning, the providers core values and basic dementia awareness. In addition to this each care staff was required to complete training in mandatory topics such as moving and handling, safeguarding, food safety and health and safety. Once the training had been delivered, care staff were required to complete competency assessments, so that the registered manager could be assured that care staff had understood the training and that the knowledge had been embedded. The registered manager confirmed that all training would be refreshed on an annual basis.

The registered manager had plans in place to ensure that all new care staff recruited would be required to work towards the care certificate. This is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support. The plans to deliver the care certificate would also include current care staff completing this qualification.

In addition to the training all new staff were required to shadow more experienced care staff before being allowed to work on their own. During this shadowing period, the registered manager visited the new care staff and completed a competency observation before confirming that a new care worker was able to work independently.

All care staff that we spoke with said that they were fully supported by the registered manager and were encouraged and felt able to access training when required. One care staff gave us an example of when it was noted that some newly appointed care staff required training with a particular piece of equipment. This was fed back to the registered manager and training was organised and delivered immediately.

Care staff told us and records confirmed that they were supported in their role through regular supervisions. One care staff said, "I have supervision every month and we talk regularly on the phone. She [registered manager] is very supportive." Another care staff stated, "Supportive? Very much. I can ring her 10 times a day and she will guide me. For supervision she comes a few times to people's homes every month."

Supervision records that we looked at discussed areas such as "How are things going?" "Any problems," training and future prospects. There were no appraisals available for any of the care staff as none of them had completed one year of their employment.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

The service had policy and procedures in place in relation to the MCA. People's capacity was assessed as part of the pre-admission assessment. Questions were structured around the assumption that people had capacity and where it was noted that people lacked capacity questions were asked whether best interest decisions were required to be made. The assessments then detailed what these were and how the person was to be supported giving consideration to any decisions that had been made. People and relatives told us that they had consented to the care and support they received and this had been appropriately documented within each person's care plan. We saw that care plans had been either signed by the person receiving care or where people had been unable to sign, the care plan had been signed by a relative.

The registered manager and care staff demonstrated a level of understanding of the MCA and how this impacted on the care and support that they provided. Training records also confirmed that each care staff had received training on the MCA. One care staff member told us, "The MCA is about supporting people who may not be able to make decisions for themselves and might not know what is in their best interest." Another care staff stated, "It is about where people are unable to make decisions for themselves. I would need to contact the family or social services if I had any concerns."

Care plans documented where people required help with meal preparation as part of the care and support package they received. The support that people received varied and depended on people's individual circumstances. Some people lived with family members who prepared and supported people with their meals. Some people lived on their own, so their care plan detailed the level of support they required with the preparation of their meal.

The registered manager and care staff were available to support people with their healthcare needs where required. People's care plans and daily recording notes contained evidence of when the agency had supported them to access the GP, district nurses, emergency services and other health care professionals. Care staff were aware of how to refer people if they thought their healthcare needed attention. One care staff told us, "I was concerned about one person who I cared for and I knew about referring to the nurse, who I called."

Is the service caring?

Our findings

People and relatives told us that they thought the care staff that supported them were caring. One person told us, "I am happy that they come, and they are happy that they are here. They are all fantastic." Relatives comments included, "Very good they take good care and look after her" and "Yes they are, they talk to her and make sure she is ok." One healthcare professional whom we requested feedback from told us, "To my knowledge, through feedback, they appear to be very caring particularly when dealing with very challenging and demanding clients."

Feedback that we received from people and relatives evidenced that positive and caring relationships had been developed with the care staff that supported them. Care staff that we spoke with knew the people they cared for well. People and relatives also confirmed that they received care and support from regular and consistent care staff who they had got to know and built meaningful relationships with.

Care plans were person centred and detailed. Care plans gave information about the person, their preferred name, their religion, their likes and dislikes, care staff preferences and how they wished to be cared for. Specific details were given in relation to how someone wanted to be supported with their personal care. For example one care plan stated, "Requires assistance with removing make-up on 5pm visit and change day wear into nightie."

Relatives told us they were involved in developing their care plans and identifying what support their relative required from the service and how this was to be delivered. One relative said, "Yes. I was able to tell them all about her [relative] needs and they wrote it all down." Another relative stated, "Yes me and my sister everything I wanted to."

The registered manager explained that she aimed to visit all people that received care and support at least once a month. Alongside this the registered manager also regularly maintained telephone contact with each person or their relative to monitor the care and support people received and resolve any issues that may be of concern. We saw records that the registered manager kept of all communication that she had with people and their relatives.

Care staff understood the importance of maintaining people's independence and gave examples of where they have encouraged people to participate in certain daily activities where they were able to. One care staff explained, "One of the people I support is housebound but doesn't have to be. I offered to take her out for short walks which she really appreciated." Another care staff told us, "I encourage the person to get out of bed, independently put on some items of clothes, encourage to walk to the bathroom with the zimmer frame and with encouragement the person would read books and do knitting."

Care staff were respectful of people's privacy and dignity and ensuring that their privacy and dignity was maintained at all times. Care staff gave examples of how they would ensure a person's privacy and dignity was maintained. One care staff told us, "When I am washing a person I cover them. I also ask people their choice as they have preferences and I follow according to their wishes. Another care staff explained, "If I am

supporting someone with washing and dressing, I make sure all things are prepared, windows and curtains are closed and that the person feels safe and secure."

We spoke with care staff about how they would work with people who were lesbian, gay, bisexual or transgender. One care staff stated, "It doesn't bother me. I can adapt." Another care staff said, "That don't bother me, they are still a person."

