Gardiner's Homecare Limited

Gardiner's

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?	Outstanding
Is the service well-led?	Good

Overall summary

This inspection took place on 8 and 10 September 2015. This was an announced inspection as Gardiner's is a Domiciliary Care Agency (DCA) and we needed to be sure someone would be at the office. A DCA is a provision that offers specific hours of care and support to a person in their own home.

At the time of the inspection a registered manager was 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.

Staff knew how to keep people safe by reporting concerns promptly through a procedure that was taught as part of the induction process and further followed through in the staff handbook. Systems and processes were in place to recruit staff who were suitable to work in the service and to protect people against the risk of abuse. There were

Summary of findings

sufficient numbers of suitably trained and experienced staff to ensure people's needs were met. Staff were matched to meet people's needs as per experience, knowledge, age and general personality.

People using the service said they were very happy with the support and care provided. People and where appropriate their relatives confirmed they were fully involved in the planning and review of their care. Care plans focussed on the individual and recorded their personal preferences well. They reflected people's needs, and detailed risks that were specific to the person, with guidance on how to manage them effectively. The care plans were going through a process of being updated. We found that the new documents contained detailed specific guidance.

People told us communication with the service was good and they felt listened to. All people spoken with said they thought people were treated with respect, preserving their dignity at all times. They were confident to recommend Gardiner's stating that this was an "outstanding" DCA service.

People were supported with their medicines by suitably trained, qualified and experienced staff. Medicines were managed safely and securely. We were unable to find the protocols for PRN medicines; this was raised with the registered manager, who assured us these would be written as priority. PRN medicines are used on an as need basis.

People who could not make specific decisions for themselves had their legal rights protected. People's care plans showed that when decisions had been made about their care, where they lacked capacity, these had been made in the person's best interests.

People received care and support from staff who had exceptional skills and knowledge to care for them. All staff received comprehensive induction, training and support from experienced members of staff. Gardiner's had created a room to replicate a person's to whom support is provided and used this to train staff in moving handling. Using live examples provided evidence of personalisation in training, staff reported that this was useful when working with people. Staff reported feeling supported by the registered manager and said they were listened to if they raised concerns.

The quality of the service was monitored regularly by the provider, and the managing director, who is the nominated individual. A thorough quality assurance audit was completed annually with an action plan being generated, although this was not always followed up on. The registered manager advised shorter audits were completed monthly, although a formal report was not always prepared. Feedback was encouraged from people, visitors and stakeholders and used to improve and make changes to the service. We found evidence of compliments and complaints that illustrated transparency in management .

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were safeguarded from abuse and staff understood how to report any concerns they had. Procedures were available in the office for quick reference.

The provider had a strong recruitment procedure in place. People were kept safe with the current staffing ratios, and the teaming of staff to peoples needs. Medicines were managed safely.

Good

Is the service effective?
The service was effective.

People and their relatives were involved in making decisions about their care. Where people did not have capacity to make decisions, support was sought from family members and healthcare professionals in line with legal requirements and safeguards.

People were supported with meals and drinks of their choice that met their dietary needs and when necessary people were supported to eat and drink. People received timely support from appropriate health care professionals.

Staff received regular supervision, training and appraisals.

Good

Is the service caring?
The service was caring.

Staff worked in a caring, patient and respectful way, involving people in decisions where possible. They respected people's dignity and privacy.

Staff knew people's individual needs and preferences well. They gave explanations of what they were doing when providing support. They remained with people when a person's health was noticeably at risk, even if this exceeded the agreed hours of support.

Good

Is the service responsive?
The service was responsive.

Care plans reflected people's needs and were reviewed regularly. People's views were listened to and acted upon.

There was a system to manage complaints and people and relatives felt confident to make a complaint if necessary.

People and their relatives were asked for their views on the service and they felt confident to approach the management with concerns.

The service was responsive to people's changing needs. Staff responded to people's needs, going above and beyond their agreed hours of support and care, if they felt this was required during a visit.

