Healthcare at Home Limited (Bristol)

Quality Report

Healthcare at Home Ltd Bristol
1-5 Whiteladies Road
Clifton
Bristol
BS8 1NU
Tel: 0117 970 7800
Website: https://www.hah.co.uk/

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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

Summary of findings

Letter from the Chief Inspector of Hospitals

Letter from the Chief Inspector of Hospitals

"Healthcare at Home Ltd provides a variety of medical, nursing and care services to private and NHS patients in various geographical areas across England. Healthcare at Home Ltd Bristol is a registered location that has seven field based teams covering, London, Devon and Cornwall, Bristol, Gloucester, Taunton and Somerset, Southampton and Portsmouth, Wales and Surrey. Nurses from these teams visit and provide treatment and care to patients in their own homes. The office in Bristol has consulting rooms, a clinic and staff offices. The registered manager is based at the location.

The location is registered to provide the following regulated activities:

- Personal Care
- Nursing Care
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Management of supply of blood and blood derived products.

We carried out an announced onsite inspection on 4 - 6 May 2016 where we observed practice, spoke with staff, patients and the provider.

We have not published a rating for this service. CQC does not currently have a legal duty to award ratings for this service. We did however, find the service provided safe, effective, caring, responsive, and well led services to patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults		We found that harm free care was being provided. The provider had a range of safety measures in place and there were systems in place to report concerns or incidents. Staff were receiving appropriate training which supported them to provide good quality care and ensured they were up to date with the latest guidance around the treatments and procedures they were delivering to patients. Nurses were well supported by their managers and had access to senior staff for guidance or clinical support. We found that nurses provided compassionate care that respected patients dignity and involved them in all aspects of their care and treatment. Patients told us they were treated with respect by nurses and consultants. Patients received a flexible service that responded to their needs and listened to their concerns. Patients were provided with information about how to make a complaint if they needed to. The provider had received few complaints. Nursing staff were provided with leadership from their clinical line managers and the registered manager. Leadership, direction and governance was also provided from the senior staff working from the providers head office located in another region. We saw areas of outstanding practice including: • We considered the opportunities for nursing staff to undertake training and the development of specialist skills to be outstanding. The electronic records system used by nursing staff and across the organisation provided an outstanding system for the monitoring of patients care and communication between professionals. However, there were also areas of practice where the provider should make improvements: • The provider should have an identifiable designated person such as a responsible officer,

Summary of findings

or the equivalent of a medical advisory committee, to give assurance to the registered manager that consultants were both competent or entitled to practice.

- The provider should complete a risk register that relates solely to the registered location in Bristol.
- The provider should complete formal risk assessments for gas cylinder storage and handling. Suitable arrangements should be put in place for tracking cylinders from the point of receipt to their return empty to the supplier.
- Nurses should monitor and record the temperatures of the fridges used to transport medication.

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Background to Healthcare at Home Limited (Bristol)

The service delivers complex therapies and treatment to both NHS and private patients.

Private patients are treated at home or in a clinic in the Bristol office. The core services and treatments provided are for an indeterminate period, and include:

- Chemotherapy, monoclonal antibody, bisphosphonate and antibiotic Infusions
- Intra-venous hydration and therapies
- Blood Product Services/phlebotomy and Transfusion
- Peripherally inserted central cather or PICC line care and replacement
- Biologic, Endocrine and Metabolic therapies
- Enzyme replacement therapies
- Rheumatology, Dermatology and Gastroenterology therapies
- Fertility therapies
- Diagnostic and screening procedures

The Healthcare at Home Clinic in Bristol provides consultation rooms for the oncology consultants and is also a treatment facility. It has an infusion suite, five consulting rooms, pathology, screening service and ultrasound facilities.

Our inspection team

The team included five CQC inspectors, including a pharmacy specialist. There were also two nurse specialist advisors who worked on the inspection.

Why we carried out this inspection

We inspected this core service as part of our comprehensive independent community health services inspection programme.

How we carried out this inspection

To get to the heart of 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?

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 4th, 5th and 6th of May 2016. We undertook an additional announced visit on the 23rd May. During the visit we talked to staff and visited patients in their homes whilst they were being seen by the nurse. We also spoke with patients attending the clinic in the Bristol office. We talked with people who use services. We observed how people were being cared for and talked with family members. We reviewed care and treatment records of people who used the service. We reviewed policy documents and other information relating to staff training.

Summary of this inspection

What people who use the service say

Patients and families told us they were satisfied with the service they received. We were told the nursing staff were caring, professional and skilled. Patients said the service was reliable and flexible and that they felt able to raise a concern or make a complaint if they needed to.

Patients said they were treated with respect by the consultants, the nurses and the office based support and administration staff.

We were told that appointments and consultations were arranged promptly and that patients felt involved and informed about the care and treatment they were receiving.

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for adults safe?

The safety of these services was inspected but not rated

- We judged that overall harm free care was being provided. The provider had a range of safety measures in place and there were systems in place to report concerns or incidents. There was an effective system in place for the reporting of incidents and for learning to be disseminated to the nursing teams.
- Medication was well managed and there were good systems in place for storage and delivery to patients.
- The arrangement and use of buildings, facilities and equipment kept patients and staff safe. Maintenance was correctly carried out and monitored and safety concerns were reported and acted upon.
- Mandatory training was provided for all staff to ensure that they were competent to complete their roles and promote the safety of patients. At the time of the inspection all staff were up to date with this.
- The provider was able to manage potential disruptions of the service and continue to meet the needs of the patients. Staff worked as team to support one another when there were interruptions to the service for reasons such as adverse weather, transport issues or traffic congestion.

However:

- There was no formal risk assessment for gas cylinder storage and handling and there was no tracking of medical gases. Suitable arrangements should be put in place for tracking cylinders from point of receipt to their return when empty to the supplier.
- **Detailed findings**
- **Safety performance**
- We judged that overall harm free care was being provided. The provider had a range of safety measures in place and there were systems in place to report concerns or incidents.
- The provider had a patient safety team based at their head office that received information from the various registered locations, including the Bristol clinic.
- The governance arrangements in place provided a clear pathway for concerns to be reported and escalated through to the patient safety team. There were also other committees based at the head office that reviewed patient risk. For example there were committees that oversaw the patient incident and complaints process and also the governance committee which looked at clinical issues.
- **Incident reporting, learning and improvement**
- There was an effective system in place for the reporting of incidents and for learning to be disseminated to the nursing teams.
- A new incident reporting system had been introduced at the beginning of 2016. This enabled staff to record incident details immediately after delivering care or treatment directly into a portable electronic device. The information was automatically shared with the provider's patient safety monitoring team. The information remained linked to the patient on the system which helped ensure any feedback or learning was disseminated to the nurse who had recorded the incident. Staff said there was an open culture for reporting medicine incidents, which was also done using the new system. There was a target for the patient safety team to respond within 24 hours. This had been met for the three months previous to our inspection visit.

Community health services for adults

- Nurses we spoke with said there was a low number of reportable incidents. They told us learning from incidents was shared if management felt it of benefit to the frontline staff. Staff gave examples when they had received feedback following reporting an incident. Examples of this were the late delivery of medications and a concern over the side effects of a new medication. There were also examples of learning being shared at the monthly nurse team meetings. If there was an urgent issue there was an opportunity at the morning daily telephone conference call between the registered manager and all the clinical lead nurses to share information.
- Provider data for the period April 2015 to April 2016 showed there were no Serious Incidents Requiring Investigation (SIRI) reported.
- Staff had been provided with training in respect of the new incident reporting process. At the time of our inspection visit 86% of staff had completed this.
- **Duty of Candour**
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This Regulation requires a provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Not all staff we spoke with were aware of this regulation but all staff did speak of a culture that encouraged candour, openness and honesty. The regulation had been a topic in a recent training event which several staff had attended. Regulation 20 was also referred to and explained within the complaints policy.
- **Safeguarding**
- There were reliable systems, practices and processes in place to keep people safe and safeguard them from abuse.
- All staff we spoke with were up to date with their safeguarding training and were confident in the processes for reporting alerts to the safeguarding lead.. Clear information was provided to the staff with regard to the process to be followed and who was to be contacted.
- Safeguard training was an annual online refresher course. One nurse gave an example of having to contact social services in the past with a safeguarding alert and said they had been supported by the safeguarding lead to do this. All staff we spoke with understood their safeguarding responsibilities and how to escalate concerns.
- We saw that examples of safeguarding practice also featured in team meetings.
- **Medicines**
- There were safe and appropriate arrangements in place for the management of medicines and medical gases. There were safe procedures in place for the delivering and administering of medications to patients in their homes.
- Medicines were delivered from the providers head office and stored safely at the location clinic. Medicines were then delivered to patients' homes the next day using three suppliers that worked to the providers standard operating procedure, under service level agreements.
- The medication storage was well managed. We saw that medicines were stored in locked cupboards, fridges and secure rooms where necessary. Rooms were secured by access cards and keys, with restricted access. There was continuous monitoring of temperatures by a remote Wi-Fi enabled monitoring and alarm system. There was back up system in place if the Wi-Fi lost connectivity. Information from the system was reviewed weekly by the pharmacy team.
- Routine access to medicines was restricted to trained nurses and trained delivery drivers.
- There were no controlled drugs in place or being used by patients through the provider.
- In order to transport medicines safely each nurse was provided with a fridge which was kept in the boot of their car. The staff reported a robust policy for fridges and medicines transportation. Fridges were checked on a daily basis when in use. Nurses knew the temperature range the fridges should safely operate within, however there was no official record kept to corroborate this. Some nurses we spoke with said they kept a log but others did not.

- There was an Anaphylaxis policy in place which promoted the safety of patients in the event of an emergency needing to be responded to by a nurse. Nurses also carried medications to treat anaphylaxis.
- Medicines were ordered by 3pm for delivery by registered medical courier to the nurse's home the following day. Drug administration was recorded onto the nurses tablet device and the patient record was updated immediately. We observed nurses checking prescriptions with patients before they began treatment.
- **Environment and equipment**
- The arrangement and use of buildings, facilities and equipment kept patients and staff safe. Maintenance was correctly carried out and monitored and safety concerns were reported and acted upon.
- All nurses carried appropriate sharps bins with them. When full they would either be collected from the nurses home when a medicine delivery was made or dropped off at the registered location. Nurses that used cytotoxic drugs had the correct sharps bins with purple lids for the disposal of sharps contaminated with cytotoxic or cytostatic medicinal products.
- We looked at a sample of consumables and equipment that were in use and saw that all were within their expiry dates.
- Equipment in use was up to date with relevant safety tests, such as PAT (portable appliance test) for all electronic devices uses. We observed staff making visual checks for sundry equipment such as blood pressure cuffs and stethoscopes.
- The location office accommodated the clinic room, consulting rooms, patient waiting areas, offices and storage space. All areas were maintained to a high standard appearing clean and hygienic and were well furnished and decorated. Regular checks were completed on the cleaning, which was contracted to an external firm who had a schedule they followed. All fire safety checks and maintenance had been completed and recorded. The nurse working in the clinic room completed a cleaning schedule for the clinical areas. Two patients told us they appreciated how comfortable and clean the waiting area and clinic room were kept.
- Staff reported that broken equipment was reported promptly and repairs done quickly.
- **Quality of records**
- Patients care records were written and managed in a way that kept them safe. Records were up to date and stored securely. Audits were completed on a regular basis. This involved the auditing of 10% of the records for all patients visited each month. If any issues were identified in an area this could be increased to 20%.
- An electronic records system was used by staff to document patient care. Staff were provided with electronic tablets to access these. These had replaced all written records of patient interaction and all the staff that we interviewed were positive about the new process.
- We observed nurses using this system to check consent, blood results and document all patient observations and interactions during or immediately after care and treatment. This ensured the system and patient information was up to date, legible, stored securely and complete for the next nurse to access. In the clinic we observed information being recorded following treatment. Nurses completed a clinical evaluation form for every appointment. This included details about allergies, vascular access, medications, any adverse events and the completion of a toxicity screening tool which supported nurses to administer treatments safely. We saw that the completed document was signed by the patient.
- The nurses explained how the system made it easy for them to check and review all the patient information and communications prior to the visit.
- We reviewed 15 care records and saw that all were completed fully and up to date.
- **Cleanliness, infection control and hygiene**
- There were reliable systems, training and appropriate equipment in place to prevent and protect people from infection.
- We observed good infection control practices from the nurses working with patients in the community and in their homes. We saw regular glove changes, hand gelling and washing and the wiping down of medical instruments and devices.

- We observed that equipment was disposed of appropriately in the clinic and in patients homes. Nurses were aware of the procedures to follow for the disposal of syringes and other potentially infected materials. There were collection procedures in place and a contract with an external firm for the disposal of waste and infected materials.
- **Mandatory training**
- Training was provided for all staff to ensure they were competent to complete their roles and promote the safety of patients. There were systems in place to monitor and remind staff when training was due. Training was provided promptly when required.
- There was a designated list of mandatory training. At the time of the inspection all staff were up to date with this. The training included fire safety, health and safety and safeguarding.
- All the nursing staff had completed basic life support training. Anaphylaxis training had been completed either during their five day induction or as a separate training session**.**
- All nursing staff we asked spoke positively of the training that was provided.
- **Assessing and responding to patient risk**
- All initial visits with patients included the completion of an assessment which would identify any potential risks and document them. Staff were aware of their duty of care to respond to and deal with emergency situations, such as a deteriorating patient, whilst in the community.
- There was a resuscitation trolley in the clinic. The contents were checked daily and well maintained and in date. All appropriate oxygen cylinders were full and in date and maintenance procedures were in place.
- We observed nurses using a Toxicity Scoring tool. This was completed on the electronic tablet prior to administering certain drugs. The nurse inputted clinical observations and asked specific questions and the system would score this information. If there was a potential risk of toxicity then the system would alert the nurse and she would contact the consultant for advice prior to any drug administration. This helped ensure that medication was given safely and reduced the risk of severe side effects.
- Staff were clear about how they would deal with incidents such as needle stick injuries and toxic spillage of medications. For example a needle stick injury would require treatment at an emergency department. All such incidents would be reported immediately to the clinical team leader or manager on call. Incident reports would also be completed.
- If a patient had developed a pressure ulcer, or was considered at risk of developing one, then the nurses would use the Waterlow Scale to assess the patients risk and document this on their tablet.
- **Staffing levels and caseload**
- Nurses said they had manageable caseloads and were able to complete the visits they were scheduled to complete on a daily basis. Staff would visit between one and four patients per day, depending on the treatment being provided, and could possibly be with individual patients for an extended period, The provider did not use agency staff and was able to cover sickness and vacancies from within the established staff team.
- We were told how the clinic staff could access additional help from the community based nurses if needed. This ensured the right ratio of nurses were in place to provide patients care safely. This extra staffing was accessed though the registered manager but was always agreed to.
- **Managing anticipated risks**
- The provider was able to manage potential disruptions of the service and continue to meet the needs of the patients. Staff worked as team to support one another when there were interruptions to availability for any reason such as weather, transport issues or traffic congestion.
- All patients we spoke to had never had a visit cancelled due to bad weather. Patients spoke of the lines of communication being kept open and any delays in a nurse arriving for whatever reason being explained.

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- The nurses we spoke with had plans as to how to cope in bad weather. This involved asking colleagues closer to visit patients if need be, however there was no actual policy in place to follow.
- Emergency numbers were provided to all patients and also there was a clinical manager on call.
- We saw a draft business continuity plan during the inspection.
- Every nurse carried an oxygen cylinder and an anaphylaxis treatment box which consisted of medication such as adrenaline, steroids and antihistamines in case of any adverse reaction.
- **Major incident awareness and training**
- At the time of the inspection the provider had produced a business continuity plan in draft form. There were also plans to test out various emergency scenarios to access the robustness of the plan. The plan included guidance for staff in respect of bad weather and interruption to essential services at the clinic.
- Nurses had access to online databases and formulary such as the BNF (British National Formulary) to check medicines and further dosage or side effect information as required.
- No empty or spare full cylinders of medical gases were at the location when we inspected, but they were routinely stored in the controlled access medicines storage room. Gases were temporarily held overnight or on weekends, and the nurses swapped one for one when required. We were told that no incidents had been raised relating to medical gases. However there was no formal risk assessment for cylinder storage and handling and there was no tracking of medical gases. Suitable arrangements should be put in place for tracking cylinders from point of receipt to their return empty to the supplier.

Are community health services for adults effective?
(for example, treatment is effective)

The effectiveness of these services was inspected but not rated

- People's needs were assessed and care and treatment was provided in line with legislation, standards and evidence-based guidance. There were systems and processes in place to support the nursing staff to follow best practice and the latest guidance in relation to treatments.
  - There were protocols in place that could be easily accessed for nurses to follow in respect of treatments and procedures they carried out, for example for blood transfusions or accessing veins.
- Staff had the right qualifications, skills and knowledge to do their jobs. Appropriate training was provided and staff were encouraged to develop their skills. There were systems in place for the monitoring and supervision of staff. Feedback from patients was very positive about the professionalism, skills and thoroughness of the nursing teams.
- The provision of portable electronic devices to nursing staff helped ensure they had access to patient records, handover information from the last visit and any new guidance or safety alerts that they needed to be aware of.
- Nursing staff understood the need to gain consent before commencing treatment.
- **Detailed findings**

Evidence based care and treatment

- People's needs were assessed and care and treatment was provided in line with legislation, standards and evidence-based guidance.
  - The provider had a national head of cancer lead who had a responsibility for benchmarking the service against the National Health Service “Manual for Cancer Services”.
  - The service used “iQemo” which was an online based prescribing system for chemotherapy and other anti-cancer drugs. There was a standard operating policy in place for consultants, nurse specialists and pharmacists. This included for example, how a consultant should use the system for prescriptions and the clinical monitoring of patients.

Community health services for adults

- When a patient was visited at home for the first time by a nurse following referral from the consultant an assessment was completed. This covered the environment, any safety issues and the completion of information about their medical background.
- The Systemic Anti-Cancer Therapy (SACT) Information Standard was a phased, mandatory implementation of national data collection which started in 2012. It applies to all organisations providing cancer chemotherapy services in, or funded by NHS England It is in line with the department of health's policy document Improving Outcomes: A strategy for Cancer January 2011. The SACT Information Standard addresses the requirement to standardise the recording of chemotherapy treatment and outcomes through electronic systems. The SACT dataset is integrated with other clinical NHS datasets, enabling the complete patient pathway to be understood. The Chemotherapy Intelligence Unit (CIU) is the central coalition point for all the data submissions in England. The provider did not supply data directly to SACT but the information was collected for this data set through the NHS trusts where the patient had originally been seen. We were told the provider also supplied various data and information to the pharmaceutical companies that supplied medication.
- There were systems and support for nursing staff to ensure they were aware of the latest guidance and had access to clinical advice and professional support.
- There were mentors within the organisation for chemotherapy training who were available to give advice to nurses. There was a lead clinical facilitator based in the providers head office who was available for advice or support. When staff were on-call they used the national oncology pathway grading system for the triage of patient symptoms and side effects.
- The nurses that we interviewed could demonstrate that all the latest guidance was on hand via the clinical portal on the electronic tablet. Alerts were also sent through if a new provider policy was added, ensuring that all the most up to date information was immediately accessible.
- There was a protocol in place for the procedure to follow for completing blood transfusions, there was a Healthcare at Home standard procedure based on national guidance. This could be accessed via the nurses portable device.
- There were systems in place to ensure that medication prescribing and delivery was working effectively. The logistic companies contracted by the provider to deliver medication audited every three months against their service level agreements. There was also an annual audit of distribution practice. There were no current issues affecting this service. The provider pharmacy leads audited staff training around medication, standard operating procedures adherence and prescription writing standards. Reports of audits were sent to the pharmacy team based in the head office for review.
- The most recent inspection and audit of the Bristol location by the Medicines and Healthcare products Regulatory Agency (MHRA) was seen and this had produced an action plan around vehicle storage and temperature monitoring. There were no major outstanding issues.
- **Nutrition and hydration**
- The nursing staff did not have a direct responsibility to assess and monitor patients nutritional and hydration needs but an assessment was completed as part of the initial documentation done when visiting a patient. Nurses explained how they responded to any concerns they identified around this aspect of a patients care and welfare when they were attending the patient in their own home.
- We discussed assessing a patient's nutritional status with nurses and asked if they used the Malnutrition Universal Screening Tool (MUST) which is a five step screening tool used to identify adults who are at risk of malnutrition. The nurses we spoke with informed us that this was not used at Healthcare at Home. If a patent was deemed at risk then the nurse would contact the consultant or GP and request a prescription for supplementary drinks.
- **Patient outcomes**
- Nurses collected information about the treatments being delivered and monitored the conditions of the

patients. Regular blood tests were completed and medications adjusted accordingly. At every home visit or clinic appointment the nurse would update the patient records with the required information for the condition that was being treated. The nurse could contact the consultant directly via email from their electronic device if they needed to.

- **Competent staff**
- Staff had the right qualifications, skills and knowledge to do their jobs. Appropriate training was provided and staff were encouraged to develop their skills. There were systems in place for the monitoring and supervision of staff. Staff spoke positively about the training opportunities and the quality of the content. Staff told us they felt supported in their roles and professional development. