

## Hazelbrook Specialist Care At Home Limited

# Hazelbrook Specialist Care At Home

### 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	

### Overall summary

The inspection took place on 24 and 27 August 2015 and was announced. This meant we gave the provider 24 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

The service was last inspected on 21 January 2014. The service was meeting all our regulatory standards at that time.

Hazelbrook is a domiciliary care provider based in Lanchester providing personal care and support to people in their own homes. Hazelbrook specialises in delivering palliative and end of life care to people with life limiting illnesses. There were 18 people using the service at the time of our inspection.

# Summary of findings

The service had a registered manager in place. 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.

We found that risks were managed and mitigated well through pre-assessment and ongoing assessment. People using the service felt safe and we saw that the service operated an out-of-hours phone line in case of unforeseen circumstances.

We saw that adequate numbers of staff were on duty to meet the needs of people who used the service. Staff underwent a range of pre-employment checks and, when we spoke with them, they were clear about their safeguarding responsibilities, having received safeguarding training recently.

We saw that no medicines errors had been made on the Medication Administration Records (MAR) we sampled and, whilst the service did not undertake internal audits of these records, we saw that they had identified this as an area of responsibility for a newly created role.

We found that staff received an induction that included mandatory training and shadowing of experienced staff, both attending to people who used the service but also at a local hospice to gain a fuller understanding of palliative care provision. Training included safeguarding awareness, moving and handling, infection control, health and safety, first aid and handling medication.

We saw that new members of staff underwent the Care Certificate.

People told us that that consent was sought both at the initial care planning stage when care staff visited people who used the service.

We saw that staff supervisions, appraisals and staff meetings all happened regularly and that staff felt supported to perform their role.

People told us staff were caring, personable, compassionate and warm in their care. External healthcare professionals also told us that people who used the service felt comfortable with the carers from the service.

We saw that people were encouraged and supported to contribute to their own care planning and review, with family members similarly involved. We saw that end of life care was compassionate and always supported by the views of people who used the service, family members and relevant healthcare professionals.

We saw that personal sensitive information was stored securely.

Care plans were reviewed regularly and, where people's needs changed, these reviews were brought forward and care provision amended accordingly. People told us the service was accommodating to their changing needs and preferences.

People's hobbies and interests were encouraged both at home and through attendance at a day centre run by the nearby hospice.

The service had a complaints policy in place. We saw evidence that one complaint had not been formally responded to but that other comments had been promptly and satisfactorily dealt with. People who used the service were made aware of the complaints procedure and told us they knew how to complain and who to, should the need arise.

People who used the service told us the registered manager and senior carer were approachable and knew them well. We saw that, whilst having recently undergone a change of staffing structure, the service maintained high levels of care for people who used the service.

The principles of the service, as set out in the Statement of Purpose and the Service User Guide, were communicated strongly by members of staff we spoke with and evident in the care practices we saw evidence of.

# 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 told us they felt safe with the care and support provided by the service.

Pre-employment processes to ensure unsuitable individuals did not work with vulnerable adults were robust.

The service operated a 24 hour phone line should people need support outside of office hours.

Good



### Is the service effective?

The service was effective.

Capacity was assumed and people who used the service were always asked for their consent before receiving care or treatment.

Staff were supported through an induction that involved shadowing at a local hospice then by mandatory training, which was managed via an effective planning system.

Communication with other agencies was consistently effective to meet the needs of people who used the service.

Good



### Is the service caring?

The service was caring.

People were actively involved in their own care planning and review. Their preferences were listened to and encouraged to ensure that care was in line with their wishes.

People's independence was supported and encouraged; relatives told us they had noticed an improved quality of life as a result.

People told us that staff took the time to build a rapport with them.

People were supported at the end of their life through the involvement of family members and relevant healthcare professionals.

Good



### Is the service responsive?

The service was responsive.

Care plans were reviewed three-monthly or as regularly as people's needs required.

Through tailored care plans people received individual aspects of care in a way they were comfortable with.

Comprehensive notes at each visit contributed to people receiving consistent and co-ordinated care when they moved between services.

Good



### Is the service well-led?

The service was well-led.

Good



# Summary of findings

During a time of organisational change the service had ensured this did not impact on the care people received.

A range of quality assurance processes were in place, or being implemented at the time of inspection.

The principles of the person-centred culture set out in the Statement of Purpose and Service User Guide were shared by staff we spoke with and reflected in the experiences of people we spoke with.

# Hazelbrook Specialist Care At Home

## 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.

The inspection took place on 24 and 27 August 2015 and was announced. This meant we gave the provider 24 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who had personal experience of using or caring for someone who used this type of care service.

During the inspection we reviewed five people's care files, looked at four staff records and reviewed a range of policies and procedures. We contacted seven people who used the service, speaking with them and their relatives. We also spoke with five members of staff: the registered manager, the senior carer, the service co-ordinator, one carer and the director. We also spoke with two external healthcare professionals.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the Care Quality Commission.

Before the inspection we did not ask the provider to complete a Provider Information Return (PIR). During this inspection we asked the provider to give some key information about the service, what the service does well, the challenges it faced and any improvements they planned to make.

# Is the service safe?

## Our findings

All people who used the service and their relatives we spoke with expressed confidence in the safety of the service, as well as stating they had trust in the carers. One relative said they had “No gripe at all with anything that the staff did” and went on to say “You cannot fault them.” Another said “I have no concerns about safeguarding.”

We saw that as part of the pre-assessment meeting with people interested in using the service, the registered manager made an initial risk assessment, considering issues such as staff access to the property, fire hazards and mobility considerations. This was then supported by a range of individualised risk assessments dependant on the person’s individual’s needs, before any care was provided. This meant that people’s needs as well as their environment were considered in order to identify and manage risks.

We reviewed a range of staff records and saw that all staff underwent pre-employment checks including enhanced Criminal Records Bureau (now the Disclosure and Barring Service) checks. We also saw that the service verified at least two references and ensured proof of identity was provided by prospective employees prior to employment, and that any gaps in employment were explored. The service co-ordinator showed us the checklist used to ensure such checks were made in a timely and consistent fashion. This meant that the service had in place a robust approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

All staff we spoke to felt staffing levels were appropriate. The registered manager stated the service had never missed a call and all people who used the service, as well as their relatives, confirmed they had never experienced a missed call. One relative told us about a time when care staff were delayed but told us that they had received a telephone call to explain the situation. This meant that people had not been placed at risk of neglect through missed calls.

All staff had either received or were booked to attend safeguarding training. Two members of staff we spoke with clearly articulated a range of abuses and potential risks to people using the service, as well as their prospective actions should they have such concerns. This

demonstrated that the service had ensured that appropriate safeguarding training had been delivered and that staff were able to identify situations where it would be applicable.

The service operated a 24hour phone line. The registered manager, senior carer and service co-ordinator currently took responsibility for operating this and all people who used the service and relatives we spoke with confirmed any telephone calls they made out of office hours were answered. We saw evidence of this working in practice. For example, one relative had contacted the service on an evening when they had concerns about a person who used the service. The provider had immediately contacted Social Care Direct, the police and an out of hours GP to ensure the person and their relative were located and supported. This meant that people using the service could be assured of support in the event of contacting the service out of office hours.

The registered manager confirmed there had been no recent disciplinary actions or investigations. We saw that the disciplinary policy in place was current, clear and robust. We reviewed the incident/accident log and saw that all incidents were documented comprehensively alongside actions. This meant that people using the service were protected from the risk of individual incidents not being managed effectively and potentially recurring.

One relative described care staff as “Meticulously clean and thorough” and told us that carers always used aprons and gloves when providing personal care. Another relative was particularly impressed with the management of catheter care by staff and their awareness of the risk of infection. Staff we spoke with were able to talk in detail about the infection control training they had received recently and we saw that all staff had undergone this training. This meant that people were protected against the risk of acquired infections.

We reviewed procedures for the administration of medicines and sampled the most recent Medication Administration Reports (MARs). There were no errors in the records we reviewed. We also spoke to an external healthcare professional who performed an audit on these records; they expressed no concerns about the service’s management of medicine. The registered manager confirmed that they did not currently conduct an in-house audit of completed MAR documents but they were able to

## Is the service safe?

show us documentation that indicated this responsibility would be part of a newly created senior role within the organisation. This meant that people were protected against the risk of unsafe medicine practices.

# Is the service effective?

## Our findings

One person who used the service said of the staff “They are extremely competent and efficient in what they do” and found the carers to be knowledgeable about their needs. They stated “They all work from the same song sheet.” Another person said that their needs were always met and that they were always asked if they consented to each treatment or aspect of care. On relative said “You get exactly what has been agreed on the care plan – they do what they have promised to do”. This opinion was shared by others and meant that people using the service experienced consistent and effective care.

