Network Healthcare Professionals Limited

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Inspection report

24 Osprey Court
Hawkfield Way, Hawkfield Business Park
Bristol
Avon
BS14 0BB

Tel: 01173015040
Website: www.networkhsc.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Network Healthcare Professionals is registered to provide the regulated activity of personal care and treatment of disease, disorder and injury. The service is a domiciliary care service, providing care and support to people in their own homes. It provides services to older people, younger physically disabled adults with complex care needs and those requiring palliative and end of life care. Care and support was delivered to people from three separate teams within the service – the domiciliary care team, the palliative care team and the complex care team.

Domiciliary care and palliative care was currently provided to people in the south area of Bristol. At the time of this inspection the complex care team were supporting people in Bristol and Gloucestershire.

There were two registered managers in post. One registered manager was responsible for the domiciliary and palliative care teams and the other was responsible for the complex care team. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. 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 was announced. We gave the registered manager 24 hours' notice of the inspection. We did this to ensure key staff were available for the inspection. At the time of the inspection the service were supporting eight people with complex care needs, six people who were near the end of their life and 53 people with personal care. The service employed in total 115 staff.

The service people received was safe. There were effective safeguarding systems in place. Staff knew what to do if safeguarding concerns were suspected or witnessed or a disclosure had been made to them. Safeguarding training was part of the provider's essential training programme. Any risks to people's health and welfare were assessed and management plans put in place to reduce or eliminate that risk. There were sufficient numbers of care staff employed to meet people's needs. Each person supported by the complex care team had their own team of staff who had received person-specific training to ensure they could look after the person safely. There were safe recruitment procedures in place, pre-employment checks were robust and ensured only suitable workers were employed.

Where people were supported with their medicines this was done safely. Staff received safe administration of medicines training and their competency to support people properly was reviewed. The staff took appropriate measures to prevent and control any spread of infections.

The service people received was effective in meeting their needs. People's needs were assessed prior to a service being delivered. This was to ensure the service had the capacity to meet their specific care needs. For those people with complex care needs, a staff team was recruited and led by a care manager (qualified nurse) and team leaders. Staff in all three teams were well trained and well supported by the management

teams.

People were supported with meal preparation where this had been identified as one of their care and support needs. Care staff monitored those people where the risk of malnutrition and dehydration had been identified. People were supported to access any health care services they required.

People's capacity to make decisions for themselves regarding their care and support was assessed and kept under review. The staff were aware of the principles of the Mental Capacity Act 2005 and understood their roles and responsibilities in supporting people to make their own choices and decisions.

People received a caring service and the staff treated them with kindness. The feedback we received from people and their relatives was positive. We were told that people were treated with respect and dignity. There was an expectation that each person was delivered a service of the highest standard. People, and where appropriate, families were involved in planning the care and support they received.

The service was exceptionally responsive and provided each person with a person-centred service. Staff were allocated to work with the same people which meant they were able to get to know the person well and provide a consistent service. Those people with complex care needs were looked after by a team of staff who could pick up and respond to any changes in their health status quickly. People were supported to achieve personal goals and live as normal a life as possible. Feedback was gathered from people regarding their views and experience of the service they received. Action was taken if people had complaints or concerns. The registered manager used lessons learnt from any complaints to make changes to improve care delivery in response to people's views and opinions.

The service was well led with two registered managers who provided good leadership and management. In addition, office based staff ensured the service was delivered as agreed, the staff were well supported and people were satisfied with the service they received. The quality and safety of the service people received was assessed and monitored and any areas needing improvement were identified and addressed.

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 rating remains Good.	**Good**
Is the service effective? The rating remains Good.	**Good**
Is the service caring? The rating remains Good.	**Good**
Is the service responsive? The service was exceptionally responsive to people's care and support needs.	**Outstanding** ☆
Is the service well-led? The rating remains Good.	**Good**

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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.

Prior to the inspection we looked at the information we had about the service. This included the provider information return (PIR). This 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 also looked at notifications that had been submitted by the service. Notifications are information about specific important events the service is legally required to report to us. We had asked three health care professionals to tell us about their experience of working with this service but although they acknowledged our request, they did not provide any feedback.

