Amcare Limited

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Amcare Limited (Amcare Group Nursing Services) are part of a larger global organisation. This organisation provide, manufacture, deliver and advise on ostomy (an opening in the body created through a surgical procedure for the discharge of body waste) and bowel care, wound therapeutics, continence, critical care and infusion devices and have prescription distribution facilities nationally.

Amcare Nursing Services are a small team of registered general nurses, based throughout England, providing urology support to adults and bowel support to adults and children living in their own homes.

Amcare Limited is a wholly owned subsidiary of it's parent company.

We regulate independent community adult services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- All staff we spoke with demonstrated a clear understanding of incident reporting processes and procedures.
- The provider had robust arrangements to ensure care and treatment was aligned to best practice and followed national guidelines.
- Nurses worked flexibly to ensure fluctuating referral numbers were managed appropriately.
- All patients we spoke with were positive about the provider.
- The provider proactively provided nurses with opportunities for further professional development.
- Patients received services, which were assessed according to their individual needs.
- Advice and support for patients was made available through the use of various technologies.
- All staff we spoke with were passionate about the services they delivered and felt proud to work for the organisation.
- Leaders were visible and promoted a positive, supportive culture. They could clearly articulate the values and business model of the organisation.

However, we also found the following issues that the service provider needs to improve:

Summary of findings

- Lessons learnt following clinical incidents were not readily accessible, however following our inspection a draft policy was submitted by the provider, which included a clear audit trail process following an incident.
- The provider did not offer training for nurses in relation to dementia care and learning disabilities.
- The provider did not formally record any patient outcome data. However, we saw plans to address this through the introduction of a new electronic recording system.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults		**At this inspection we found :** • Staff had a good understanding of the processes for incident reporting and there were arrangements in place to investigate serious incidents. • Staff were fully able to describe duty of candour and we saw examples when this was applied. • There were sufficient numbers of staff to deliver safe care and services. • There was proactive commitment from the provider to supporting staff to be able to perform their roles safely. • All patients we spoke with were positive about the provider. • The provider maintained a robust risk assessment process, which reflected the challenges with the service. • Advice and support for patients was made available through the use of various technologies. • Patients and their families were encouraged to be involved in decision making about their end of life care needs • All staff we spoke with were passionate about the services they delivered and felt proud to work for the organisation. • Leaders were visible and promoted a positive supportive culture. They could clearly articulate the values and business model of the organisation. **However** • Lessons learnt following clinical incidents were not readily accessible, however following our inspection a draft policy was submitted by the provider, which included a clear audit trail process following an incident. • The provider did not offer training for nurses in relation to dementia care and learning disabilities. • The provider did not formally record any patient outcome data. However, we saw plans to address this through the introduction of a new electronic recording system.

Summary of findings

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Summary of this inspection

Background to Amcare Limited

Amcare was acquired in 2002. It operates Monday to Friday, with nurses located throughout England, working in specific geographical areas. The provider's registered location is Sunderland, but nurses work in various locations across the country and are based from home.

The service consists of 12 registered nurses, and two registered managers.

The nominated individual had been in post since 2016, but has been an employee of the larger organisation since 2007.

Amcare have not been inspected previously.

The service is not commissioned but had several contracts in place to provide services in local NHS hospitals and private units.

Our inspection team

Our inspection team was led by:

Team Leader: Lisa Hall

The team that inspected the service comprised of two CQC inspectors, a assistant inspector, and a specialist advisor.

Why we carried out this inspection

We inspected this service, as part of our ongoing comprehensive community adult's inspection programme.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on the 29th-30th March 2017. During the visit, we spoke with a range of staff who worked within the service, such as nurses and managers. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members, and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

During the inspection visit, the inspection team:

- Visited the provider headquarters and distribution centre, looked at the governance arrangements in place and interviewed the managers based at this location, and observed how staff were caring for patients;
- Spoke with seven patients who were using the service;
- Spoke with the nominated individual and registered managers.
- Spoke with 11 other staff members; including qualified nurses.
- Received feedback about the service from four health care organisations.
- Looked at four patient care and treatment records.

Summary of this inspection

- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Comments we received from patients during our inspection were positive. Staff were described as kind and caring.

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Summary of findings

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- All patients we spoke with were positive about the provider.
- The provider proactively provided nurses with opportunities for further professional development.
- Patients received services, which were assessed according to their individual needs.
- Advice and support for patients was made available through the use of various technologies.
- All staff we spoke with were passionate about the services they delivered and felt proud to work for the organisation.
- Leaders were visible and promoted a positive supportive culture. They could clearly articulate the values and business model of the organisation.

However

- Lessons learnt following clinical incidents were not readily accessible however, following our inspection a draft policy was submitted by the provider, which included a clear audit trail process following an incident.
- Nurses did not receive training specific to dementia care and learning disabilities.
- The provider did not formally record any patient outcome data. However, we saw plans to address this through the introduction of a new electronic recording system.

Community health services for adults

Are community health services for adults safe?

At this inspection we found:

- Staff we spoke with had a good understanding of the processes for incident reporting and there were arrangements in place to investigate serious incidents. There were a low number of incidents and staff were clear regarding when and what to report.
- Staff were fully able to describe duty of candour and we saw examples when this was applied. The provider took an open and transparent approach when investigating and responding to clinical incidents.
- There were sufficient numbers of staff to deliver safe care and services.
- There was proactive commitment from the provider to supporting staff to be able to perform their roles safely.
- Patient records were maintained securely and staff had access to a centrally held electronic recording system.
- The provider maintained a robust risk assessment process, which reflected the challenges with the service.

However

- Lessons learnt following clinical incidents were not readily identified and not collated in a consistent manner.

Safety performance

- The provider had procedures and policies in place to ensure patients received care and treatment in a safe and appropriate manner.
- Internal meetings were held on a monthly basis to review safety and discussions included learning from incidents.
- Staff received training in relation to health and safety and we saw that nurse training compliance was 91% at the time of inspection, against an internal target of 90%.

Incident reporting, learning and improvement

- All staff we spoke with understood their responsibilities about reporting incidents. Staff were able to explain how to log an incident on to the electronic incident reporting system. Staff were able to provide clear examples of the types of incidents that should be reported and who they should report these to.
- The provider reported four clinical incidents between March 2016 and March 2017. One of the four incidents involved skin damage to a patient due to incorrect size of equipment used, which was dispensed in error.
- We reviewed documentation specific to this incident and saw that the provider had added an alert to the electronic dispensing system, to show the exact size of product required. However, the product was dispensed by a different pharmacy and they did not have access to this alert. The provider was not responsible for the prescription which was dispensed.
- We saw examples of completed electronic incident reporting forms. The forms were divided into three sections, which clearly outlined the escalation and investigation processes once an incident form had been submitted.
- There were no timescales identified in which investigations were to be concluded, however we saw three completed examples of incident investigations which were all completed within 14 days of submission.
- All incidents were discussed at the clinical governance meeting in the same month in which they occurred, which drove forward the process. We saw minutes of these meetings to corroborate this; however the provider ensured priority when dealing with incidents.
- A serious incident was recorded in February 2015, which involved the loss of patient records during transportation. We reviewed the investigation report following this incident and saw that actions were taken to mitigate further issues. One of the actions included the roll out of staff training relating to information governance.
- A manager told us that incidents were also discussed at nurse team meetings and we saw minutes of clinical supervision, which included this.
- Clinical incidents were not subject to any external scrutiny. One honorary contract required the provider to submit clinical incident data and a manager told us that consideration would be made in future contracts to share this information.
- Lessons learnt were not consistently captured through the existing governance processes and changes to practise following incidents were not clearly recorded. Following the inspection however, the provider submitted a revised Standard Operating Procedure (033) which made provision to include this information in the future.