A healthcare professional we spoke with stated “They understand palliative care better than a general agency” and “They practice well.” They agreed that carers had a good knowledge of the needs of the people they cared for. This meant that people with specialist knowledge considered carers to have the necessary skills to perform their caring role.

The service stated a main objective in its Statement of Purpose as “To communicate effectively and efficiently with other agencies to provide a package of care to meet the needs and preferences of our service users.” We found there was evidence that people were supported through accessing healthcare through close liaison by the service and there were a number of instances where people and their relatives cited this co-ordinated approach as having a positive impact on their wellbeing. For example, one person told us about the liaison between staff and another agency in order to manage one aspect of their care. They told us the thorough approach to documentation meant there was never any confusion or duplication of work and that this gave them “Confidence and peace of mind” in the care they received.

Staff had recently been trained in areas such as safeguarding, infection control, moving and handling, health and safety, equality and diversity, safe handling of medication, and first aid. We also saw that, in order to support a person using the service with specific complex needs, specialist training had been provided for all staff in that area. All training courses were recorded by the service co-ordinator and future training plotted on a training

matrix. This meant that staff had been trained in core areas and that the service planned ongoing training to ensure the skill mix and knowledge of staff was appropriate to the needs of people using the service.

The service was committed to the care certificate and the registered manager was able to talk through the benefits of the process and their plans to roll out the certificate for existing staff and not just new staff. The director supported this approach. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. This meant that people could be assured a consistent level of knowledge and skills from new and long-serving staff.

All new members of staff also completed a day shadowing at a nearby hospice, in order to ensure they understood and experienced the nature of palliative care. The service is a subsidiary of the hospice and they shared a Human Resources department. We saw that through this relationship the service was able to offer staff places at training events the hospice was running. This meant that staff had the knowledge and skills to carry out their role and was supported by a service that accessed sector-specific training and best practice through effective liaison with other stakeholders.

Consent was an integral part of care, with all people who used the service telling us that they were asked if they were happy with particular aspects of care before it was given. This meant that people’s right to be involved in decisions about their own care was continually upheld and respected.

We saw that people who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place had been fully involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. Anyone with a DNACPR in place had this reviewed regularly. This meant people were involved in regularly monitoring their needs and making prompt changes where required.

We spoke to one new member of staff who was positive about the support they had received since starting the role. For example, they praised the fact they were introduced to each new person they would be caring for by an



## Is the service effective?

established member of staff. This meant people using the service were supported by a service that recognised the benefits to people of providing a continuity and familiarity of care.

We saw that staff supervisions were undertaken three times during the year along with an annual appraisal. When we spoke with staff, they spoke positively about the opportunities they had to contribute to the improvement of the service. We saw that supervisions and appraisals were planned over the coming months. Communication of best practice also happened through the bi-monthly newsletter and bi-monthly team meetings. Additionally, the registered manager undertook observation visits, whereby they would attend a call with a carer to observe their practice and identify any areas to improve or areas for praise. For example, we saw that one such visit led to a further training

session for the member of staff. This meant that, through formal supervision and more practical supervision, staff were supported to maintain the skills and knowledge required to carry out their caring duties.

Some people who used the service were supported to eat meals during visits. All staff we spoke with were aware of the nutritional preferences of people who used the service and people we spoke with were pleased with the support they received. One relative of a person who used the service told us the provider had liaised with the hospital and Speech and Language Therapy teams to ensure that the person could make an informed choice about whether to continue their particular means of food intake. Since making the decision, their relative told us they “Have actually gained weight and feel much better”. This meant that through involving people and relevant healthcare professionals, the service encouraged and supported people to maintain a balanced diet.

# Is the service caring?

## Our findings

People we spoke with were unanimous in their praise for the caring attitudes of staff. One relative told us “All the care staff treat [person] with warmth, kindness and respect.” Another relative said “The Hazelbrook staff are very friendly and chatty.” One person said of the staff “They feel like part of the family.” We saw similar statements had been sent in by way of thank-you cards to Hazelbrook staff. One read “You all showed concern when things weren’t so good...I couldn’t have managed without you” and another “We can never thank you enough for the care you gave.”

A healthcare professional we spoke with said “They care very well”, “The carers are liked” and “They are compassionate; the bit you can’t tick a box for.”

