Hanover Care Limited

# Hanover Care Worthing

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 comprehensive inspection took place on 21 and 22 February 2018. This was the first inspection for this service. The inspection was announced and we gave two days' notice of this inspection. This was because they provide care to people in the community and we wanted to be able to speak with people using the service and ensure the registered manager was available.

This service is a domiciliary care agency and provides care for people with complex medical needs in their own homes It provides a service to both adults and children. At the time of the inspection, there were three people being supported in their own homes by the agency.

There is 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.

The risks of abuse to people were reduced because there was an effective recruitment and selection process in place. Staff were able to demonstrate a good understanding of how to recognise and report abuse. There were systems in place to ensure that risks to people's safety and wellbeing were identified and addressed.

People received a service that was based on their needs and wishes. A bespoke care team supported each person, which meant staff knew people very well. Care plans were personalised and contained detailed information about the support people needed. Staff were specifically trained according to the needs of the person. Staff competencies were assessed annually.

Clinical review meetings were held regularly to ensure the support was meeting people's needs. The service was flexible and responded to people's requests where possible. Health and social care professionals were regularly involved in people's care to ensure they received the right care and treatment.

Relatives spoke highly of the quality of care given by the nurses. They said they trusted the nurses to have the skills to keep them safe. People had positive relationships with their nurses and nobody expressed any concerns about any of the care provided.

People received their medicines on time and in a safe way.

People were supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice

There had not been any accidents, incidents or complaints. Policies and procedures were in place which would ensure any accidents, incidents or complaints would be effectively dealt with in a timely way.

Environmental risk assessments were completed for every new person using the service. This included checks to ensure their home was safe with adequate access, heating and lighting.

There were effective audit and monitoring systems in place to check the people received good quality and safe care. Staff felt well supported and worked as a team to provide people's care.

## 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.

The risks of abuse to people were reduced because there was an effective recruitment and selection process in place.

People received their medicines on time and in a safe way.

The provider had completed comprehensive risk assessments to help ensure people's safety. Staff were aware of the risks people faced.

### Is the service effective?

Good

The service was effective.

Relatives praised the care and support people received. People received highly specialised, personalised care.

Families were supported as well as the person receiving care.

Nurses received specialised training which enabled them to feel confident in meeting people's needs. Staff told us their training was excellent.

Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

### Is the service caring?

Good

The service was caring.

People's relationships with nurses were strong, considerate and supportive.

Relatives said nurses were caring and compassionate and treated people with dignity and respect.

Nurses spoke confidently about people's specific needs and how they liked to be supported. They protected people's privacy and supported them sensitively with their personal care needs.

## Is the service responsive?

Good

The service was responsive.

People's needs were assessed before their care commenced and care plans were regularly reviewed and updated as people's needs changed.

People received individualised, personalised care and support to meet their needs.

People were supported to express their views of the service they received.

People and their relatives knew how to raise concerns and complaints.

## Is the service well-led?

Good

The service was well-led.

The provider was forward-thinking and continually investing in systems which would benefit people using the service.

Nurses were proud to work for the provider and had a good understanding of the values of the service.

There were effective systems in place to assure quality and identify any potential improvements to the service.

# Hanover Care Worthing

**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 21 and 22 February 2018. We gave the provider two working days' notice because they are a small service providing community care and we wanted to be sure we could talk with the registered manager. It was carried out by an adult social care inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

The inspection was informed by feedback from questionnaires completed by a number of staff.

We visited the office to meet with the registered manager, clinical lead and office staff; and to review care records and associated documents. We also looked at records that related to how the service was managed, such as quality audits, complaints, four staff files and policies and procedures. In addition we discussed the service on the phone with three people who used the service, two relatives and two nurses.

Good

# Is the service safe?

## Our findings

Everyone we spoke with told us they felt safe using the service and with the staff who supported them. When asked if they thought their relatives were safe, relatives said, "Definitely" and "100%."