Community health services for adults

- Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There were no never events reported by the provider between March 2016 and March 2017.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with understood their role in the duty of candour and senior managers were aware of the process to follow. Staff told us apologies were offered to patients and their families, where it was felt there had been issues and the provider encouraged openness and transparency.
- We saw that within the four clinical incidents reviewed, that clear reference was made to the duty of candour.
- All staff received guidance on duty of candour, which was refreshed annually.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. All staff were required to complete adult safeguarding training as part of the organisation's mandatory training requirements. The training was delivered through e-learning and incorporated information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs), consent and the use of restraint.
- We saw that the provider had a clear safeguarding policy which had been recently reviewed in March 2017.
- Amcare nurses achieved 91% compliance for mandatory levels one and two adult and children safeguarding training for the period March 2016 to March 2017. This was against an internal target of 90%. The mandatory training schedule has been changed to an annual training programme, which is booked for all nurses to attend in November 2017.
- Bowel nurses also provided care and treatment to children. Between March 2016 and March 2017, we saw that the service received 23 referrals for children. All staff we spoke with were aware of the safeguard procedures specific to children.
- All bowel nurses were expected to complete level three children's safeguarding training and we saw that nurses had achieved 100% compliance.
- All staff we spoke with were able to clearly describe safeguarding examples and when they would be required to raise a safeguarding alert. A nurse gave us an example of a safeguarding concern, which was escalated to a local authority and all nurses we spoke with knew which local authority to contact regarding a concern.
- Both of the registered managers were safeguarding leads for the organisation. Both had completed level three safeguard training for adults and in addition one manager, responsible for the bowel services, was due to complete level four children's safeguarding in July. We saw that arrangements for this training were in place.

Medicines

- Medicines were not administered by the Amcare nurses and were not part of their role.

Environment and equipment

- All nurses carried with them personal protective equipment, paper documentation and an electronic tablet.
- Some equipment was obtained through a prescription such as stoma bags. A stoma is an incised opening that is kept open for drainage, such as the opening of the abdominal wall for a colostomy or urostomy. Nurses told us that they kept a small stock of 'sample' equipment with them for demonstration purposes only. All other equipment was obtained through prescription.
- All staff we spoke with told us they had no difficulty obtaining equipment when they required it. Equipment was ordered through the electronic ordering system 'magic button' and delivered to their home.

Quality of records

- Nurses used portable electronic devices to record patient care and treatment. Nurses told us that they did not experience any technical problems with these devices.

- Each patient had a dedicated care and treatment plan outlining the patient history, current illness / medications and equipment to be used as part of the nurse's visit to the home.
- We reviewed four patient records. All documents were legible, dated and were referenced by the named nurse delivering the care and treatment.
- Managers told us that the quality and compliance manager completed documentation audits twice a year, in attendance with senior nurses. We reviewed three audits dated September 2016 which showed the completion of a comprehensive audit tool, observation summary and actions where required. All audits we reviewed required only minor actions and patient documentation was shown to be completed to the required standard.
- Risk assessments were undertaken by the clinical lead and held on an electronic recording database. These risk assessments were accessible by all nurses prior to visiting a patient at home and we saw completed examples of these.
- Staff received Information Governance training. We reviewed the compliance figures and saw that nurses achieved 100% compliance at the time of inspection.

Cleanliness, infection control and hygiene

- There were infection control and prevention policies in place to keep patients safe.
- Staff were required to complete infection control training as part of the annual mandatory training programme. Staff consistently achieved high compliance rates in relation to infection control training. 100% compliance was recorded during the period of March 2016 and March 2017.
- We observed staff visiting patients at home and saw staff used appropriate protective equipment such as gloves and aprons. Alcohol gel was readily available and staff carried their own supply.
- Clinical leads told us that handwashing standards and practice was observed during field visits, which were carried out twice a year. We saw written documentation to corroborate this.

Mandatory training

- Mandatory training was provided for all staff and was undertaken by all staff including clinical and non-clinical roles. Data showed that 91% of nurses were compliant with all mandatory training requirements, at the time of inspection. This was above the organisations target of 90%.
- All staff received refresher training annually in relation to Consent, Equality and Diversity, Health and Safety, Manual Handling, Safeguarding, Lone Working, Caldicott Principles, Basic Life Support and conflict resolution.
- Staff told us they felt the mandatory training was well managed and were always reminded when a specific session was due. Time was made available for staff to undertake courses and there were opportunities to attend additional training opportunities to further develop clinical skills.

Assessing and responding to patient risk

- Nurses told us that concerns relating to patients were escalated where appropriate.
- Two nurses gave examples of concerns that they had noted regarding the general deterioration in health of a patient and how they had escalated these concerns to other health care professionals, ensuring appropriate action was taken.
- The provider used a 'risk likelihood' rating system for all risks identified. These were rated One-Five with one being insignificant (green) and five being catastrophic (red).
- We saw examples of the rating system in use as part of the incident reporting and investigation processes.

Staffing levels and caseload

- Patient caseloads were divided across the 12 nurses based across the country. Caseload numbers for each nurse varied according to the number of hours that nurses were employed.
- All nurses we spoke with told us that they felt their caseloads were manageable and sufficient to ensure patient care was safe.
- Clinical leads told us that they would provide support with patient's visits where appropriate.
- There were two nursing vacancies at the time of inspection. Caseloads were provided by existing nurses working within the area and additional support provided by the clinical leads.
- Both vacancies had been filled following a recent recruitment campaign and staff were awaiting start dates as they were progressing through recruitment and barring checks.

Community health services for adults

Managing anticipated risks

- The provider maintained a risk register. There were 19 risks identified on the register, ten of which were open at the time of inspection. Risks were reflective of operational concerns. For example, the transfer of patient data was rated as red due to an incident involving the loss of patient data in February 2015.
- All staff we spoke with told us they felt safe during working hours but were advised to carry personal alarms whilst travelling.
- Patient risks were identified at the point of referral and two staff completed the first home visits to further assess the risk. These were identified on the risk tab within the patient electronic record system.
- The provider had a lone worker policy in place, which was up to date. Staff told us teams ensured colleagues remained in touch with each other throughout the duration of the day. Two staff saw patients who were not known to the service or were receiving visits for the first time.
- Nurses maintained calendars, which allowed colleagues to see which patients they were visiting and when they were travelling.
- Staff in all areas we spoke with were aware of daily arrangements for their service, their role within the service and who to escalate the concerns to.
- A senior manager on call was available every day and staff were clear as to who they should contact.
- Issues or risks which potentially could affect patient service delivery were managed by the senior management team. Should services be interrupted for any reason, patients would be advised immediately, the referrer and the patient's general practitioner would also be informed.

Major incident awareness and training

- The provider had developed a crisis management policy, which covered all business functions and operations and related to any serious incidents, which impacted on patients, products and the general public. The policy allowed the provider to escalate any situation to board level should a serious incident have taken place. All staff had access to this policy, through the shared electronic system.

Are community health services for adults effective?

(for example, treatment is effective)

At this inspection we found:

- The provider had a robust arrangement to ensure nurse practice was adherent to best practice and followed national guidelines.
- Staff were skilled and confident in the care and treatment that they provided.
- The provider held strong relationships with local NHS trusts and private health organisations.
- Nurses were supported with revalidation and additional training offered to maintain and further develop their clinical skills.

However

- The provider did not formally record any patient outcome data. However, we saw plans to address this through the introduction of a new electronic recording system.

Evidence based care and treatment

- The provider actively reviewed practice to ensure clinical practice met with national guidelines and best practice.
- A number of nurses were assigned as link nurses, which meant they held additional responsibilities to feedback to all other nurses. We saw that a link nurse was aligned to National Institute for Clinical Excellence (NICE) guidelines and these were fed back each time there was new guidance through group supervision. Handouts were also sent to all nurses with the most recent update.
- We were told by a senior manager that some of the nurses were also involved in research trials aligned to local NHS trusts. We spoke with two nurses, which were part of these trails.
- We saw that a manager provided a journal club for the nurses to review the latest clinical articles relating to stoma and urology care. Several nurses told us they felt that this was a valuable group as best practice was shared and there was an opportunity for reflection.

Technology and telemedicine

- All nurses carried an electrical tablet during patient visits, which held data regarding all patients that were to be visited within the day. Nurses were able to input care and treatment delivered and review risks and care plans specific to the patient's needs.
- All nurses told us that the technology was reliable and functioned without any difficulty.
- The provider actively encouraged the use of technology to reach patients and offer a personalised programme of care and treatment options. An electronic platform provided stoma patients with the option to join a network which offered functions such as stoma advice, life and style advice and specialist advice.