Outstanding

Summary of findings

Is the service well-led?

Good

The service was well-led. Staff, relatives and professionals found the management approachable and open.

Effective processes were in place to monitor the quality of the service. Audits identified where improvements were required and action was taken to improve the service.

Gardiner's

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 8 September 2015 and 10 September 2015. This was a comprehensive announced inspection. The provider was given notice because the location provides a domiciliary care service and we needed to be sure that senior staff would be available in the office to assist with the inspection.

Prior to the inspection the local authority care commissioners were contacted to obtain feedback from them in relation to the service. We referred to previous inspection reports, local authority reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service.

During the inspection we spoke with ten members of staff, including the four care support workers, four care managers, the registered manager and the nominated individual. We spoke with ten people who are supported by the DCA staff.

Care Plans, health records, additional documentation relevant to support mechanisms were seen for ten people. In addition a sample of records relating to the management of the service, for example staff records, complaints, quality assurance assessments and audits were viewed. Staff recruitment and supervision records for seven of the regular staff team were looked at.

Good

Is the service safe?

Our findings

People were being kept safe, by robust recruitment procedures. This included obtaining references for staff in relation to their character and behaviour in previous employment and a Disclosure and Barring Service check (DBS). A DBS enables potential employers to determine whether an applicant has any criminal convictions that may prevent them from working with vulnerable people. A robust system had been implemented by management to ensure staff were able to carry out their duties both safely and effectively. This included declaration of health and fitness, a documented interview process, reference character checks, gaps in employment explained – all of which were obtained and qualified prior to employment being offered.

People using the service told us they felt they were kept safe. One person reported "oh very safe. I trust them completely." We found that staff had a comprehensive understanding of safeguarding and whistleblowing procedures. They understood the types and signs of potential abuse. Training records showed all staff had undertaken training in safeguarding people against abuse, and that this was refreshed on a regular basis. In addition the service provided all new staff with the safeguarding procedure within a comprehensively detailed staff handbook. A copy of the local authorities safeguarding protocols and the services procedures were available for staff as well as guidance should these be required. Details were given of external agencies that should be contacted in circumstances where the staff thought that either the manager or the organisation were involved in the abuse. This included, the police, local authority, safeguarding team or the CQC. One member of staff when asked about reporting abuse stated "I wouldn't hesitate, my job is to protect." All staff felt both able to raise concerns and felt that management would effectively deal with these.

People were kept safe by staff with the use of appropriate risk assessments, to ensure least restrictive options were used and proactive plans implemented as necessary. The registered manager told us that during one visit, a member of staff realised that the person's home phone wasn't working properly, and as such, should an emergency occur no one could be notified. The member of staff , collected her old mobile phone from home and gave it to the person using the service in case of an emergency. She then returned in the evening for a welfare check which was outside of her contractual obligations. This illustrates how the service was going above and beyond their contractual agreement to ensure that people were safe at all times. We were given another example of when staff noticed the primary carer, a partner was beginning to become agitated and tired when supporting the person. Staff supported the carer by spending time with him discussing possible useful techniques to support his partner, and allowed him respite time. Therefore ensuring both were kept safe.

Staff administered medicines for people who required support with this. These were signed off on a MAR (medication administration record) sheet. Whilst this was not checked frequently by Gardiner's care managers, part of the staff remit was to ensure that medicines were administered appropriately by colleagues (where applicable) raising any concerns immediately with the registered manager or on call. This was an effective way of safe medicine management. The registered manager told us that staff had reported when medicines had not been correctly administered or had been missed, allowing this to be discussed with the staff who were responsible. The care manager completed on site observations and checked records to ensure staff were correctly carrying out medicine checks.

