Connect Nursing Limited

Connect Nursing

Inspection report

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Date of inspection visit:
14 September 2017

Date of publication:
09 November 2017

Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14 September 2017 and was unannounced.

The inspection was a focused inspection and was prompted by notification of an incident, which occurred whilst care workers were supporting a person outside of the service. The information shared with CQC about the incident indicated potential concerns about the management of risks in relation to the safety of people who used the service and people in the community. This inspection examined those risks.

This report only covers our findings in relation to one outcome; safe. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Connect Nursing on our website at www.cqc.org.uk. At the last inspection the service was rated 'Good' overall. This inspection only considered whether the service was safe and therefore the overall rating was not reviewed.

Connect Nursing is a domiciliary care service providing support to people with complex health needs which includes people who have suffered a stroke and spinal cord injury. At the time of our inspection 20 people were using the service.

Risk assessments were in place for people who used the service and were reviewed every month. They included assessments by health professionals and were readily available for care workers to access.

People who used the service and their relatives expressed that they felt safe with their care workers and safe using the service.

Accidents and incidents were reported and investigated in a timely manner and records were kept of all investigations and findings.

Care workers told us they knew what to do in an emergency situation and felt confident in acting accordingly.

Care workers had access to protective equipment such as gloves and told us they were able to order equipment or come into the office to collect it.

Medicines were managed in a safe way and records were completed and audits were carried out to ensure that medicines were correctly administered and documented.

Relatives of people who used the service told us that carers were not always reliable and reported episodes of lateness and missed calls and as a result we found the provider to be in breach of the regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. You can see what actions we have asked the provider to take at the end of the full version of this report.

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

The service was not always safe. People told us about occasions where their carers had not turned up.

Risk assessments were in place and care workers had access to additional information about people and their needs within care plans to support them.

Accidents and incidents were reported and investigated promptly.

Medicines were managed safely.

Recruitment checks were carried out prior to care workers commencing employment at the service.

Connect Nursing

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 an unannounced focused inspection of Connect Nursing on 14 September 2017. The inspection was a focused inspection and was prompted by notification of an incident, which occurred whilst care workers were supporting a person outside of the service. The information shared with CQC about the incident indicated potential concerns about the management of risks in relation to the safety of people who used the service and people in the community. This inspection examined those risks.

We inspected the service against one of the five questions we ask about services: 'is the service safe? This was because the inspection focused on the management of risk for people with autism and behavioural needs.

The service had a registered manager. 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 inspection team consisted of two inspectors 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 service.

Prior to the inspection we reviewed information we have about the provider, including previous inspection reports and notifications of any safeguarding or other incidents affecting the safety and well-being of people. By law, the provider must notify us about certain changes, events and incidents that affect their service or the people who use it.

During the inspection we spoke with a case manager, training manager and two care workers. After the inspection we spoke with one person who used the service and six relatives of people who used the service. .

We checked six people's individual risk assessments and daily notes within their care plans as well as medicine records, policies, procedures, accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

The risk assessments we looked at were robust and detailed, for example one person had a risk assessment in place due to being PEG fed. A PEG tube is a feeding tube which passes through the abdominal wall into the stomach so that food, water and medication can be given without swallowing. It stated, "Staff to ensure [person] is in an upright position during feeding. Ensure PEG tube is flushed before and after feed and medicines administration. Staff to give feed as prescribed by nutritionist/dietician." Another person had an emergency procedure print out in their care plan to guide staff about a certain condition that could occur in people with spinal cord injury. This gave staff information about symptoms to look out for and action to take. This meant that staff had guidance on how to mitigate risks in order to provide safe care.

Risk assessments were reviewed on a monthly basis and records confirmed this. Staff told us they were expected to read care plans and risk assessments. One staff member said, "I get the time to go through the care plans, they asked me to come into the office to read them." This ensured that staff had the information they needed about someone prior to providing support, to enable them to provide safe care.

People who used the service and their relatives told us they felt safe with their care workers. One relative told us, "Yes yes, he's fine. The agency provides a good service; an experienced carer worker looks after [relative]." Another relative told us, "Oh yes, I trust them [carers]."

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw examples where the provider took immediate action and recorded all investigations. For example, the provider took action in relation to the incident that prompted this inspection by suspending the care workers who were supporting the person at the time whilst an investigation took place. Since the incident, they showed us how they had been monitoring the care that was being provided and this was done on a daily basis where they liaised with the care workers throughout the day to check whether there were any issues or any further incidents. In addition a relative made us aware of an incident where staff had failed to operate equipment correctly. The provider told us they were aware of this incident and said, "The carer in question was called to the office and she had to go through a moving and handling refresher course. We spoke with the family and apologised for this one incident." This meant that the provider was taking a pro-active approach in ensuring that safe care was being provided and following up with staff to prevent incidents from happening again.