Patient outcomes

- At the time of inspection, the provider did not record specific patient outcome information. However, plans were in place to introduce an improved electronic patient assessment system. This system would have the capability to capture patient outcome measures in required detail. Introduction of the system had commenced in January 2016 and we saw several phases of roll out planned across the period of 2017.
- We saw that the provider had produced an action plan to integrate a Patient Reported Outcome Measures (PROMs) questionnaire to this improved system. Patient outcomes would be measured throughout the entirety of the patients journey, which included first patient assessment, follow up visits and discharge.
- The provider participated in a number of internal audits. A documentation audit regarding patient records and staff training status was carried out twice a year. We saw that compliance was consistently high. Where practice had declined, we saw detailed action plans in place to support improvement. Actions included reminder memo's to be sent to ensure patient allergies were recorded and General Practitioner (G.P) letters to be scanned and uploaded to the electronic system.
- Referral times and delayed visits were also monitored and reviewed twice a year. We saw results of these audits, which did not highlight any specific concerns.

Competent staff

- All qualified nurses providing care and treatment were band six as a minimum.
- Prior to appointment, all nurses were expected to have several years post qualifying experience in either urology or stoma care depending on which specialism they delivered, prior to commencing their role within Amcare.
- We saw that the provider ensured all nurses completed a robust induction programme when they first joined the company. This was completed within an agreed period of time with the clinical lead prior to working alone. We saw completed examples of these.
- All of the nurses we spoke with were supported with mandatory training and additional learning such as attendance at national conferences. One nurse told us they had recently commenced a module for continence promotion at master's level.
- Nurses who were required to use bladder scans as part of their role were competency checked by the clinical lead.
- All clinical leads were expected to undertake a first line management course, which was provided by the company. All managers we reviewed had completed the course and we saw one member of staff who was newly appointed was due to commence the course this year.
- We saw the provider maintained a competency framework. Nurse competencies were checked each year and we saw a record relating to each individual nurse, which was comprehensive and up to date.
- Senior nurses provided 'field visits' to staff every month to observe clinical practice and support when required.
- The provider offered a variety of study days for the nurses to share good practice and review current national guidelines.
- All staff received an annual appraisal. Figures for March 2016 – March 2017 showed 100% compliance.
- We reviewed a spreadsheet, which provided an overview of staff performance. Staff requiring additional support or progress development would be discussed within people review meetings and an action plan devised in order to support this.
- Nurses were supported fully through re-validation by the provider.

Multi-disciplinary working and coordinated care pathways

Community health services for adults

- The provider held a number of honorary contracts, which were in place at the time of inspection with local NHS trusts and private clinics. We saw details of each contract and arrangements, which were in place to review them annually.
- All nurses we spoke with worked closely with the local NHS specialist nurses, occupational therapists, social workers and G.P's to facilitate seamless care and treatment for patients.

Referral, transfer, discharge and transition

- The provider maintained a two week referral target to first appointment standard which was in line with the national target.
- Referrals were made by community district nurses, G.P's, urology and colonoscopy departments within local NHS trusts and private clinics. Referrals were then triaged by the clinical lead for that particular area before being sent to the nurse working in the location.
- All referrals were also logged onto the electronic database to ensure caseloads were managed effectively.
- No formal data was captured to measure this at the time of inspection; however a report could be produced following the implementation of the electronic patient recording system in September 2017.
- Discharge arrangements were flexible and patients were discharged when they felt confident to use the products.

Access to information

- All nurses we spoke with were able to access patient records and information through the electronic tablet.
- We saw clear care plans for patients receiving visits at home and risk assessments should they be required.
- One nurse told us that patients were discussed each week within team meetings and all care and treatment delivered was recorded within the electronic database.
- Another nurse told us that quarterly meetings were held within the local nurse teams to discuss complex cases and ensure learning was shared.
- Policies and procedures were held on a shared drive and were accessible to all staff through a secure network
- Nurses were actively encouraged to attend meetings and events in conjunction with nationally recognised professional bodies such as Crohns (a type of inflammatory bowel disease) and Colitis (an inflammation of the colon) UK and local stoma associations.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- All staff received training relating to consent, mental capacity, which was in addition to mandatory training. This included deprivation of liberty information.
- The two registered managers held governance of the Mental Capacity Act and the responsibilities for consideration within practice.
- Staff understood the mental capacity processes but could not provide any examples of using the process within their clinical practice.
- We observed staff obtaining patients consent before performing any observations or providing patient care.
- We saw the provider had developed a policy regarding consent and mental capacity and this had been recently reviewed.

