Nurse Plus and Carer Plus (UK) Limited

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Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Nurse Plus & Carer Plus (UK) Ltd in Chichester is a domiciliary care agency registered to provide personal care to people living in their own houses and flats in the community. It provides a service to older people, people with a learning disability, physical disability, people living with a mental health condition, dementia, sensory needs or people who misuse drugs and alcohol. Not everyone using Nurse Plus in Chichester receives a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care which means help with tasks related to personal hygiene and eating. Where people receive personal care we also take into account any wider social care provided. At the time of our inspection, two people were supported with their personal care needs by the provider.

At our last inspection in December 2015 we rated the service as Good. At this comprehensive inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Quality systems and audits were in place to monitor the service people received. We found audits had not identified some discrepancies in care plan documentation relating to the Mental Capacity Act 2005 and the recording of staff competency assessments. Quality processes had not identified aspects of the care plans that required improvement, such as recording activities, and changes in people's needs such as deterioration in health and/or mobility. The provider recognised these areas needed to be addressed. The impact of this was reduced due to the size of the current service.

Good systems and processes to keep people safe had been maintained. Risks to people had been identified and assessed on a regular basis. Staff received guidance on what actions to take to manage risk to help ensure people were safe. The provider had a lone worker policy to ensure staff were kept safe in the community.

People continued to be protected from avoidable harm. There was a safeguarding policy and staff received training. Staff knew how to recognise the potential signs of abuse and followed the procedure regards what action to take to keep people safe. A relative told us, "They are really good. They do keep her safe and comfortable."

The acting manager ensured that when new staff were employed appropriate recruitment practices continued to be followed. Staff received an induction and ongoing training and were supported to undertake additional training they identified. Staff were supported to work towards a National Vocational Qualification (NVQ) and the Provided funded their study. Staff told us they had regular supervision and appraisal as well as contact with each other. Staff told us they felt well supported by the acting manager and the wider management team. One member of staff told us, "I really enjoy working for Nurse Plus, they stick to the book and do things the right way, I feel quite proud to work for them."

People were supported to maintain their health and had assistance to access health care services when they needed to. Staff supported people by arranging healthcare appointments for them. A GP told us that when carers had concerns about people's health they were contacted appropriately. People were supported to receive their medicines safely by staff that were trained in administering medicines.

One relative told us the provider was caring and kind, "They are very patient with her. They understand it's frustrating for her, and they are very empathetic." Staff understood the person's emotional and health needs as well as their social history and this was reflected in the care plan. Staff supported people to have choices over food and drink. People were supported to remain as independent in their home as possible. One member of staff said, "If she wants help she'll let us know. She'll do her teeth and her hair; again, if she needs help she'll call us."

People's care and support was planned to meet their needs, at the time they wanted and staff arrived when expected. There had been no complaints at the service in the previous 12 months. People were confident their concerns would be responded to and knew how to raise any concerns and make complaints if needed. People were supported to pursue activities and interests that were important to them.

A relative and care staff told us the service was well managed. The acting manager was supported by a quality assurance manager and a homecare co-ordinator. The acting manager understood their responsibilities in relation to registration with the CQC. Staff told us they felt supported by the management team and there were clear lines of responsibility and accountability. Staff achievement was recognised and encouraged. We saw that the provider sought people's views on the quality of the service during annual reviews and satisfaction surveys.

Further information is in the detailed findings below.

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 service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service has deteriorated to Requires Improvement The provider had systems and processes in place to monitor the quality of the service, including audits. These audits did not always identify issues and areas for improvement.	**Requires Improvement**

Nurse Plus and Carer Plus (UK) Limited

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 provider under the Care Act 2014.

We last inspected this provider on 17 December 2015 and we rated the service as Good.

This comprehensive inspection took place on 11 June 2018. We gave the provider 48 hours' notice of the inspection visit because we needed to be sure the manager, staff and people we needed to speak to were available.

We visited the office location to see the manager and office staff and to review care plans and records relating to the management of the service. During the inspection process we spoke with the acting manager, the quality assurance manager, the homecare co-ordinator, four care staff and the training co-ordinator. We also spoke to a GP who had contact with the provider. People were offered the choice to speak with us, but preferred for us to speak with their representatives. We spoke to one relative by telephone so that we could further understand their experiences. We have included their feedback in the main body of the report.

The inspection team consisted of two inspectors. Prior to the inspection, we gathered and reviewed information we held about the provider. This included notifications from the service. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This included feedback from service users gathered through a questionnaire. We looked at two people's care plans, two staff files, staff training records, policies and procedures, quality assurance documentation, audits and action plans, health and safety assessments, staff and service user feedback and information and policies in relation to people's medicines.

Good

Is the service safe?

Our findings

A relative we spoke with told us they felt the service was safe and their family member was well cared for. They told us "They are really good, every transfer needs a lot of thinking about because of her condition, they do keep her safe and comfortable. When they take her out, I can relax, I'm happy. If mum wants to do anything the carers will make sure it's done in the safest way."

People were protected from the potential risk of abuse because staff had received training and had access to current policies and procedures. Staff understood how to identify and raise safeguarding concerns according to the provider's reporting procedure. They had a good understanding of the needs of people living in the community and could explain types of abuse that they may experience such as financial, physical, emotional and self-neglect. Information about recognising abuse and on how to report it was available in the staff handbook and reporting procedure. Staff were able to describe the steps they would take to record and report a safeguarding concern to the office. The acting manager described the steps they would take to report safeguarding concerns to the local authority and the Care Quality Commission when required.

Care plans showed that risks to people were identified so staff could provide care in a safe environment. Before starting to care for people, the homecare co-ordinator visited the person in their home and carried out several environmental risk assessments such as identifying hazards in the home. Other assessments included how to move people safely, the person's risk of falls, bathing or showering, skin integrity, malnutrition and dehydration, infection control, communication as well as how to support people with activities safely. There was an assessment of people's general health and wellbeing.

There was a lone working policy to keep staff safe in the community. Staff were given personal attack alarms and the office placed safeguarding calls to staff who live alone to ensure they return home safe after a late shift. Health and safety risk assessments were appropriately carried out on the registered office and training room facilities.

Staff recruitment processes showed that suitable staff were selected to work with people. Staff files showed staff had completed an application form and been interviewed. Their file included previous work history and the provider had obtained written references from previous employers to assure themselves of a candidate's suitability. Photographic identity was also on file. Checks had been made with the Disclosure and Barring Service (DBS) before employing any new member of staff and this was renewed yearly. The DBS is a national agency that keeps records of criminal convictions.

There were sufficient staff to meet the needs of the small number of people that currently used the service. Staffing levels were planned around the needs of people and one relative told us that consistent rotas ensured staff knew the person well. The homecare co-ordinator told us that they did not provide short call visits and all shifts were between six and twelve hours. Staff absence, such as annual leave or sickness, was covered by regular staff. The acting manager and care staff confirmed they would always advise people if there were any changes or if they were running late. A relative told us "they are always on time. They rarely

switch shifts, I've never known them to be late. Any changes I'm always informed."

The provider had policies and procedures to ensure medicines were managed and administered safely. This included procedures to manage medication errors. Staff had received medicines training which was delivered by the training co-ordinator who is a registered nurse. Staff also attended a refresher workshop every six months. Only one person received help with medication administration at the time of our inspection and this was because they were physically unable to manage it themselves. Staff could describe how they completed safe medicines practice including taking the medication out of a blister pack, placing them in a pot for the client to take. Staff described using the Medication Administration Records (MAR) and the process they would undertake, including other medication taken as and when needed. One relative told us staff ensured the person received her regular medication, "They put them in little medicine pots and give them to her with her lunch or at other times. They always make sure she takes them."

People were protected by the prevention and control of infection where possible. Staff received infection control and food hygiene training as part of their induction. Staff were aware of the importance of using personal protective equipment to avoid cross contamination when supporting people. One relative we spoke to confirmed they observed this in practice, "Yes, they go through gloves like anything. They regularly hand wash - we go through a lot of Carex."

We had received no notifications relating to significant accidents or incidents since our last inspection, but records demonstrated that there were systems and processes to manage them. Incidents and accidents were monitored both at branch and head office level. There was one example where a person had been bruised by a wheelchair footplate. The member of staff had recorded the minor bruising to the person on a body map and reported the incident to the acting manager. The person's family had been informed and the person was monitored afterwards. The homecare co-ordinator followed this up one week after the incident to check if the person was safe.

Good

Is the service effective?