We found the records of 'as required' (PRN) medicines did not provide sufficient information on when these should be administered. Reference was made to a PRN protocol however this could not be found. This is a document that gives guidance to staff on what action to take prior to offering a person PRN medicines. This is to ensure that medicines are only given when absolutely necessary. Staff were able to describe appropriately when PRN medicines should be administered, therefore reducing the immediate risk of not having the guidelines in place. Whilst most people had capacity to inform staff when they required medicines to be administered, some relied on staff or family member members to make this decision, predominantly for pain relief medicines. The registered manager recognised that the document needed to be in place, and assured us this would be completed as a matter of urgency.

Good

Is the service safe?

Incident and accidents were monitored, although none had been reported since implementation of these records. Systems were in place for trends to be noted, which would then alert the manager to complete written guidance to prevent the likelihood of similar incidents.

Good

Is the service effective?

Our findings

People were cared for by a team of staff who underwent a comprehensive induction process. This included completion of mandatory training and additional training that would be supportive to their role. For example, all staff had completed training in dementia which was relevant to the people they supported. Before commencing work they shadowed experienced staff until they felt confident to work independently. The training matrix showed that 100% of all required and suggested training had been completed, with staff having the opportunity to attend continual rolling training offered by Gardiner's. An IT system was used by the service that alerted the manager in advance to when training was due to expire. This was effective in ensuring that staff knowledge and skills were continually updated. The registered manager told us that she checked the competency of her staff team following training. This allowed her to be confident staff were able to put into practice the learnt theory, and therefore ensure effective care was delivered. This was checked through observations, meetings, staff discussion forums and supervisions. The service further offered "open days" for staff where they asked them to share their experiences with one another to illustrate how they worked effectively with people. A recent day had led to the creation of the "Digini-Tree", a visual reflection of skills used effectively by Gardiner's.

Staff received regular supervision. This provided both the staff and the relevant line manager the opportunity to discuss their job role in relation to areas that needed support or improvement, as well as areas where they excel. This was then used positively to improve both personal practice and the practice of the service as a whole. Annual appraisals were carried out. Staff told us they found both the supervision and appraisal process useful. One said, "it's my chance to discuss things and learn new ways."

Staff understood the principles of the Mental Capacity Act 2005 (MCA). They told us they had received training in the MCA and understood the need to assess people's capacity to make decisions. The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. They all stated how they asked for permission before doing anything for, or with a person.

We saw written evidence in the care plans of the importance of seeking consent by asking people before doing something and giving appropriate explanations. These stated to give the person the choice before completing a task. All staff were able to give examples of how choice is offered. One said, "if a person does not want me to complete a task, I won't do it. I give them time and then ask them a little later. I work at their [people's] pace". Staff were able to describe examples of best interests decisions, for example whether a person should be using a hoist, if they did not have the capacity to make the decision. They could tell us who had been involved in best interest meetings and the importance of involving people who knew the person well to help make a decision. This was evidenced within the care files for relevant people.

Careplans clearly indicated where people needed support with food and drink, and how this support was to be carried out. In addition people told us, "They always leave a drink near me before they leave" another person said, "oh she always makes sure I have a drink and a snack left out".

Each person had a nutritional profile and health information in place. If a person had dietary requirements for medical, cultural or religious reasons, these were catered for, as required. Where necessary documents were prepared and used through multi agency working with the local speech and language therapist (SALT), which meant a thoroughly comprehensive care plan had been prepared.

Good

Is the service caring?

Our findings

The service was caring towards the people supported. People told us, "They are ever so respectful". One person reported, "if I have a private call, they [staff] always leave the room so that I can talk privately". People reported that they were treated with dignity and care. One person said "They treat me like I matter. They make time to talk with me, see I am okay." We found during conversation with senior management, this was an important part of the induction ethos. Induction training reinforced treating people in a caring manner, and how this was a service specifically catering to help people retain their dignity by remaining in their own home whilst being supported.