Are community health services for adults caring?

At this inspection we found:

- All patients and their relatives we spoke with were positive about the care they received in the community.
- We observed interactions between staff and patients and saw these were kind and compassionate.
- Relatives told us staff ensured the privacy and dignity of patients was maintained when providing care and patients who were supported were not rushed.
- Patients and their families were encouraged to be involved in decision making about their treatment and care needs.
- Staff communicated well and worked together to plan the care and treatment.
- Advice and support for patients was made available through the use of various technologies.

Compassionate care

- All patients and relatives we spoke with told us staff were professional, supportive and kind. We observed care being provided and saw patients were treated with compassion, dignity and respect.
- We observed staff providing care and support to five patients. Staff were caring and understanding and provided product information and guidance specific to stoma care.

Community health services for adults

- Patients and relatives we spoke with told us they were happy with the quality of care they received and staff treated them with respect and maintained their dignity. A relative told us, 'I cannot fault them in any way. Very caring'.
- The provider actively sought feedback from relatives and families. Patient satisfaction surveys were sent out every six months, and satisfaction rates were consistently high. Between March 2016 and August 2016, 15 patients responded (35%) and showed 100% would recommend the service, and 100% felt their care and treatment needs were met. Survey results for September 2016 with 34 patients responding (28%) again showed 100% satisfaction rate in these areas.

Understanding and involvement of patients and those close to them

- All patients and relatives we spoke with told us they were involved in their care and treatment. One patient told us, 'all of the equipment was new to me. The staff gave me lots of reassurance'.
- We saw staff supporting patients with their questions and offering guidance and explanations, when using the products.
- We observed staff involving patients in their care in a way they could understand.

Emotional support

- Staff were supportive to patients and showed empathy and compassion during their procedures.
- We observed staff interacting with patients and relatives in a supportive and reassuring manner. Patients told us they 'did not feel rushed' and the nurses 'take their time', to ensure patients felt confident using the various products.
- The service provided a patient support group and patients could access this through skype or facetime calling.
- A patient community facility was incorporated into the electronic platform to enable stomas patients to liaise with patients receiving similar care and treatment.

Are community health services for adults responsive to people's needs?
(for example, to feedback?)

At this inspection we found:

- Nurses worked flexibly to meet the needs of patients and staffing numbers were adjusted to meet the demands of increased referral numbers.
- Patients were assessed according to their individual needs and provision was made for patients with complex needs.
- Cancelled appointments were monitored and logged and there was a process to ensure appointments were reorganised at a suitable time.
- We saw a Saturday telephone advice line to provide support and advice to patients.
- Patients were able to provide feedback regarding their service and we saw that complaints were logged and investigated appropriately and shared with staff.

However:

- The provider did not offer training in relation to dementia and learning disabilities for the nursing team.

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet the needs of patients. Nursing services were not commissioned and referral numbers fluctuated according to demand. Nurses had a clear system to manage and record referrals that were received.
- We saw that staff worked flexibly to accommodate changing caseloads. We spoke with two nurses who told us they would help colleagues in neighbouring areas if referral numbers increased.
- Nurses worked from 8.00am to 5.00pm Monday to Friday and offered patients an advice line which operated from 9.00am to 1.00pm every Saturday.
- Patients told us that they knew which staff were due to visit them and always received appointments which suited their needs.

Equality and diversity

- Patients receiving care and treatment were treated as individuals and were assessed according to their needs.
- Equality and diversity training was delivered to all staff as part of their induction with the organisation and annually as part of a refresher programme.
- We saw that the training compliance record at the time of inspection was 91%, against an internal target of 90%. The mandatory training schedule has been changed to an annual training programme, which is booked for all nurses to attend in November 2017.

