Tony O'Flaherty Limited

HomeInstead Senior Care, Wandsworth, Lambeth & Dulwich

Inspection report

Unit A122, Riverside Business Centre
Bendon Valley
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Date of inspection visit:
22 March 2017
23 March 2017

Date of publication:
23 May 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 22 and 23 March 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. This was the first inspection of the provider since it had registered at a different address with the Care Quality Commission (CQC).

HomeInstead Senior Care, Wandsworth, Lambeth & Dulwich provides personal care for people in their own homes. The office is based in the Earlsfield area but provides care to people in Wandsworth, Lambeth and Dulwich. At the time of the inspection there were approximately 80 people using the service.

There was a registered manager at the service. 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.

Care workers were known within the organisation as 'caregivers,' we have called them this in the report.

People and their relatives praised the caregivers for their empathy and were pleased with how they were supported. The minimum length of calls the provider offered was one hour, regardless of the level of support needed. This meant that caregivers were given time to complete their tasks but also to offer companionship to people which in turn allowed for caring relationships to develop.

Care plans were written in a person-centred manner and were easy to read. They contained information about people's background, their working and family life and other information. Caregivers were familiar with people, their support needs but also their personality, their life and the things they enjoyed.

We found there were enough caregivers employed to meet people's needs. The provider tried to ensure a team of caregivers were allocated to each person, which helped to provide continuity of care and familiarity if caregivers were away on leave.

Although there were recruitment checks in place which helped to ensure caregivers were safe to work with people, we found that not all references we saw were verified for their authenticity.

Caregivers completed an induction programme which was based on the Care Certificate, thereafter they received regular training and supervision.

An initial assessment was completed in people's homes before they started to use the service, this included risk assessments in relation to physical needs, moving and handling and the environment. Person centred care plans were developed using the information gathered during the initial assessment. People were given time to decide whether they wanted to be supported by the provider and consent was sought before care

was started.

Supervisors reviewed care plans at regular intervals which helped to ensure they were up to date. They also carried out client audit reports and service reviews which helped to ensure records were being completed correctly and people and their relatives were happy with the service provided.

People and their relatives were given an information pack which included details about the providers' complaints policy and how they could raise concerns if they were not happy with any aspect of the service.

Although people and their relatives told us they were supported appropriately with respect to their medicines, we found there was inconsistency in some of the records we saw in relation to the level of medicines support that was provided.

We received positive feedback about the management of the service. People and their relatives told us that they could always contact someone and they were kept up to date about any changes. Care plans were reviewed regularly and people were asked for their feedback about the service by independent external companies. The registered manager was active in the community, working with community organisations, raising awareness about dementia.

We have made two recommendations in relation to medicines management and staff recruitment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

There were sufficient numbers of staff to meet people's needs. However, we have made a recommendation around more robust recruitment checks.

People were supported to take medicines by caregivers, however we have made a recommendation around accurate recording of the level of support provided in relation to medicines.

People and their relatives told us they felt safe in the presence of caregivers.

Risk assessments were completed for a number of areas, such as physical needs, moving and handling and the environment.

Is the service effective?

Good

The service was effective.

Caregivers received a thorough induction and ongoing training which helped them to support people.

People were involved in planning their care.

The provider managed people's dietary and healthcare needs appropriately.

Is the service caring?

Good

The service was caring.

People told us that caregivers were extremely caring and took a genuine interest in them.

Caregivers demonstrated a caring attitude towards the people they supported.

Is the service responsive?

Good

The service was responsive.

People's support needs were assessed and care plans developed prior to their support starting.

People and their relatives told us they had not needed to complain. Information on how they could raise concerns was provided to them when they first started to use the service.

Is the service well-led?

Good

The service was well-led.

People using the service and their relatives were extremely satisfied with the service and how well it was managed.

There were a number of audits which took place to monitor the quality of service, including regular quality assurance checks, client audit reports and service reviews.

An independent company sought the views of people using the service and caregivers.

HomeInstead Senior Care, Wandsworth, Lambeth & Dulwich

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 checked 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.