Staff told us they knew what to do in an emergency situation. One care worker told us, "If someone has fallen down or there is a serious injury I'll call an ambulance and inform the office as well."

Staff told us they had access to protective equipment and supplies in order to carry out their jobs safely and effectively. One care worker told us, "We always have enough [supplies]. When I forget to order, I'll come in [to the office] and pick it up. I demand I have the tools to do my job because I'm the one responsible for ordering for my client, for example sliding sheets and gloves. Have to make sure the client is safe." This meant that staff ensured that they had the appropriate equipment in place to provide care safely.

The provider had systems in place to protect people from the risk of abuse. There was a safeguarding adults procedure in place. This made clear staff responsibility for reporting any allegations of abuse to the local authority and the Care Quality Commission. Records confirmed that safeguarding allegations had been dealt with appropriately in accordance with the policy. Staff had undertaken training about safeguarding adults and had a good understanding of their duty to report any concerns. One member of staff said, "I will make notes of what I have seen and contact the office and speak to the person who is in charge. We report everything. If anybody has a fall we contact the office." Another care worker told us, "At first I'd speak to my manager and they'd report it. Or I'd report it to the police." This meant that staff had a good understanding of how to recognise and report any safeguarding concerns.

The service had robust staff recruitment practices in place. Staff told us and records confirmed that the service carried out various pre-employment checks on prospective staff.

Records showed that checks carried out by the service on new staff included criminal records checks, employment references, right to work in the UK visas and proof of identity. This meant the service had taken steps to help ensure suitable staff were recruited. One member of staff said, "Yes, I got my DBS and they did references." DBS stands for Disclosure and Barring Service and is a check carried out on staff to see if they have any criminal convictions or are on any list that bars them from working with vulnerable adults.

The service supported people to take medicines in a safe way. There was a medicines policy and procedure in place which provided guidance to staff about the safe management of medicines, including its administration and recording. Staff undertook training about medicines before they were able to administer it. Staff were aware of what action to take in the event of making an error with medicines. They told us they would report it to the office staff and seek advice from the person's GP. They told us details of people's GP were included within care plans and records confirmed this. Medicines risk assessments were in place which included details of the possible side effects of medicines.

Medicine administration record charts were maintained. These included the name, strength, dose and time of each medicine to be given. Staff signed the chart after each administration so there was a clear record of the medicine being administered. A member of staff said when administering medicines, "I read the information on the medicine chart and on the label." We checked completed charts and found they were completed accurately, up to date and did not contain any unexplained gaps. When the medicines charts were completed they were returned to the office where a senior member of staff carried out an audit on them to make sure they were completed correctly. Records of these audits showed they included a check that black ink was used by staff, and that staff had signed them appropriately.

The service had procedures in place to protect people from the risk of financial abuse. Although we were told at the time of inspection the service did not support any person with their money, the service was available if required. Systems were in place to mitigate the risk of abuse. Staff were expected to record all monies they spent on behalf of people and keep receipts. These receipts and records would then be periodically checked by a senior member of staff.

Staff told us they had enough time to carry out their duties on their allocated visits and that they had enough time to get between people when providing care to more than one person on the same day. One member of staff told us when a person required two to one staff support, this was always provided and they had never had to try and manage this on their own. Another member of staff said, "There's always a person on standby to help [if there is an unexpected absence] and they'll use someone who knows the client [to cover]." One relative told us, "Yeah, they provide the time as required. They come on time and leave when they are supposed to."

However, some relatives of people who used the service told us that carers were not always reliable. For example, one relative said, "We will be using a new care agency from October [2017]. There have been 5 occasions when the double up carer has not turned up." We spoke to the provider about this and they told us they were aware of the situation and had carried out an investigation. They told us they have since changed the carers attending to this person. Another relative told us, "The care is all upside down. The carer did not turn up on Saturday. The agency lied. I asked what happened yesterday and he said he booked a day off a long time ago. During the day I had no carer during the day at all." The provider has advised us that disciplinary action had been taken against this carer and that staff supervision was taking place to avoid this from happening again.

The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not always deploy a sufficient number of staff to make sure that they can meet people's care and treatment needs. Regulation 18(1)