People were able to be involved in decisions related to their care. A key worker (care manager) system had been implemented within the service. This meant that one member of staff held primary responsibility to ensure that all documentation related to the care the individual received was in line with their needs and how they wished to have a service delivered. The new care plans were reflective of this, for example we found that where appropriate these were written in the first person, with "I would like staff to help me with…" The care plans were also reviewed with the individual where possible, during reviews, and earlier if there were changes to needs.

People were visited by consistent members of staff, who had been chosen based on their knowledge and skill base related to the person's needs. We were told that the staff specialism was matched to people's needs as were hobbies and interests. This meant that people were able to talk to staff about things that were important to them, developing a relationship. The registered manager told us that when a person did not build a relationship with a member of staff, a replacement was sought to ensure correct partnership development. A new role was being developed within Gardiner's specifically focusing on ensuring correct staff were being chosen as a team to work with individual people. One person reported, "When [name] comes, we have no problems, both my wife and I are blind, we know exactly where things are left with her. When she's on leave, we have to explain everything again – that can be a problem, but she's allowed to go on holiday". This person was new to using Gardiner's, and although highlighted a problem, was able to see how this was manageable, with the updating of care plans detailing exact locations items should be left. He continued by stating "they are a lovely bunch of people, I would have no problems recommending them".

We found evidence that staff had gone above and beyond their duty whilst supporting people. In one case we noted in records and compliments from people's and family, that although staff had been working with a person for long hours, they accompanied the person to hospital and remained there until family could attend. It was later established that if staff had not persevered and persuaded the person to attend hospital this could have had serious repercussions on their health. In another case we found evidence that staff had encouraged and motivated a person with a particular task, this helped to develop their independence and eventual achievement of a long term goal. We found that people valued their relationship with the staff team, especially as they had been noted to go the extra mile.

It was evident that staff had read the care and support plans for the people whom they provided support to, staff were asked to add comments of any changes they thought were necessary and sign to say read. A list was retained on the computerised system that highlighted who was involved in each individuals care. These staff ensured they documented any changes or information of importance on the person's file that may be of relevance. All records were kept securely in a paperless computerised system, with restricted access.

People were shown respect and staff were able to describe how they maintained this. They told us they addressed people in their preferred manner and always took note of what people wanted. For example, one member of staff told us, "some people want us to talk with them about things, they have no one else." Another said, "I listen to people, try to understand and empathise with them." One person told us the staff were, "Excellent with managing my dignity… always respectful."

Outstanding ☆

Is the service responsive?

Our findings

People had their needs assessed prior to support being offered to them. This often involved family members at the request of people. The case manager would compile a document that would allow a care plan to be developed. Risk assessments were completed during the initial assessment.

Care plans focussed on the individual. They contained information such as, their past life history, how they liked things done and how they communicated their everyday care needs. Care plans were amended as required, these were always signed to say they had been reviewed. The registered manager was in the process of rolling out a new care plan format. This was highly detailed and provided step by step guidance for staff when working with each individual.

The service responded to people's individual requirements. For example, some people preferred to be supported by staff who wore casual clothes rather than a uniform. This was clearly recorded in the care plans and the service accommodated people's wishes by requesting staff dressed casually when supporting them. One person told us they did not like staff wearing uniform as they felt it "advertised to neighbours" they were receiving support. "Staff now wear normal clothes… they have their ID badges, but I know them now".

People advised us that reviews were held either six monthly or annually. They would be involved in reviewing their plans. If any changes were noted to their health, the service would ensure an immediate responsive review of their health and support needs. The general consensus of people using the service and of staff was that the service aimed to facilitate a high level of care that catered to the needs of the people.

We found the service was responsive to changing needs of a person. For example, when working with someone requiring assistance with mobility staff assessed whether the person was able to move any limbs so to encourage them to maintain their independence. In one particular case we were told that staff physically assisted a person during their period of being unwell with all movements. As the staff noticed the person's health had improved they began to encourage the person to move independently, whilst continually risk assessing and monitoring. As time progressed, the person began to become more independent. This resulted in the a reduction of hours for the service provider, however increased the safe independence of the individual concerned. This is an example of how the service supported and motivated the person to regain their independence and maintain their dignity.