Risks of abuse to people were minimised because there was an effective recruitment and selection procedure in place. Nurses did not start work until their registration with the Nursing and Midwifery Council (NMC) and their work history had been checked. Other pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions helps prevent unsuitable people from working with people who use care and support services.

Staff told us, and records seen confirmed that all staff received training in how to recognise and report abuse. Staff received safeguarding training for both adults and children. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. Feedback from staff questionnaires showed that 100% of staff who responded knew what to do if they suspected someone was at risk of being abused or at risk of harm. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. There were no safeguarding concerns at the time of the inspection.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. People told us, "I have a team of five or six core members. It's the same [nurses] all the time" and, "Yes, we have one [nurse] at night from 8pm to 8am." One person told us, "I haven't always been able to get enough staff, but most of the time it's ok." Staffing rotas showed the required numbers of staff to support individual people were allocated.

Nurses always had access to on call support for clinical or other needs. The clinical lead worked alongside nurses twice a week and always worked one of the first shifts with people new to the service. This meant as well as supporting nurses, the clinical lead was able to review care plans on an on-going basis. A peer-checking system was also in place which meant any risks to the person were reduced and safety was maintained. There had not been any missed calls; this is when nurses were scheduled to be with a person but did not arrive for their shift. This was achieved because there was a core group of staff who worked with each person, and a back-up group to cover annual leave and sickness.

People had risk assessments which helped to ensure that staff cared for them safely. Assessments were clear and covered a range of potential risks to people. For example, people had risk assessments in place for their mobility and other health needs. They provided details of how to reduce risks for people by following specific guidelines or the person's care plan. Both the care plans and risk assessments we looked at had been reviewed regularly. Advanced care plans were in place which used digital information systems used by emergency services. This meant if people phoned the emergency services the paramedics and ambulance staff had information about the person's medical needs as well as their wishes and preferences.

The management team completed an environmental risk assessment for every new person using the service. The assessment included a check to see if there was safe access to their premises and that heating, lighting and the power supply were working properly. Risk assessments covered all aspects of the support the person needed, such as the type of bed the person used, temperature and humidity as well as any space constraints for equipment in people's homes.

Medicines were administered safely by nurses who had their competency assessed on an annual basis to make sure their practice remained safe. Nurses were required to complete an intensive training course and the clinical lead undertook spot checks. The provider's medicines policy was based on the NMC code of conduct and NICE guidelines. All staff and families we spoke with said medicines were safely given and staff knew what they were doing. One person said, "I have a mixture of medication including a syringe driver and also via a tube. Both are managed by the team." Other people confirmed the support staff gave them. One member of staff said, "Hanover Care is very strict about medication."

Medicines records showed medicines received by people from pharmacies were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. Protocols were in place for medicines which people could take as needed; GPs had signed these to authorise their use. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately and clearly recorded. Unused or wasted medicines were returned to the pharmacy correctly for destruction. Regular audits of medicines took place, and where any actions were identified, we saw these were completed. Staff told us support was always available for them if needed.

Where any learning was identified the registered manager ensured this was shared with staff. For example, learning was identified around recording the advice given by a GP for an as needed medicine. Staff received supervision, further training and support and the processes in place were looked at. Staff had a form to record any guidance given by another healthcare professional; the clinical lead said that ideally this professional would complete the form. Nurses had regular clinical supervision with the clinical lead. Staff confirmed this and said, "Every month or sometimes every two months."

Where people used equipment such as hoists, they were able to choose to take responsibility for arranging servicing and maintenance themselves, or equipment could be managed under contracts arranged by the provider. Occupational therapists assessed people for the use of equipment and staff were aware of the guidance in people's care plans.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns about people's changing needs. The provider had a policy and procedure for recording and monitoring accidents and incidents. There had not been any accidents or incidents.