Community health services for adults

- Managers told us information leaflets could be obtained in different languages and formats through the quality team.
- The provider had access to an interpreter service, although there were no patients who required this service at the time of inspection.
- Advocacy services were arranged for patients through professional organisations such as the Colostomy Association, Breakaway Foundation and the Crohns and Colitis Group.

Meeting the needs of people in vulnerable circumstances

- We saw examples of person centred care. Notes were recorded on the electronic tablet and records were made regarding patient choice.
- Staff could access the specialist dementia care and learning disabilities link nurses within the local hospitals or community nursing services should they require specific support.
- Specific training regarding dementia and learning disabilities was not offered to the nurses by the provider but most nurses told us they would contact the relevant GP for advice.
- All nurses employed by Amcare were female. A manager told us that should a patient request a male member of staff they would contact the district nursing service to try and arrange a chaperone.
- Counselling services were available to those patients that required it through a team of externally contracted counsellors and triaged by a link nurse employed by the provider.

Access to the right care at the right time

- The provider worked towards a two week referral target, from submission of referral to first patient visit.
- There were no known delays in relation to this but data was not formally captured to corroborate this.
- All nurses told us that they worked together as a team to manage peak periods of referral numbers.
- All patients told us they were happy with the timeliness of their visits and general response times.
- The provider maintained a log of cancelled appointments, which were documented with an explanation and a re-arranged date. Numbers fluctuated but we were very small. In March 2017, we saw a total of five cancelled visits for all of the nurses nationally.

Learning from complaints and concerns

- Patients we spoke with were aware of how to raise a complaint and told us that staff were 'approachable and friendly'.
- We saw the provider had developed a complaints policy and procedure. All of the staff we spoke with were aware of the policy.
- Staff in both the community units and community nursing teams felt they had a low number of complaints and we saw one complaint was recorded in the last 12 month period.
- An information leaflet was provided for patients and gave clear advice as to how to make a complaint.

Are community health services for adults well-led?

At this inspection we found:

- The leadership, governance, and culture promoted the delivery of high quality person-centred care.
- The vision and values were clear to staff we spoke with at all levels. The service was well-led by the senior managers and clinical leads. There was a strong sense of team work.
- Staff spoke highly of the senior team, stating that they felt valued and supported. Staff engagement and morale was good.
- The governance arrangements for committee structures were clear to staff and meetings were well attended with good representation from the team. Key messages were shared.
- Risk management systems and processes were good. We saw local quality action plans that informed the corporate risk register.
- There was clear recognition given to staff to acknowledge their hard work and commitment.

Leadership of this service

- Staff we spoke with spoke highly of the senior team and their colleagues. Managers were visible and accessible at all times and there was a strong sense of leadership at all levels.
- We saw that managers were visible and were passionate about the services that they provide.
- Senior managers and nurses were able to define the business objectives and vision of the service.

- We observed professional communication amongst all staff, and positive rapport with one another. Teamwork was clearly demonstrated during observations of practice. There was a patient-centred, open and approachable culture. Staff we spoke with felt respected and supported by senior staff and by each other.

Service vision and strategy

- The Amcare vision was to be recognised as the most respected and successful MedTech (medical devices) company worldwide. Success was translated to the nursing service as the delivery of excellent care to the patients. All staff we spoke with were clear about the purpose and vision of the organisation.
- Managers told us that the provider's drive for excellence was central to the business and staff were supported to deliver excellent care through appraisal objectives.
- Amcare manufactured and delivered several medical products in addition to the provision of the nursing service.
- The provider promoted core values and behaviours, which was caring for people, driving innovation and excellence and earning trust. We saw that these were embedded throughout all of the governance processes.
- In addition to clinical governance meetings, the provider held business review meetings to monitor the progress of business objectives which included the market strategy.
- We saw clear business objectives for the nominated individual and business director, which included measured outcomes to improve the lives of patients and customers.