We saw these caring attitudes evidenced in care planning and application. For example, one care plan regarding someone with mobility difficulties gave clear and detailed instructions regarding how they might communicate their difficulties and how carers should best support them. The care plan factored in periods of rest to the time allotted for the care. This meant that the person received personalised care that had regard to their disability and ensured care was provided in a dignified way.

Staff were aware of the needs of the people they cared for and we saw that rapports were built between care workers and people who used the service through, wherever practicable, people receiving care from the same carer. Staff were made aware of people’s histories, likes and preferences through the initial assessment of needs, which a number of relatives praised for its thoroughness. People we spoke with told us that staff took the time to get to know them and that the person-centred plans were not merely an administrative exercise.

One relative described how one person who used the service preferred for them to provide one aspect of personal care and how staff supported this through

incorporating it into the care plan. This meant that people received care that centred on their preferences, emotional as well as physical, and was delivered in the dignified manner they wanted.

Relatives and people who used the service confirmed their permission was sought before the service shared their confidential information with other healthcare professionals. People also confirmed they were active participants in care planning and their views were sought. Whilst no one using the service was using an advocate, the involvement of relatives meant there was a level of natural advocacy supported by the service. We saw there was also clear information about how formal advocacy support could be sought in the Service User Guide provided to people who used the service. This meant that people were empowered and supported to be involved in their care planning and reviews.

We saw that sensitive personal information was stored securely in locked cabinets and entrance to the service was via a door requiring a security fob. This meant that people’s confidential information was stored securely.

All people we spoke with and their relatives had confidence that, should they need to raise any concerns, their views would be listened to and acted on.

With regard to end of life care, people and their families were involved in planning. One relative told us that only because “The support has been so sensitive” did they feel able to discuss end of life planning decisions. We saw that, where Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were in place this had been discussed with people, their families and relevant healthcare professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant the service involved and enabled people and their families to fully contribute to advance decisions about their end of life care through sensitive, respectful discussions.

# Is the service responsive?

## Our findings

We saw evidence that people were supported to live their lives as they chose with the help of flexible support by the service. For example, one person was concerned about prospective impact on their full time job, as their job did not have set start and finish times. They described how the service “Wouldn’t have to ‘fit me in’ between other calls” and would “Give me greater flexibility.” They stated that such flexibility had “An enormous impact on my life.”

One relative stated that, when they and the person who used the service had requested changes to the times of visits by care staff “At the last minute” that these requests had always been “Respectfully accommodated.” This meant the service made sure people’s views on their own independence and pursuit of their own interests were taken account of and acted on where possible.

We saw that all care files were reviewed regularly and were person-centred, including personal histories of people, likes and dislikes. There was a range of personalised and comprehensive care plans and risk assessments, going into a level of detail that ensured effective care was supported through clear documentation.

Care was personalised through involvement with people receiving care and those who know them best. All people and relatives we spoke with confirmed that they were involved in care plan planning and reviews. People’s preferences were noted prior to using the service and care planning was responsive to the changing needs of people. For example, we saw in one person’s daily records that they had been feeling more fatigued than usual. Staff had comprehensively documented this, ensured that the person was offered further support during their personal care, along with the addition of a shower stool, and relevant healthcare professionals were notified of the change in the person’s condition. This meant that staff responded to the changing needs of people.

The Statement of Purpose sets out Hazelbrook’s first principle as “to provide a service that is driven by the needs and aspirations of our service users by listening to them and maintain privacy, dignity and choice.” We saw this ethos was put into practice. For example, one person who used the service had typed their interpretation of what their care plan should look like, indicating specific tasks for the two carers. The tasks were clearly set out and the plan

ended with the instruction “Go home and put your feet up!” We saw that this care plan was incorporated into the person’s care package alongside other plans and risks assessments. We saw further evidence that the person had been fully involved in the review of their care package, contributing in writing with analysis of their level of independence, which the service had acted on. This meant that people were able to contribute in the fullest possible sense to the planning of their care. Individual needs were assessed regularly. The registered manager told us that care plans were reviewed quarterly or whenever the need arose. For example, we saw evidence that the service acted promptly to ensure one person received additional support during a time of an unexpected deterioration in their health. We saw the persons’ relative had provided feedback to the service stating the support was “Excellent” and highlighted the fact that the service had “Pre-empted” their relatives’ needs and that the attention to detail was “First Class.” People we spoke with unanimously confirmed that their needs were reviewed regularly with the involvement of family and healthcare professionals.

One person who used the service told us staff had encouraged them to pursue their hobby of gardening by planting vegetables at the day service run by the hospice. This meant that the person was supported by staff to pursue an interest important to them. A relative we spoke with told us that this had led to an improved quality of life.

We reviewed a range of care plans and saw each person’s needs varied dramatically. We saw that care plans were suitably tailored to those varied needs. Every person we spoke with agreed ample time was allotted to provide calm and sensitive care.

The service had a complaints policy in place and we saw that one complaint had been received. We could not find a formal response from the provider to the complainant, nor were there clear details of what the complaint entailed. The registered manager agreed this complaint should have received a written response and undertook to ensure any future complaints adhered to the formal complaints policy. We also saw evidence of one comment from a person who used the service regarding the regularity of invoicing and saw this had been promptly responded to with the individual satisfied with the response. We saw that the complaints procedure was clearly available in the literature

## Is the service responsive?

given to people who used the service and people we spoke with were clear they knew how to complain and who to if they needed to. This meant the service was able to show it listened to the concerns of people who used the service.

The comprehensive nature of daily care notes ensured an accountability of care but also allowed for a co-ordinated, consistent transition to other services, should the need arise. For example, we saw that when one person had

needed to spend time in the hospice, the hospice were able to anticipate aspects of needs based on the information given to them by staff regarding the individual's care. This meant that people received care that was fully informed and could be assured of a consistent, co-ordinated approach to care should they move between services.

# Is the service well-led?

## Our findings

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service.

During the inspection we asked for a variety of documents to be made accessible to us. These were promptly provided, mostly well maintained and organised in a structured way, making information easy to find. The recent changes to staff rotas meant that care review planning documentation was not as easily accessible but we saw that this information had been transferred to a shared diary on staff members' computers. The management of documentation was such that key policies and procedures were clearly accessible for any member of staff. This meant that the registered manager maintained up to date and accurate records.

The registered manager was clear about the values set out in the Statement of Purpose. They spoke about the preferences and rights of people using the service determining staffing and training. We saw this attention to the details of individual need in an array of care plans and through speaking with a range of people who used the service and their relatives. Other staff members were consistent with the registered manager in their understanding of the ethos of the service. This meant the service operated with consistently shared goals that put the rights and preferences of people who used the service first.

Numerous people who used the service and their relatives praised the leadership of the service. One relative commented positively regarding the registered manager's "Hands-on" approach to their role and stated that they "Led by example." We saw that, on average, the registered manager would have contact with each person once a month, whilst the senior carer would see people twice a week. One person said "I have 200% confidence in their staff." Likewise the senior carer was praised by a number of people we spoke with for their knowledge of people's needs and an attention to detail, with one relative describing them as "Very much on the ball" with regard to their partner's care.

The registered manager told us they visited relatives of people who had used the service a number of months after

the person had died as a means of offering relatives an opportunity to reflect on the care given. The registered manager acknowledged that the feedback from these meetings was not recorded and committed to documenting information gathered by these means in future in order to contribute to the service's ongoing analysis of its own practice.

We saw the recently created senior carer role would include responsibility for staff supervisions, rotas, observation visits and a range of quality assurance work. We saw the documentation for these aspects of work was in place and that there had been no detriment to people who used the service during a time of organisational change. This meant that the registered manager was putting in place systems that assured the service could sustain its current performance and drive improvement.

All relatives we spoke with agreed that the registered manager was approachable and easily accessible should they have any queries. They were also clear that the queries they had were resolved promptly and satisfactorily. One healthcare professional told us that the service had been recommended to people by a GP. This meant that the service had built a strong reputation with the people it supported but also a healthcare professional.

We spoke with the director of the service. They were able to give a clear vision for the future of the service in line with the goals of the Statement of Purpose. We saw the service ensured corporate risks were documented on a risk register and that board meetings from the service fed any lessons learned or concerns into the wider board meeting of the hospice. This meant the service was able to demonstrate strong leadership and oversight at registered manager and provider level.

We saw there were strong links with a hospice (the service being a wholly owned subsidiary of the hospice), with people using day services and staff benefitting from onsite training. This relationship with the hospice was one that the registered manager was planning to build on in the future, particularly with regard to hosting more training and learning events. This meant resources were available to support staff to continue their professional development and provide people with a high level of care.