The service was last inspected in April 2017. At that time the service was rated as Good and there were no breaches of regulations. This inspection was announced and was undertaken by two inspectors.

During our inspection we spoke with five people who were assisted by Network Healthcare and four relatives. We spoke with eight members of staff plus the business manager and branch manager as well as the two registered managers. We also received approximately 30 emails from staff who shared their experiences of working for this service, with us.

We looked at the care records of nine people, five staff records to look at the recruitment process and training records, policies and procedures, audits, quality assurance reports and survey results.

Good

Is the service safe?

Our findings

People received a safe service. We spoke to people, or their relatives, who received support from the complex care team or the domiciliary care team. Their comments included, "The staff are fabulous, I trust them completely", "I am looked after so well and feel safe in their hands", "The staff are very competent and know what they are doing", "The staff are very competent using the hoist to get X out of bed" and "No concerns at all. I leave the staff to get on with what they have to do. I have no concerns regarding the safety of (named person)".

Effective safeguarding policies and procedures were in place to ensure people were protected from harm. All staff received safeguarding training as part of the provider's induction and refresher training programme. Staff we spoke with were knowledgeable about safeguarding issues and said they would report any concerns to the registered managers or the senior staff. They knew they could report directly to the local authority, the Police or the Care Quality Commission as well. Both registered managers had undertaken additional safeguarding training aimed at managers and had previously demonstrated their competence in dealing with any safeguarding concerns. The service looked for any learning points following safeguarding events to prevent or reduce the chance of a reoccurrence.

A range of risk assessments were undertaken as part of the assessment of care needs process. Where risks were identified a management, plan was included in the care plan. For those people supported by the complex care team, their risk assessments included plans for how to use any equipment. For example, ventilators, suction equipment, oxygen cylinders and moving and handling devices. All care staff received moving and handling training and did not assist people until they had been trained.

An assessment was completed of the person's home and the care staffs working environment so that control measures could be implemented where necessary to reduce or eliminate any risks. The assessment covered the external and interior aspects of the home, access, fire safety, the utilities and the presence of any pets. One staff member told us about a situation where the home environment of one person compromised the safety of the staff team, had been resolved but was likely to return. Another staff member told us about concerns regarding the storage and the movement of large oxygen cylinders which were being addressed. Staff were expected to report all health and safety concerns to the registered manager. Any accidents and incidents that occurred during the course of care and support being delivered were investigated and analysed in order to identify any trends. This meant the service was then able to make changes to mitigate the risk and either prevent or reduce the likelihood of the event happening again.

At the time of our inspection the service employed sufficient numbers of care staff to cover the needs of the people supported. The domiciliary care team would not take on any additional care packages from the local authority unless they had the capacity to meet the person's needs. The service was actively recruiting additional staff at all times to meet demand for domiciliary care provision. Prior to new packages of care being taken on by the complex care team, care staff were recruited to work specifically with that person.

Staff recruitment procedures were safe. Appropriate pre-employment checks were completed and these

included written references from previous employers and an enhanced disclosure and barring service (DBS) check. A DBS check allowed employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people. These measures minimised the risks of unsuitable staff being employed.

The service had safe measures in place in respect of the management of medicines. Where people needed support with their medicines, the level of assistance they needed was assessed and a plan of care written. Before care staff were able to support people with their medicines they received safe administration of medicines training and then their competency was checked to ensure they followed safe practice. Where staff were required to administer medicines by specialist techniques, for example via a tube directly into the stomach, additional person-specific training was completed before care staff (complex care team) could deliver that support. Staff completed medicine records after administering medicines, these were returned to the office monthly and audited for completeness and correctness.

All staff received health and safety training as part of the mandatory training programme. This included infection control and food safety training. Staff were provided with personal protective equipment (PPE), gloves, aprons and hand sanitising gels.

One of the registered manager discussed with us a number of occasions where lessons had been learnt where things had gone wrong. The investigations had been used to support improvement and prevent the event happening again. One such example was when a person's medicines had been missed (this has happened in March 2018 when the area had experienced excessive snowfall), another when a person's electric wheelchair had malfunctioned.

Good

Is the service effective?