Appropriate precautions were in place to prevent the spread of infection. The registered manager monitored the service to ensure any outbreaks of infections would be appropriately responded to. People told us staff washed their hands and used gloves and aprons. People said, "They are really scrupulous about that", "Oh yes all the time. I am very lucky as I have an en-suite wet-room and the nurses are in there all the time cleaning up" and, "Yes they follow full procedures. All very clean." Staff spoken with confirmed they had completed infection control training, records confirmed this. Staff also received regular updates regarding any current infection risks. Audits showed staff used the personal protective equipment provided.

Good

# Is the service effective?

## Our findings

People received effective care and support from staff who had the skills and knowledge to meet their needs. People using the service had complex medical conditions. When people first considered using the service, a clinical lead identified the skills, training and qualities staff would need to be able to provide effective and appropriate support. The clinical lead said, "People have diverse and very complex needs, it's about more than just nursing. We give our nurses everything they need to do that."

People's individual needs determined the skills and competencies staff supporting them were required to have. A team of staff was identified with the specialist skills to be able to support that person exclusively, this included supporting people who needed feeding through tubes, catheter management and administering medicines via syringe drivers. Staff had to complete the necessary training and competency assessments before being allocated to support someone. . Staff said, "We have regular training on line and at the local hospice. Moving and handling training is done in the office" and, "I am always reminded by Hanover Care what I need to do, and train on line or locally. They are very efficient about training and if you are not trained, you don't get the work." Relatives told us, "Yes, staff seem to have the right skills for the syringe driver, morphine, and amounts and timings" and, "Two people from Hanover Care are so brilliant; [name] is sent from heaven, and [name]. They are out of the top drawer." However, one relative also said, "Two others nurses are not in the same league."

The registered manager told us they ensured families were happy with the staff, and the staff team for each person was right. Relatives praised the care and support people received very highly, and told us how much they valued the staff.

People were supported by staff who had undergone a thorough induction programme which gave them an introduction to the service and the requirements of their job. The registered manager told us staff were required to have a minimum level of training before they were able to work. Induction covered the requirements of the Care Certificate, which is a nationally recognised qualification to ensure staff had the basic skills needed to provide care. New staff were required to learn about the policies and procedures in place; these gave staff the information they needed about the processes and systems in use. Staff told us,

Staff were supported to carry out their role effectively. Staff had access to immediate support at any time via the registered manager or the clinical lead. Staff received support and information from managers via quarterly team meetings. Nurses confirmed they had regular clinical supervisions and regular clinical updates. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner.

Care plans reflected people's health and social care needs and demonstrated that other health and social care staff were involved. We saw health and social care professionals such as GPs and speech and language therapists were involved in people's individual care on an on-going and timely basis. Processes were in place which ensured healthcare professionals were involved in regular reviews. Reviews with healthcare

professionals and staff were important to ensure people received the most appropriate care in a timely way. One person confirmed the involvement of healthcare professionals and told us, "They do mainly GP and District Nurse appointments."

People told us staff gave them choices about their care and said, "Especially on timing of doing things; they ask me when I want to do something and if I'm ready" and, "Yes, [Names of staff] would recommend things and get things done and a very efficient and pleasant way" and, "Yes, they always ask."

Staff had a clear understanding of the Mental Capacity Act 2005 ( MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. Everyone using the service had capacity to make decisions for themselves and no-one was subject to a Court of Protection authorisation. There was a policy and process in place which meant people's capacity to make specific decisions could be assessed if necessary. The registered manager was aware of the processes to follow and said, "We would hold best interest meetings if necessary, the paperwork is in place if we need it and advocates are available." A 'best interest' meeting is where a decision about care and treatment is taken for an individual, who has been assessed as lacking capacity to make the decision for themselves. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. People and their relatives told us staff respected their decisions and said, "Yes, they definitely do" and, "Yes, they refer to his wife on everything and ask advice on everything."