Our findings

One relative told us the needs of their family member were met and they were confident in the skills of the staff, "They are a godsend for mum. Mum knows she can't do things by herself, it took time for her to accept. Getting carers in the first place was a huge decision, so she was very particular."

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

We checked whether the provider was working within the principles of the MCA. Staff files confirmed that MCA training formed part of mandatory training. Initial assessments prior to people receiving care included whether people could make decisions for themselves. Where people had capacity to make decisions for themselves, they were supported to be engaged in their care. One member of staff told us, "she is very involved in her care. She recently printed out information about her condition herself which is in the care plan." Where people may lack capacity, an assessment of capacity was made. Consideration was given to whether people were supported by others to make decisions, such as an advocate or a person with legal authority to do so known as a Lasting Power of Attorney (LPA). A person can have an LPA support them with finance and property matters and/or for health and welfare decisions. Health and welfare LPA's only apply when the person lacks mental capacity to make decisions for themselves around their health and welfare. Staff had a good understanding of the principles of the MCA. Staff recognised that when people lacked the capacity to make some decisions, staff must act in their best interests and the person should be supported to make decisions where they can. One member of staff told us, "her capacity fluctuates; it's about guiding her and monitoring her so she's not unsafe but letting her do what she wants."

Staff told us that they felt well supported and that regular supervisions and annual appraisals took place. One member of staff told us, "It's one of the best companies I've worked for. Very supportive, I feel very confident and safe working for them. Other places I've worked are more focused on getting things done quickly. Nurse Plus like to get things done right." Staff undertook an induction when joining the company which included training specific to the needs of people using the service, such as dementia awareness, learning disability awareness and mental health awareness. Staff were offered additional training they felt they needed, such as end of life care, epilepsy, diabetes and further mental health training. The induction for new staff included shadowing experienced staff. Staff files and care plans confirmed staff had ongoing supervision every three months by being observed while working. The provider recognised the importance of continual professional development and supported those staff who wished to work towards a National Vocational Qualification (NVQ) and funded their study.

People chose what they wanted to eat and staff helped to prepare this. One member of staff told us, "She has a list of what she has in her freezer, what meals she wants. If she wants help she'll let us know." People's care plans included guidance on how they wanted their food to be prepared and how they needed assistance. One relative told us, "She can feed herself, it takes a little while, they ask her what she wants,

they are careful to give her food that's not too difficult to cut up. They always check she's eating, they are very conscious of her drinking and always suggesting and offering drinks."

Staff told us that the team worked well together and supported each other. Effective systems were in place to ensure information about the person's care needs and wellbeing was current and shared between other care staff and the office. Staff described how they received a verbal handover from the previous shift and updated the care plan. We saw evidence of this in the care plan where staff recorded daily notes.

People retained their independence for managing their health care and staff knew about people's health needs and how this affected their support. Staff told us that they assisted people to access support from community health professions for example by booking and taking people to routine appointments. One relative told us that care staff knew the person well, "Regular carers recognise when she's not right – for example if she's quiet they always ask if she's ok. Her mobility can go down quickly." We spoke to a GP who had contact with the provider and they told us that carers recognised when the person's care needs had changed and had appropriately sought their involvement. A member of staff told us about one person whose health needs had changed, "her condition changed her care was reviewed and changed as she changed."

Through discussions with staff, they demonstrated an understanding of human rights principles learnt through the organisational policies. Best practices of how to treat individuals with dignity, respect, fairness, equality and autonomy were explained to staff upon joining the company. Induction training covered equality and diversity issues, including applying equality in practice and respecting people's differences. The homecare co-ordinator acted as Dignity Champion for the branch to spread the concept of compassionate care.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring, knew their likes and dislikes and got to know them as a person. The acting manager told us, "The first thing we think of is our clients. We want to go over and above." One relative told us, "I don't know what we'd do without them, the staff are really lovely. They've just been brilliant."

People received consistent care from staff that knew them well. Rotas were organised so that the support was provided from a small number of staff. Staff could describe the person's likes, dislikes, background and routines. One staff member told us, "She likes to be out, I've been on many walks with her and she thoroughly enjoys it."

People were happy with the service they received and were asked for their feedback about the care they receive. Care plans were reviewed every three months with people and their families. The provider sent out an annual survey to people to obtain their views. In one recent survey people who responded rated their satisfaction of the service as "excellent". People felt their quality of life had improved since receiving care from the provider, staff were well matched to meet their needs and staff were caring people. One relative told us, "They are very patient with her. They are like friends with her, they sit and chat with her, ask her if she needs anything. They understand it's frustrating for her, and they are very empathetic."