Our findings

People received an effective service that met their individual care and support needs. People or their relatives said, "I could not manage without the help I get and I am desperate to stay in my own home", "All tasks are completed as I expect", "The staff have the right skills and are well trained" and "The service I receive is very reliable. All the tasks on my care plan are completed".

People's needs were always assessed by the relevant staff member (domiciliary care, end of life care and complex care) prior to any service being delivered. Where there was a referral for the palliative or the end of life care team the assessment was carried out promptly. The criteria to receive this service was the person was in the final 12 weeks of their life. Referrals for domiciliary support were either taken from the local authority or direct from the person themselves. The assessment was comprehensive and ensured the service was able to meet the person's specific care and support needs. It also ensured the care staff had the required skills and experience to deliver care effectively. From these assessments a plan of care was devised and agreed upon. The plan was regularly reviewed and updated as necessary.

Where people were referred for support from the complex care team, this required greater planning and transition from other care providers, for example hospital care teams. In these circumstances the complex care team would work in tandem with the other care provider for a handover period. This gave the complex care staff, team leaders and nurses the ability to get to know the person well and how their care and support needs had to be met.

The staff teams were well trained and had the required skills, knowledge and experience to deliver effective care and support. New staff completed a full induction programme at the start of their employment and this was aligned to the Care Certificate, the minimum standards introduced for all health and social care workers. New staff completed a number of shadow shifts with an experienced member of care staff until they were confident and competent to work on their own. Staff confirmed these arrangements. Care staff recruited for the complex care team would already be experienced care staff, will undergo a key clinical skills assessment and receive training specific to the person they would be looking after.

The provider had a programme of mandatory training all staff had to complete. This included safeguarding adults, the Mental Capacity Act 2005, safe medicine administration, dementia care, food hygiene and moving and handling. Staff confirmed the induction programme and the training programme. There was an overwhelmingly positive response from the staff we spoke with and those who emailed us the training was good and prepared them to do their job well. Care staff were supported to undertake qualifications in health and social care as part of their ongoing development.

Individual supervision meetings were arranged for staff within the different teams of staff but we received a mixed response from staff about how often they were arranged. Comments ranged from "few and far between" to "they are arranged regularly". Despite these comments all staff said they were well supported by their line manager and would always be able contact someone senior if they needed to. Staff meetings were held regularly. The complex care team had a weekly teleconference with the registered manager,

business manager and qualified nurses where there would be discussions about staffing, people's requirements and any concerns arising from feedback received.

Where people needed support with meal preparation or eating their meals, the level of support would be detailed in their care plan. Care staff would be given clear instructions on the care and support they needed to provide. This could involve making breakfasts, lunch and tea time meals and hot and cold drinks. The staff who worked in the complex care team may need to support people who were fed through a gastrostomy tube and they would have the necessary skills and competencies to support the person with this. Some people with complex care needs required the care staff to monitor their dietary and fluid intake and they completed food and fluid intake records. Those we saw had been totalled at the end of each 24 hour period and evidenced the person's needs were being effectively monitored.

People were supported to consult with health and social care professionals as necessary. This may be the person's GP, a district nurses or community based occupational therapists and physiotherapists. Those care staff who worked with the end of life care team could also be liaising with hospice services.

Staff completed basic Mental Capacity Act 2005 (MCA) training to ensure they understood the principles of the MCA. Some staff commented they would like further MCA training so they had a greater understanding. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. When people were assessed to have support from the service, the person's capacity to make decisions for themselves was assessed and then reviewed ongoing. Care staff said they always checked with the person they were happy for them to provide care and support. Where a person who had no verbal skills was supported, decisions were made with their main carer and agreed as their care plan. Care staff would make best interest decisions where needed and would justify their reasons in the written records they made. Where people had given power of attorney to a relative, this was recorded in their care notes. We suggest the service should also record they had seen the appropriate documentation.

Good

Is the service caring?

Our findings

People received a caring service, from the domiciliary care team, the palliative care team and the complex care team. Comments they and relatives made included, "I think the service I get is really good and the staff are very caring", "The care staff are very kind, caring and willing to help" and "The staff are very nice and friendly. I have heard them chatting away to mum and they are polite and respectful even though mum had dementia and can be repetitive".