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Where people required food to be administered via tubes, controls and processes for doing this safely and effectively were in place. Some people were able to eat independently and made their own arrangements for meals. People told us, "Drink yes. I'm on artificial nutrition. They help with fluids" and, "Yes, staff help me with fluids." Care plans contained assessments and guidance for staff about people's eating and drinking requirements.

Good

# Is the service caring?

## Our findings

Everyone we spoke with said they were supported by kind and caring staff. People told us, "They are all very kind. They always go above and beyond. They sometimes bring in tea bags etc. and do nice things for me." One relative praised the service and said, "They go to the pharmacy for us. When my relative was in hospital over 36 hours, Hanover Care [staff] came and stayed with her in hospital overnight and did the syringe driver. Hanover Care collected my relative's mother and took her to hospital as she doesn't drive. The senior nurse helps get morphine and speaks to GP regular on their behalf. Helps a lot and picks up medication from pharmacist when I can't get there myself as I don't drive." Another relative told us how the service supported one person and said, "The family asked the carer not to wear a uniform and the person is more than happy, and is very pleased to have a friend rather than a carer."

The registered manager said, "We've got a fantastic team of nurses" and, "Our nurses go above and beyond." One person had not been outside for a number of years due to their medical condition. Nurses arranged for a window to be converted to a French window, so the person could be taken outside in their bed.

People's dignity and privacy was respected and all personal care was provided in private. The registered manager told us the first step towards ensuring staff respected people's privacy and dignity was to ensure they employed the right staff. People told us, "Yes, absolutely 100% they respect my privacy and dignity", "Absolutely. I couldn't rate that more highly." Relatives confirmed people's privacy and dignity were respected and said, "Yes definitely."

We saw in each care file there was a comprehensive profile of the individual including their likes and dislikes. All staff spoken with demonstrated they knew people's preferences. Staff said, "We talk to people, and its very much a two way process" and, "I like to discover what colleagues know about them first, and then I chat to the patient to find out how much they like to talk about themselves." One relative said, "She knows so much about [names] and seemed genuinely very interested in their lives."

There were ways for people to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and view their opinions. People told us, "I do a form at the end of a shift and make comments so am able to give feedback. The manager and I email all the time" and, "Yes on a regular basis."

People were supported by staff to maintain their personal relationships. This was based on staff understanding who was important to the person, their life history, their cultural background and their sexual orientation. Where people expressed any equality, diversity and human rights preferences, these were respected.

People were asked about their equality and diversity needs. For example, people were asked if they had any religious preferences, how they preferred to identify themselves and if they had any cultural requirements. Where people expressed any preferences, these were recorded and staff knew how to support the person.

Good

# Is the service responsive?

## Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. Three people told us the care they received was excellent and said, "Just excellent care", "We are really happy. It's brilliant" and, "The care we receive is excellent."

People told us they were involved in care planning and could ask for changes if they wished. People said, "I am involved in care planning" and, "Yes I'm involved, especially with motor skills, balance etc." Staff said, "We always get permission for everything before we do new things."

Each person had their needs assessed before they started to use the service. This was to make sure the service was appropriate to meet the person's needs and expectations. The process included assessing the home environment, the person themselves and the equipment and staff they needed. The clinical lead completed the initial assessment with information from other professionals such as the person's GP. Staff told us, "We always get the patient's full nursing history and past medical history."

Care plans were personalised and identified the relevant people involved in people's care, such as speech and language therapists and dieticians. They reflected the service's values that people should be at the heart of planning their care and support needs. For example, one person's care plan stated "Can become exceptionally cold due to a skin condition. [Name] then becomes slightly agitated at night and it can take hours for [name] to get warm." Staff had guidance about how to support the person. Staff were given information about situations and triggers which could cause medical emergencies, what they should look out for and how they should treat the person if this happened.

Nurses were given weekly updates and people were involved in any decisions. Nurses said, "Before you go, you are given the notes from the hospital and get all the info. You get to know the person and talk to them. You can see if the person's needs are changing because you get to know them well, and you read reports and read the GPs notes" and, "Notes are very clear. We refer to the care plan and talk to the head nurse, and each folder has strict notes. Paper work is very important." Nurses completed clinical reviews during a face to face meeting with the person. These meetings were held every month and care plans were updated as necessary.

Staff had information about people's preferences for their end of life care in advanced care plans. Families, friends and anyone the person wanted to be involved, including any faith representatives, were included in these discussions. Where one person's health was rapidly deteriorating their relatives' comments were positive. They told us, "Things have galloped away. [Name] from Hanover Care has been extremely helpful in keeping me informed as to the 'next stage' and what will happen next. He is absolutely brilliant." Recognised tools for assessing people's pain levels were in place, so that if the person were not able to say they were in pain, staff would recognise this and the person could receive pain relief. People's choices around whether they wished to be resuscitated or not were recorded.

Systems were in place to support people if they needed to make a complaint. Each person received a copy

of the complaints policy when they started using the service. The policy identified good practice and specified time frames for dealing with complaints. Everyone we spoke with knew the process for raising any concerns or complaints; however no formal complaints had been received. Where concerns were raised informally, the registered manager addressed these. One relative told us, "One or two nurses are slightly less flexible. I have discussed this with manager and it has been addressed and changes are in progress." One person said, "No I haven't complained but I have raised a couple of issues about the way the care was provided but this has now been resolved and I'm quite happy." The service had received several compliments. Comments included, "[Staff name] has completely made a relatives day", "This group of women were not only the nurses who cared very much for [name] for so many years, but also beautiful friends to her. They loved [name] and we knew it."

Good

# Is the service well-led?

## Our findings

The provider had a range of arrangements in place to ensure the service was well managed. This included involving people by ensuring they could express their views.

People and those important to them had opportunities to feedback their views about the quality of the service they received. People told us, "Yes, I've just recently completed a survey for each of the nurses and there were lots of categories to complete", "Yes, all very good" and, "Yes we got one." People told us they felt able to make suggestions to improve the service, but couldn't think of any improvements.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. There were different types of audits which looked at all areas of the service, including care plans and staff training. Medicine records were audited weekly, and daily records were checked monthly. The clinical lead checked care plans weekly. Spot checks were also completed; these included a questionnaire for the person to comment on the care and support they received. This meant the skills of staff were reviewed and checked so they met the person's needs. The registered manager had weekly compliance reports which identified staff training needs three months before their current training expired.

There had not been any accidents or incidents in the past 12 months. However, there was a policy and procedure in place which would ensure where any accidents or incidents occurred; these would be looked into thoroughly to identify the cause. Nurses we spoke with were aware of the need to report anything and one nurse said, "There are forms to fill in and if there is an incident, we would report to the clinical lead straight away."

There was a staffing structure in the service which provided clear lines of accountability and responsibility. The Clinical Lead worked alongside nurses and had access to either the clinical lead or the registered manager at any time. Nurses told us they were supported to maintain their registration with the Nursing and Midwifery Council and said, "If you don't keep your PIN you can't get the work. Hanover Care are strict about this."

All staff we spoke with said they felt supported, and were able to raise anything that concerned them. Staff said, "We have a very good relationship", "Probably yes, I am supported and it is team work when we talk about patients. They always listen to me. I am really happy working with Hanover Care." The registered manager said, "Staff can talk to us and we are open and transparent with staff." The clinical lead said, "We listen to staff and don't send them into an environment where they won't cope."

Staff were able to feedback their views of the service during supervision and during staff meetings. Staff told us they were encouraged to visit the office for open days and coffee mornings.

The registered manager was passionate about caring for people and said, "Although I'm not a nurse, if something comes in I'll deal with it immediately." The registered manager had a clear vision for the service which included providing a safe environment for people and staff. Their vision and values were

communicated to staff through staff meetings and formal one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner.

The provider had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.