When organising support, people were involved in the development and review of their care plans. The provider considered people's preferences and these were reflected in their daily routines of care. Care plans reflected the person and covered all aspects of their lives including their health, specific risks to them and an About Me section which detailed the person's life history. Staff understood that people's support was based on their individual needs. Staff told us the care plans gave sufficient detail about the person for them to provide person-centred care.

People were encouraged and supported to be as independent as they wanted to be. One member staff said of a person who used the service, "She knows what she wants and what she wants to do." Staff were aware of the need to preserve people's dignity when providing care to them in their own home and could describe how they would approach personal care. One member of staff described to us how they always knock on the door before entering the premises and the person's bedroom, before helping the person out of bed and supporting them with personal care and using the bathroom, "I always give her some privacy. She has a little bell which she uses when she's finished and needs help." The homecare co-ordinator ensured that confidential paperwork such as the daily notes were regularly collected from people's homes and stored securely at the registered office.

Good

Is the service responsive?

Our findings

People's care and support was planned to meet their needs and they could contribute to the development of their plan. Staff told us they understood people's needs and described positive relationships with people and their relatives.

Assessments were carried out before starting to care for people and people's preferences were recorded. For example, people were asked if they had a gender preference for the staff caring for them, and people were asked their preferred times to receive care. People's emotional and social needs were considered together with their religious, spiritual and cultural needs. The homecare co-ordinator carried out the care plan reviews and changes were made to reflect how people wanted to be supported and they sought people's views on the service they received. Staff told us that they found the care plans helpful and had recently been updated. One member of staff told us they were asked for their input along with relatives, and that the care plans contain sufficient information and are regularly checked and updated when things change.

A relative told us they knew how to raise concerns and they were confident their concerns would be responded to. We saw from the Provider Information Return prior to inspection that no complaints has been received in the previous 12 months. One relative told us "The only thing that's ever been an issue is where there's been a personality clash. When I've had a concern about staff not being the right fit, I went into the office and was happy with how it was handled. I let them know and they will accommodate it – we can normally work through it. Nurse Plus have always been able to sort something".

People were supported to pursue activities and interests that were important to them. For example, one person was supported with trips out shopping, to the hairdressers or for lunch or coffee. One relative told us, "they involve her in decisions like shopping, going out. She chooses what clothes to wear, they supported her doing some gardening recently, potting some plants and cutting a hedge." During these support visits, personal care was not provided and therefore this support is not regulated by the Care Quality Commission.

We looked at how the provider had incorporated the Accessible Information Standard (AIS) when assessing people's needs. This is the standard that aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. providers must identify record, flag, share and meet people's information and communication needs in line with section 250 of the Health and Social Care Act 2012. All organisations that provide NHS care or adult social care must follow the Standard in full from 1st August 2016 onwards. Care plans reflected people's sensory and communication needs and preferences were being considered and recorded. Following the inspection visit, the acting manager sent us a copy of their policy which demonstrated the provider understands their legal obligations with respect to AIS.

Some staff had received training and had previous experience in supporting people with end of life care. At the time of this inspection the provider was not supporting people with end of life care, so therefore we have not reported on this.

Requires Improvement

Is the service well-led?

Our findings

The provider had a registered manager. A registered manager is a person who has registered with the CQC 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. When we inspected the service, the registered manager was on long term leave and the role was being covered by another member of the team. For the purpose of this report we have referred to this role as acting manager. The acting manager had received a handover and was being supported by the wider management team. The provider notified us of this change in the appropriate way.

While systems were in place to monitor the running and overall quality of the service, we found areas that required improvement.

Quality systems and checks were in place to monitor the service people received. On-site audits were conducted every three months when care plans were reviewed along with risk assessments and audits of log books were completed. The acting manager and homecare co-ordinator conducted an audit on 14 and 15 May 2018 to ensure the provider was maintaining documentation and processes in accordance with Nurse Plus policies and procedures. Findings from the audit identified some areas for improvement within the documentation which required further action, though at the time of the inspection we did not see an action plan to address the issues raised.