There was an expectation by the provider and registered managers that people were always treated with kindness and this was reflected in feedback we received from staff who worked within the three teams. Staff told us, "It is very important to me to know that I have done a good job and made a difference to that person's life", "I am new to the team and I have the greatest regard for the care staff I work with", "The team I work in has some of the most dedicated, caring and conscientious personnel that I have ever worked with. The focus is always on the person" and "I would highly recommend this service to work for and also provide for my relatives".

All parts of the service kept the thank you cards they received. Comments made in the sample of cards we looked at included, "Please extend our family's gratitude for the excellent care and support given to (named person)", "Thank you for wonderful care and thoughtful ways, "I cannot thank the amazing team enough, for caring for my mum" and "Without you mum would not have been able to remain in her own home for as long".

Staff we spoke with told us about the people they supported and assisted. They talked about them with great respect. One said, "I would be happy to receive care from Network. I believe they are a really caring company", "It is important to put a smile on your face when visiting people as I may be the only person they see that day" and "I go to regular people and I consider them as part of my family. I look after them as if they were my grandparents". When asked, all staff said they would recommend the service to friends and family.

People and, where appropriate their relatives were involved in planning their care and were encouraged to have a say in how the support was delivered. Each person was provided with a person-centred package of care and this took account of their individual care and support needs. Those people who received a service from the complex care team were looked after by a team of staff and those receiving a domiciliary care team were looked after by the smallest number of care staff as possible. Those in receipt of larger packages of care (three or four visits per day), were supported by a greater number of staff. Where two staff attended a care call at the same time, the service aimed to allocate at least one familiar member of staff. These measures ensured that people received continuity of care and were able to form good relationships with the staff teams, nurses and care staff.

Outstanding ☆

Is the service responsive?

Our findings

People received a service that was responsive to their specific care and support needs. People and their relatives made the following comments about the service they received: "I need to have help four times a day now", "I think mum will need more help soon and the manager has said this can be arranged as and when needed. The staff come twice a day at the moment and do all that was arranged", "The staff team are highly attuned with his specific needs and his medicines" and "Only care staff who are trained and can recognise and respond to any changes in his needs can come to X".

People's needs were met because of the way the management team planned and delivered their care. Their care and support needs were fully assessed and people were always involved in developing their care and support plan. Where the person themselves could not participate in this process, their family representative acted on their behalf. People's preferences and choices about how their needs were to be met were recorded. A copy of the care plan and other documentation was kept in people's homes as well as in the office. For those people who were supported by the complex care team, their care plans were reviewed very regularly by the nurses, team leaders or registered manager.

The complex care team were able to tell us about examples where the staff team had gone over and above, in order to assist people they supported to achieve personal feats. Despite wide-ranging physical disabilities, one person had been supported during their university studies and work placements and also to compete in strenuous sporting events. Another person had been supported to have a holiday with friends and this had required the staff team to transport essential equipment and set this before the person's arrival. Other staff had helped out by feeding the cat whilst the person was away, something that was very important to them and their wellbeing. The staff team for one person had researched activities and groups they could attend and had advocated on behalf of the person.

Each person had a care plan and these provided clear instructions for the care staff to follow. The level of care the person needed was recorded in the plans. For those people receiving a service from the domiciliary care staff, their plans listed the tasks to be attended to each visit. For example, where people had morning visits, midday, afternoon and evening visits, it was clear what tasks had to be completed when. The plans for people with complex care needs contained a high level of detail including information about changes in health status, any emergency care that could be required. Where risks had been identified, the care plans had been developed to minimise the risk whilst also maintaining the person's independence and their individual preferences.

In every person's home who receives support from the complex care team, there is a clinical procedures folder. As the staff have to work with ventilators, suction equipment and other sophisticated moving and handling equipment, this folder was vital. It enabled them to be able to deal with any emergencies and equipment failure. The registered manager talked about a number of occasions when the care teams had had to deal with emergencies when they were out and about with the person they were looking after. It is evident the skills of the care team means they can respond to people's needs.