Governance, risk management and quality measurement

- The governance structures in place were simple, clear and effective. The compliance manager had oversight of a clear committee structure than met monthly or bimonthly. This included the senior management team, quality lead manager and registered managers.
- Clinical leads met with local nurses on a monthly basis. Outcomes of clinical governance meetings were shared and discussed and action plans were put into place where specific improvements were required.
- Minutes from each meeting were held on a shared drive, which meant all staff had access when they were not able to attend.
- The provider's risk register was an accurate reflection of risk assessments that were in place. A quality action plan was determined by capturing risks and issues raised through the Clinical Governance Committee.
- The provider had recently developed this within the last 12 months; however the matrix was clear, risk rated and had been reviewed.
- Business challenges were reported within the business review meetings however these were not shared with the nursing team. This did not affect the quality of services provided to the patients.
- The nominated individual was not always present at the clinical governance meetings. However, the senior team were knowledgeable about priorities and understood the challenges, taking action when required.

Culture within this service

- Staff spoke with pride regarding the delivery of the care that they provided. Staff were committed to ensuring patients received excellent support and care.
- Nurses in the community felt they had sufficient support and there was a strong sense of team work.
- Managers told us they operated an 'open door' policy and encouraged staff to discuss any concerns that they might have.
- A freedom to speak up guardian had recently been introduced and was in post at the time of our inspection.
- Staff we spoke with, without exception, told us that they enjoyed working with the team and felt proud to be part of the organisation.

Public engagement

- The provider encouraged patients to feedback through comment cards.
- We saw that between March 2015 and March 2016, 213 cards were sent out and 71 were returned. Of these, 100% of patients stated they would recommend the service to others.
- Patient feedback was shared within monthly team meetings.
- One of the senior nurses offered a patient support group. This was accessible through electronic devices to enable patients who lived some distance away to participate.
- The provider had developed a comprehensive events calendar which included local patient support groups and patient open days.

- The provider held bi-annual engagement meetings with local patient representative groups, hosted by professional bodies such as the Colostomy Association. Monthly phone calls were carried out to provide an update on corporate activities.

Staff engagement

- Staff received email updates from both the local Amcare management team and the larger global group.
- Local nurse group meetings were held monthly however, clinical leads supported nurses on an individual basis as required.
- Nurses held teleconferences each week to share patient and general operational issues.
- The provider held a company conference each year and all staff were invited to attend. Nurses were supported with this and caseloads were amended to accommodate the visit.
- Clinical group supervision was provided by the clinical leads, which gave nurses the opportunity to share practice and feedback on any concerns.
- Staff were invited to complete an annual staff engagement 'Pulse' survey. We saw the results from the last survey completed in October 2016, which covered the Amcare group as a whole, received an 83.2% response rate.
- We saw the provider had a detailed events calendar, which enabled nurses to attend national conferences and external events. Examples of events included European Stoma Conference and Coloproctology (Colorectal surgery within the field of medicine) Conference.
- The provider offered a 'nurse award' each year, which acknowledged individuals' hard work and gave recognition for a specific piece of work.

Innovation, improvement and sustainability

- The provider had a clear business model and we saw a business case in which to develop and strengthen specific aspects of the service.
- All patient details were recorded on the electronic patient record system and there had been a move away from paper based records.
- Data was stored on the shared drive, which meant all staff could access information from any site through a secure network.
- The provider had recently invested in an electronic web based patient record system, which enabled managers to measure specific patient outcome activity, provide a live interactive feed for patients, link to counselling services and offer a network community for patients requiring help and support to each other.
- Several of the Amcare nurses had produced clinical articles and information posters which were published in various nursing journals. Examples of these included:
- Hemming, L., 2017. Breaking bad news: a case study on communication in health care. Gastrointestinal Nursing, 15(1), pp.43-50.
- Rudoni, C. and Russell, S., 2016. Physical activity and the ileostomy patient: exploring the challenges of hydration. Gastrointestinal Nursing, 14(7), pp.20-27.

Outstanding practice and areas for improvement

Outstanding practice

- The provider demonstrated a clear commitment to the professional development and recognition of their nurses and proactively sought to ensure they applied clinical best practice skills in this specialist area.
- We saw all staff positively embraced the use of technology to deliver personalised tools and resources to deliver individualised treatment and care.

Areas for improvement

Action the provider SHOULD take to improve

- Should ensure all lessons learnt following incidents are clearly identified and are accessible to staff.
- Provide training for staff in relation to dementia and learning disabilities, to support the understanding of patient need.
- Monitor and record patient outcome data in accordance with the improved patient electronic recording system.