We found discrepancies in the care plan documentation which had not been identified by the most recent audit. For example we found inconsistencies with respect to the Mental Capacity Act 2005 (MCA) in relation to recording capacity, best interest decision making and whether others had responsibility for decision making on behalf of the person. In one care plan it was recorded that the person had mental capacity to make decisions for themselves. The person had stipulated they felt confident to be fully involved in the development of their care plan, and wanted their representative involved with them. This was supported by what staff described happened in practice and we found no evidence that the persons legal rights were not being protected. However, we found the documentation contained inconsistencies as it was recorded that the person had a Lasting Power of Attorney (LPA) in place who had responsibility for health and welfare decision making. There was no health and welfare LPA in the care plan and no MCA assessment to suggest the person lacked capacity. We also found that sometimes the person was not involved in regular reviews of care and that decisions were deferred to family members. It was not recorded that it was the person's choice to defer decisions to others, though this may have been the case. We saw on one regular review form that the person's consent was not recorded.

We found that documentation relating to staff training and competency assessment contained discrepancies. This had not been identified by the provider despite a new training programme which started in April 2018 which all new staff would undertake and current staff would receive as part of their annual update training. We saw in the training files several inconsistencies in how assessment of competency was documented. For example, we saw that one member of staff waited four months after the induction to have

competency assessed and no explanation for this was documented. In another example, competency checks formed part of annual update training, and it was documented that the member of staff was assessed as competent, but there were no details of the specific task or activity being assessed. We saw a "Basic Skills Competency Assessment" form in staff files which lacked sufficient detail of how competency was being assessed.

We found the care plans required improvement in other areas such as people's goals, ensuring expected outcomes for specific risks and people's changing needs, such as deterioration in health or mobility, are recorded clearly. We also found documentation relating to people's activities could be improved. Staff and one relative told us that in practice the service is providing good support for people to engage in activities, but the documentation did not reflect this.

The acting manager recognised that these issues needed to be addressed. The impact of this on people currently using the service was reduced due to the size of the service.

The acting manager was supported by a quality assurance manager and a homecare co-ordinator. On the day of inspection saw the team were present and actively engaged in running the service. There were six staff providing care and support to people receiving personal care as part of the regulated activity. Staff told us they felt supported by the management team and there were clear lines of responsibility and accountability. One member of staff told us, "If I have any concerns or issues I can talk to them one to one." The provider encouraged an open culture and the acting manager told us the vision for the service was to be, "transparent and honest, we won't set unrealistic expectations, we're family orientated, and we want to be a friendly face." We saw several care staff working in the community come into the office on the day of the inspection and observed positive interactions with the management team. One member of staff told us the values of the service were "to provide the best care for the clients, to be person centred, friendly, reliable, caring staff who never let people down". Staff felt comfortable to raise any issues with the acting manager. Staff told us that the management team listened to them, and were responsive to their concerns. A member of staff told us "if there's a problem, they always get back to you". Staff achievement was recognised and encouraged. The provider nominated one member of staff as employee of the month which was publicised within the service via a staff newsletter and the member staff received vouchers as a thank you.

The acting manager understood their responsibilities in relation to the Care Quality Commission (CQC) in the absence of the registered manager. The acting manager understood that they were required to submit notifications to us, in a timely way. Prior to the inspection we saw that the provider had identified no significant events to report to us in accordance with the requirements of their registration. However, the acting manager could describe the types of incidents that required notification to us, for example such as safety incidents or safeguarding concerns. It is a legal requirement that a provider's latest CQC inspection report is displayed where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. At the time of the inspection we found the provider had displayed this via their website.

The provider sought people's views on the quality of the service during annual reviews and a satisfaction survey. The areas discussed in the survey included rating the care received, whether the person's quality of life had improved, whether people felt involved in their care, access to regular and consistent staff, whether staff are well matched to meet the person's needs, safety, care and wellbeing, punctuality and communication. The survey outcomes were positive and where people gave feedback that required a change the acting manager took action. An action plan had been developed to address survey responses in 2017. For example, one person had rated the continuity of staff as "adequate" and this was taken forward as an action for the branch team to improve. The annual survey also sought feedback from staff and an action

plan was in place to address issues they had raised. For example, some staff fed back that communication between care staff and office staff could be improved. The action plan addressed this by implementing regular team meetings and more staff engagement events to encourage staff working into the community to come into the office. Staff told us they had regular team meetings and found them useful. One staff member told us, "The meetings are an opportunity to bounce things off each other, we're a good team."