New packages of care provided to people with complex care needs were reviewed two weekly, then four weekly, then three monthly. The registered manager did a lot of forward planning because of the complexities of their care packages and the high level of support provided. For each person who was supported by the complex care team, there was a case manager (a qualified nurse), a team leader and a team of experienced care staff. The nurses worked alongside the care staff but we did receive many comments from staff saying communication with the nurses was inconsistent but clinical support was there when needed.

Following the start of a new domiciliary care package, the first review was completed between four to six weeks of start and then on at least an annual basis. These time scales were adjusted where necessary. Care staff were expected to report changes in people's needs to the management team so that a reassessment could be arranged. These measures ensured the service provision matched people's care and support needs.

Within the service there was also a separate team of eight care staff who provided a palliative care service. This team supported people who were in the last 12 weeks of life and who wanted to spend their last days in their own home. Following referral, the team were able to provide a prompt service and worked with family, friends and hospice services to look after the person. The level of service provided was in response to the person's individual care and support needs. Compliments received by this team included, "Thank you for all your help and laughter", "Your humour, care and empathy helped the family at a very difficult time" and "Sincerest thanks for all the care received. Your care enabled (named person) to remain at home".

People were given information about the service, including their care plan, out of hours contact arrangements and a copy of the complaints procedure. This explained how to make a complaint and set out how they could expect any concerns or complaint to be handled. This meant that people and their relatives knew what they could expect the service to do if they were unhappy. People and relatives, we spoke with said if they had any concerns or complaints they would feel comfortable about raising these with the management team. People were encouraged to express their views and make comments about things during their care plan reviews.

The service had handled a number of concerns or complaints raised by people or their relatives. The records kept by the service evidenced that each 'complaint' had been responded to appropriately. The registered managers used the opportunity for lessons to be learnt following any concern or complaint being raised to make improvements in care delivery.

Good

Is the service well-led?

Our findings

People and relatives told us the service was well led and planned care calls were made as agreed. They also said the timing of care calls was generally good and the office kept in good contact with them if staff were going to be delayed (traffic or another reason). The comments we received from people who used the service, their relatives and staff members were positive. They said the service was well led, person-centred, open and inclusive. People were able to achieve the outcome they wanted which was to be cared for in their own homes.

The service has two registered managers, one responsible for the complex care team and the other for the domiciliary care team and the palliative care team. Both registered managers provided good leadership and management for their staff teams and were supported by a team of office staff, a branch manager, and business manager, nurses, team leaders and senior care staff.

There was an out of office hours (evenings until 10pm and at weekends) on call service, provided by another branch office in Birmingham for the domiciliary care service and palliative care team. For the complex care team there is one nurse on call at all times however the registered manager and business manager were also available for advice and guidance.

Both registered managers demonstrated a commitment to providing good leadership and management for the staff team and all other staff we spoke with said they were proud to work for Network Healthcare. Both registered managers were well qualified with one in the processing of completing a level five qualification in leadership and management. Feedback we received from the office staff, care staff and the complex care team members who emailed us, was positive. Comments included, "I am happy with the clinical support I get and also the support from the manager who is very approachable", "I feel valued. I have a good relationship with the staff in the office and find them helpful" and "The management team are supportive and the clinical support is there when needed". All the staff we spoke with said they were expected to deliver the highest standard of care.

The service had a business continuity plan. This set out the arrangements that would take place if a number of different events occurred. The plan covered traffic delays, severe weather, fuel shortage, staff sickness, loss of IT and telephone, office damage and any other disasters. One of the registered managers talked about how their 'snow plan' had worked in March 2018 and the alterations they had made to procedure for the next heavy snowfall.

The service had robust quality assurance and auditing arrangements in place to monitor the quality and safety of the service. Care records and medicines administration records, were returned to the office monthly and checked for completeness. A sample of staff files had been audited in September 2018 by an external auditor. They had checked recruitment procedures and staff training compliance. Care records and care plans were reviewed and audited to ensure they were complete and remained an accurate reflection of the person's care and support needs.

The service used surveys to gather feedback from people who used the service, their relatives and staff members and used feedback to identify where any further improvements were required. It was evident the provider and registered managers engaged with people using the service, their families and the staff team and used feedback to develop the service.

Both registered managers knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received appropriate notifications from the service.