We undertook this comprehensive inspection on 22 and 23 March 2017. The inspection was announced, the provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The inspection was carried out by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During the inspection we spoke with, the owner who was also the registered manager, the care manager, the care co-ordinator, the office manager and three caregivers. We looked at five care records, four staff records, training records, complaints and audits related to the management of the service.

After the inspection, we spoke with two people using the service and five relatives.

Requires Improvement

Is the service safe?

Our findings

People using the service and their relatives told us they felt safe in the company of the caregivers. Comments included, "Absolutely, 100%", "Definitely feel safe" and "Yes, I don't have any concerns in that area."

Caregivers were aware of what steps they would take if they suspected any abuse and who they could contact. They told us the continuity of care they provided and the fact they got to know the families well allowed them to know when people were not their usual self. One caregiver said, "I would report it straightaway." Other comments included, "I look out for any cause of concerns, either expenditure sheets or receipts not in place or if people are not themselves" and "If I had any concerns about safety, I would approach [the care manager], I can also contact social services."

The Disclosure and Barring Service (DBS) provides information on people's background, including convictions, in order to help providers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. DBS checks were in place and had been renewed for longstanding staff. Application forms, identification and references were also on file. However, in one staff member's file there was no employment history recorded and reference to termination from their previous employment. There was no record on file that this had been followed up however, the registered manager told us this had been discussed with the previous employer before the staff member was employed to ensure they were suitable. In addition we noted that not all professional references had been verified to ensure their authenticity. We spoke with the staff member who dealt with recruitment and they told us that referees were initially telephoned and then sent reference forms to complete and that it was usual practice to ask for references to be stamped or returned with headed paper to demonstrate their authenticity. We saw that four out of the five professional references we looked at had not been verified. The provider wrote to us after the inspection stating their policies and procedures did not require references to be provided on stamped or headed paper.

We recommend that the provider seeks guidance from a reputable source to ensure that robust recruitment checks are completed and recorded for all new staff.

A caregiver told us about their experience of the recruitment process, they said they had a telephone conversation with the registered manager and was then invited in for a formal interview and completed an application form. They talked us through their induction programme which included a three day induction and four shadowing shifts.

We found that there were enough caregivers employed to meet the needs of people using the service.

People and their relatives said they had no concerns about the timeliness of caregivers. They told us, "It's not often they are late but not a problem at all", "Always come on time", "Seldom late", "We get one carer all the time", "Never had a call about lateness", "Got a team of people going in, all familiar and always on time" and "Many times they have stayed well beyond what they need do."

Caregivers clocked in and out using people's home phones. A system called people planner was used for scheduling visits. A care giver told us, "I get enough time to travel, you can choose the hours and days that you want to work."

The care manager told us, "We have a team of caregivers for one client, this helps us to manage annual leave and emergencies."

We were shown the system used to schedule appointments, this was colour coded providing a visual dashboard of the calls that were in progress at a particular time and those that had been completed. The caregivers were also colour coded so the scheduler could see which people had been supported by a particular care giver. This helped when allocating caregivers. The care manager also told us, "I always introduce the team (of care givers) to the client and their family beforehand."

An assessment of needs was carried out for physical needs, moving and handling and the environment. These covered a number of areas, for example the physical health section looked at people's support needs in relation to nutrition, medicines, personal hygiene amongst other areas. The moving and handling needs assessment included people's support needs in relation to transfers, bathing and using the stairs. The environment needs assessment looked at people's support needs in relation to the home environment. The provider then completed risk assessments for those areas where people were identified as being at risk of harm.

These were completed well, however we did see one instance where the risk assessment had not been completed. In the moving and handling needs assessment, in the section for washing it stated the person needed to be supervised, that they required support and there were some identified risks, however the associated risk assessment was blank. In the indoor mobility needs assessment, it said there was an identified risk but there was no risk assessment for this. We highlighted this to the care manager who agreed to rectify this. The provider wrote to us after the inspection stating the care plan for personal hygiene wash and shower did document the risk.

We asked people using the service and their relatives if staff supported them with medicines and they told us they were happy with the support received. Caregivers were aware of the importance of asking people's consent before supporting them with medicines. They said, "You explain the medicines, what they are for."