Hedgerow Homecare Service provided end of life care and received regular referrals from a local authority specifically requesting palliative care services. Care plans that we looked at did not specifically identify people as requiring end of life care. The registered manager explained that she chose not to record on a person's care plan that they were at the end of their life as she believed that this was not something that needed to be visually recorded and stated. Her opinion was that people did not need to be constantly reminded of that stage of their life. However, the registered manager ensured that details of the care and support required with details of other healthcare professionals involved was noted and that all care staff who were to provide care and support were briefed with this information. Information handed over also included people's choice and wishes of how they wished to be cared for at the end of their life and after their passing. One commissioning professional told us, "They have managed a number of palliative care/end of life packages as well as some longer term complex cases for us. They liaise with the district nurses and palliative care nurses spontaneously and appropriately."

Is the service responsive?

Our findings

Relatives told us that they knew how to complain and who to complain to. One relative said, "Yes I have spoken to nearly everyone in the office. They are all very good and they are helpful." Another relative stated, "Yes we have the phone numbers here." The provider had a complaints policy and procedure in place, a copy of which was also included within the service user's guide and given to people when a package care was agreed. The service had not received any complaints since they had begun providing a service. However, appropriate systems were in place and available to allow the service to effectively record, investigate, respond and learn from any complaints that they may receive in the future.

People and relatives told us that their care had been planned in partnership with them and their relatives. Care plans were person centred and detailed. A pre-admission assessment was completed before any package of care was provided. This assessment identified people's support needs and also looked at their medical history and key people involved in the person's care and support. A care plan was then developed which documented the person's care needs as well as their likes, dislikes, choices and preferences. In addition to this a one page overview called 'My Care Plan' was also devised which provided care staff with an overview of the person and key information about their care and support needs. A visit planning sheet also formed part of the care plan that stated the timings of the calls and the tasks to be undertaken. Care plans were reviewed regularly and updated as changes occurred.

Each care plan included a life history booklet that contained background information about the person, their past, details of people in their life who held significance as well as details of what the person did for occupation and their hobbies and interests. This information gave care staff and in-depth understanding of the person and who they were. One care staff told us, "Care plans – she [registered manager] has it down to a tee. Everything that you need to know is in the care plan, everything about the person."

Care staff ensured that daily records were kept each time they visited a person and provided care and support. Records detailed the time they started providing care, the time they left and the tasks that were undertaken.

Care staff demonstrated a good understanding of what the meaning of person centred care was. Care staff explained what person centred care meant to them by saying, "Everybody's needs are individual. Everyone is different" and "We don't treat everyone the same. Everyone is an individual and we follow their care plan and not what we want to do."

People and relatives told us that they received care that was responsive to their individual needs and preferences. This also included relatives stating that people were supported to partake in day to day activities. One relative told us when asked if their relative gets to do day to day activities, "Yes. Things like doing crossword, reading and watching TV."

Is the service well-led?

Our findings

Relatives confirmed that they knew the registered manager and told us that she was approachable. One relative when asked if they knew the registered manager told us said, "Yes I do. Nice and approachable seems to know what they are doing." Relatives felt able to contact the office if they had any concerns or issues and felt confident that these would be dealt with. One relative explained, "I would talk to the carer first but if that wasn't an option I'd ring through to the office. Yes definitely they are good."

Care staff that we spoke with were generally positive about the registered manager and the way in which they were supported in order to carry out their role. One care staff told us, "My colleagues and manager are so cooperative. I can't say anything bad whenever I need her [registered manager] she is available." Another care staff stated, "I love her [registered manager] she has given me so much support and allows me to progress." However, we did receive some negative feedback where two care staff did not feel as supported as they wished to be. Both care staff stated that they would speak to the registered manager directly about their concerns. The registered manager may wish to look at the support mechanisms in place for care staff with a view to ensuring that all care staff feel supported in their role.

The provider had not held any team meetings since they had begun providing a service. This was due to not having access to an appropriate venue to hold the meetings. However, the registered manager confirmed that she kept in touch with all staff on a regular basis. This was either through the telephone, visiting care staff whilst they were at work or through regular information sharing emails. Care staff confirmed these various methods of communication that were used by the registered manager. One care staff stated, "She [registered manager] usually calls us if there are any changes." The provider informed us that they were in the process of acquiring new premises with a view to moving in November 2016. These new premises would have suitable and available space, so that team meetings and training could be delivered effectively.

We received positive feedback from external professionals that we had contacted both of whom had commissioned care from Hedgerow Homecare Services Ltd. One professional stated, "I am happy to report that I find Hedgerow Homecare good. I am in regular contact with [name of registered manager] and find her efficient, caring and very approachable. I have no difficulties with communication at all." The second professional said, "We deal with [name of registered manager] the Care Manager who is extremely approachable, knowledgeable and caring. The service is managed well."

People and relatives were regularly asked their opinions about the quality of care they or the person being cared for received. The registered manager maintained regular informal contact with people and their relatives by telephone, details of which were recorded on a communication sheet. People and relatives were also asked to complete quality assurance questionnaires each time the registered manager visited the person's home. A record of these were kept as part of the person's care plan and where any concerns were noted all details of any action taken was recorded. Relatives confirmed that they had received a questionnaire to complete but only a small number of people or relatives had completed the annual questionnaire as people had only been receiving care and support for less than 12 months.

In addition to this, regular announced and unannounced spot checks were completed to review the quality of the service provided. Spot checks also included reviewing the care records kept at the person's home to ensure they were appropriately completed and reflected any changes that had taken place.