We found exceptional evidence of responsiveness by the service when working with people. The service offered specialist training tailor made to people's needs and deliverable in their home (if agreed), to staff working directly with the people. This met the criteria of Continuing Health Care. The CHC focuses on meeting clinical and nursing needs of a person following discharge from hospital. Gardiner's nurse trainer, ensured the training followed guidance by specialist and district nurses, by developing the training in conjunction with them. This meant that people were able to be promptly have changes to nursing needs met, rather than rely on external health professionals. District nurses were still involved in care, however with the agreed training, the registered manager stated, "it enables us to be responsive to the service user's changing need and tailor the training to booked duties, increasing efficiency and minimising disruption to the service user." The training was used by all staff within Gardiner's who provided support to people within their own home.

There was a complaints procedure and information on how to make a complaint was provided to people when they took on Gardiner's services. People and their relatives told us they were aware of how to make a complaint. We reviewed the complaints log and noted that complaints had been appropriately dealt with. A full investigation was carried out, with the complainant being told of the outcome. People and their relatives were confident that the service would correctly deal with a complaint. One person stated, "I'd go straight back to Gardiner's, but I haven't got a reason to complain".

Good

Is the service well-led?

Our findings

At the time of the inspection the registered manager had been in post for just over a year. Within that time positive changes had been implemented within the culture of the service. One member of staff reported, “the service is moving in the right direction.” The registered manager had an open door policy. People using the service, staff, relatives or other professionals had the opportunity to raise any concerns or complaints with the registered manager at any time. We were shown evidence of complaints and concerns that had been raised by either people using the service or their families, and how these had been dealt with.

There was an honest and open culture in the service. Staff showed an awareness of the values and aims of the service. For example, they spoke about giving the best care and respecting people. One staff member said, “We give it our 100%.” The registered manager held meetings with the care managers on a fortnightly basis. This allowed cases to be discussed that were complex, new referrals to be discussed, and any other operational issues. They told us they felt able to voice their opinions or seek advice and guidance from management at any time.

Staff told us the registered manager was open and approachable and created a positive culture but was not afraid to speak to staff if they did not perform to the standards expected. Staff reported that the registered manager did not conduct frequent spot checks, or complete general observations, as this was part of the role of the case managers. Case managers felt that this would be a useful task for the registered manager to complete more frequently, as it would highlight areas for further development for themselves and highlight areas of development within the service. This was discussed with the registered manager, who advised that she would look at incorporating this into her schedule.

We looked at records of complaints and found that in one incident a family member had stated they were unhappy regarding the hours offered. The registered manager had considered the concerns raised and responded to them appropriately. The registered manager was aware of the new regulation Duty of Candour (Regulation 20 of the Health and Social Care Act 2008 Regulations 2015) and importance of transparency. This was reflected in how investigations were carried out and the reporting of outcomes of investigations within a suitable timeframe. We found that the communication within the service was good. The service would send out emails to staff with any amended policies, updates in service agreements, as well as two monthly newsletters. This was an excellent way of communicating any changes related to operations, as well as remind people of upcoming training, social events and new staff appointments. The service was looking at developing a similar newsletter for people too.

Quality Assurance Audits were completed annually by the Nominated Individual. This sought feedback from stakeholders, people, and staff. This information was then used to create an action plan. The action plan was not always followed up on in recording how tasks had been completed. The registered manager noted that it was important to evidence any changes required as a result of the audit. We were reassured this would be completed from the next audit.

We found there to be good management and leadership. The registered manager was supported by the managing director (who was also the nominated individual). He offered on-going guidance and support. The registered manager stated that she did not hesitate to ask for assistance to ensure the service was well led. In addition the nominated individual offered back up on call services for care managers should they seek any additional advice.