There was a blister pack medicine administration record (MAR) chart and a standard MAR chart in place for caregivers to complete if they were supporting people with medicines. MAR charts also included an area for recording where medicines were not administered and PRN (given when required within prescribed limits) medicines. One MAR chart was not signed for a few days for the week commencing 16/01/2017, however this had been identified in the client audit report as an action for the caregiver to be reminded. We also saw from the client activity log that the person had received their medicines as prescribed.

In some instances, we found the provider was not always accurately recording the level of medicines support given to people. We reviewed the medicines policy which stated there were three levels of medicines support. Level one support was prompting and medicines administration record (MAR) charts were not required to be completed, level two support was administration and MAR charts were needed to be completed and level three support was specialist such as eye/ear drops or PEG (percutaneous endoscopic gastrostomy) feed. (This is a procedure that provides a means of feeding for people when their oral intake is not adequate).

In the required services for one person, it stated medicines support level three was required as the caregiver

would apply cream, however the client audit and the client activity logs stated level two support was provided.

In another needs assessment, it stated that level one support was needed. However, in the required services section it stated 'prompt' and 'level three support'. In the client activity log, the caregiver had circled level two. In the client audit report, the supervisor recorded that level two/three medicine support was given.

Although these issues did not constitute a risk to people as people were receiving support with their medicines, we recommend the provider reviews systems used to record the level of support caregivers provide in relation to medicines to minimise any potential risk.

Good

Is the service effective?

Our findings

People were supported by staff who were supported to meet their needs effectively. Caregivers told us, "I'm very happy" and "The office is supportive. If I'm lacking training, I can always approach them."

Induction for new caregivers consisted of four modules, these were the ageing process, safe client/safe caregiver, building relationships and personal development plan. Each module had a workbook that caregivers completed during their induction. The 15 standards of the Care Certificate were covered within these four modules. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health. There was some evidence of personal development workbooks covering the Care Certificate standards in the records we saw.

The system used for scheduling caregiver visits was also used to monitor staff training, however this system had recently been introduced to the service and was still being updated at the time of our inspection. Training was monitored by the care coordinator and the registered manager.

All the staff files we saw contained records of regular supervision sessions, these were taking place every three months and detailed any training or support needs. We saw that annual staff appraisals were taking place to assess staff performance, however we noted that one person had not had an annual appraisal since March 2015. The office staff could not provide an explanation for this at the time of the inspection.

The supervision and appraisal policy stated that 'each employee will receive regular (at least three monthly) supervisions, two of these must be one to one, the third could be a spot check and the fourth could be attendance at a caregivers meeting. Each employee will receive a yearly appraisal.'

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Caregivers were aware of the importance of offering people a choice in how they wanted to be supported and to make decisions for themselves wherever possible. They were familiar with the MCA and how it was to be applied. Comments included, "We don't assume someone hasn't got capacity", "We allow clients to make decisions for themselves whether we agree with them or not", "Even if I am putting a cardigan I would ask them first. The same with food, I always give them a choice" and "If clients refuse care I would respect that."

Each care plan contained a service agreement, a client consent form and a data protection form. These were signed by people using the service or their Power of Attorney (POA) if appropriate.

People or their relatives did not raise any concerns about how their healthcare needs were being managed. People's medicines were recorded even if they were not being supported to take their medicines, the care manager told us this was, "In case there are any emergencies if we need to contact the hospital or GP."

We saw correspondence from a local hospice praising the caregivers for the support they provided for a person who was receiving end of life care. A relative spoke to us at length about how caregivers had managed their family member's health condition and told us that they received positive feedback from their GP about the caregivers.

People or their relatives did not raise any concerns about the support they received in relation to food. In many instances, food was prepared by relatives and if care workers did this task it was done according to people's individual preferences.

Good

Is the service caring?

Our findings

We received positive comments from people using the service and their relatives about the caregivers. They included, "Very caring individual", "It's always lovely to have her coming", "Couldn't praise them highly enough, courteous, care of [family member] is first and foremost", "The people who come are extremely kind, friendly and pleasant", "They have gone back if they are concerned, for example if [family member] is running out of bread and milk", "They write notes down for her to help with her medicines, it's the attention to detail that make a difference", "Help me to remain independent", "Compassion", "Couldn't praise them highly enough", "Very good and thoughtful" and "I've used others (agencies) and they are excellent."

Caregivers were aware of the importance of respecting people's privacy and dignity, "I would ensure the personal care is in an appropriate place, try and make sure they were comfortable and felt safe with me" and "I would ask their permission before starting personal care and wait for them to say yes."

Caregivers demonstrated a caring attitude towards the people they supported, "You need to respect people's beliefs and values, you may not always agree with it but you have to respect them" and "The best medication is companionship." The registered manager told us he told caregivers to "Always leave them with a smile and looking forward to you coming back." A relative told us, "[The caregivers] aim is to make my [family member] happy."

The minimum length of calls the provider offered was one hour. This meant that caregivers were given time to complete their tasks but also to offer companionship to people which in turn allowed for caring relationships to develop. This was highlighted by caregivers, people and their relatives as the one standout feature of the provider. Comments included, "Very kind and helpful, we are friends", "Having a minimum call for one hour is really important to me; it means I have time to support people and also get to know them and give them companionship", "HomeInstead give you an hour, this gives you time to spend quality time with people", "The consistency allows you to build relationships", "The organisation is very interested in people", "They do things I don't even think of sometimes, the caregivers get emotionally involved. I go to them as a port of call" and "They engage well in conversation."

Care plans were written in a person-centred manner and were easy to read. They contained information about people's background, their working and family life and other information. In addition to this, the provider tried to ensure that a team of caregivers were allocated to people using the service who were all familiar to the person and their family, this helped to ensure continuity of care if the main caregiver was on leave. Caregivers were familiar with people, their support needs but also their personality, their life and the things they enjoyed. They told us they used the information contained in people's care plans to provide a more personal service, "I use the personal information when I first go and see the client. It helps me to build a rapport", "It is a conversation starter." The care manager told us, "We use the client information all the time, it's important for caregivers to know about the people they are supporting."

We saw a number of testimonials from people praising caregivers for their commitment to training, companionship and understanding nature.

Good

Is the service responsive?

Our findings

People's needs were assessed and met. We spoke with the care manager about the process in place if people were interested in receiving care from the provider. They told us, that after receiving an initial enquiry, they made an appointment to visit people in their homes during which they completed an assessment of people's needs. This included a detailed understating of people's support needs and a face to face discussion about their requirements and expectations. An introduction pack was given to people providing them with information about the service. People were given time following this assessment to make a decision. One relative said, "They discussed [my family member's] needs, had a look at the provision and the home." The care manager told us, "People are given time to make a decision, we don't force anyone."

We spoke with the scheduler who said they were usually the first point of contact when caregivers or people using the service rang. Decisions regarding which caregivers were allocated to each person were decided jointly between the scheduler and the care manager. The care manager said they had a good idea regarding the type of caregiver who would be suitable for each person when they carried out the initial assessment. The scheduler told us, "Matching caregivers to clients is so important. "[The care manager] comes back and tells me the type of person and we have a discussion and try and match" and "Some people are chatty, others are quiet, so you try and find a suitable match."

People's care plans were kept up to date to ensure that the information contained in them was current and accurate.

Once an agreement had been reached, each person was given a courtesy call 24 hours after their first visit to see how they found the service, then after four weeks they received another phone call or a home visit and then every six months they had a service review in their own homes.

People using the service and their relatives told us they were fully involved in planning their care and said their care plans were regularly reviewed. They told us, "They offer to review more than required", "They almost call too many times, so keen to make sure if everything is right" and "They come periodically to see how I am getting on."

Each care plan contained a service agreement, a client consent form and a data protection form. Care plans contained a number of sections including client information, emergency client information, client profile and background information. There were standard support plans in place for all people, regardless of the support they were receiving that covered all areas of daily living and any health concerns or specialist care. The registered manager told us they completed support plans in all areas of daily living as this gave caregivers a comprehensive overview and understanding of people's lives and preferences.

The provider recorded a list of 'required services', areas where people had requested or needed support. These were either in relation to companionship, home help, medicines and/or personal care.

Caregivers also completed client activity logs at the end of every visit. Caregivers completed expenditure record sheets at the end of every visit where they had supported people with shopping or bill paying. Client activity logs were bought back to the office after three months for review by the supervisors. One person said, "They complete the books, it's very good."

We asked people using the service and their relatives if they ever had to use the complaints procedure. They told us, "Never had any problems at all", "Never had to make a complaint" and "No, any issues are quickly sorted out." A caregiver told us, "I have never met a family member who has complained."

There had been two recorded complaints in the past year. In both cases, the provider had rectified the concerns immediately.

The complaints procedure was included in the statement of purpose which was given to every person using the service. We looked at the complaints policy which had details of other organisations that people could contact other than the provider if they wanted to escalate their complaints. It gave timescales for responding to complaints that the provider adhered to.

Good

Is the service well-led?

Our findings

The registered manager told us, "Our vision is to be the homecare provider of choice in Wandsworth, Lambeth and Dulwich."

People using the service and their relatives were extremely satisfied with the service and how well it was managed. Comments included, "They strive for consistency", "I am so satisfied", "They are all you could have possibly wanted", "They are fantastic" and "They came recommended and I would have no hesitation in recommending them to others."

Staff told us they enjoyed working at the service and they felt pride. Comments included. "I love working here." Caregivers were given incentives for length of service and told us they felt supported and part of a team, "Someone is always at the end of the phone", "It's top notch, no matter how often you phone they never get flustered", "I attended a presentation recently in recognition of my length of service, it's nice to know you are appreciated" and "We have quarterly meetings with the other caregivers."

The office based staff consisted of the owner of the service who was also the registered manager, the care manager, the care co-ordinator/scheduler and the office manager. Roles within the team were clearly defined and documented in an organisational structure which included areas of responsibility for each staff member, which promoted smooth and cohesive delivery of service for clients. Office team roles were divided into marketing, service delivery, engagement, national compliance and office management. The registered manager oversaw the marketing of the service. The care manager was responsible for carrying out initial assessments including assessing people's homes, developing care plans and putting a team of caregivers together. They were also responsible for supervising and appraising supervisors. The office manager was responsible for payroll and a junior staff member.

There were three supervisors in place with one vacant position, who also acted as caregivers. They told us this helped them to see things from the perspective of the caregivers. Supervisors were allocated to a geographical area and were responsible for responding if caregivers in their allocated area needed anything and they also carried out quality assurance and service review checks for people using the service. A supervisor told us, "I review the service and make a note of any changes."

Supervisors also provided opportunities for caregivers in their area to meet with them and have informal discussions with them to see if they were happy or needed any extra support, "We try and meet up informally every so often over a coffee. They (the caregivers) appreciate seeing a familiar face and it helps to build the team."

Care plans included evidence of regular quality assurance checks completed for people. People were asked their opinions about the service, what worked well for them, what wasn't working and how the service could be improved.

Service reviews were more comprehensive in scope and included a review of people's care plans. People

were asked if they were happy, if there were any improvements, their views about the caregivers, if the support they received was appropriate, if any changes were needed to their risk assessments and/or care plans. They were completed every six months.

Client audit reports were completed. These covered a month period and were completed by the supervisors. They checked the quality of the client logs and the medicine administration record (MAR) charts that were completed by the caregivers.

An external company surveyed people using the service and caregivers, the client survey was completed in June 2016 and 22 surveys were completed out of 84, a 26% response rate. 95% of those surveyed said they would recommend the provider, 100% said their caregivers were well matched to them, 95% said their caregivers arrived on time and 100% said the caregivers took an interest in them as a person.

The registered manager told us he received valuable support from the franchise and met with other registered managers across the country every quarter. The service was measured in areas such as profitability and productivity against registered services of a similar size to help drive improvement.

The registered manager was active in the community, working with the Alzheimer's society. He had spoken at Parliament raising awareness about dementia. He was a dementia champion and had worked with the Dementia Action Alliance, an alliance for organisations across England to connect, share best practice and take action on dementia. Members include leading charities, hospitals, social care providers, government bodies, pharmaceuticals, royal colleges, and wellbeing organisations. This provided him with up to date knowledge of developments in the field of dementia care.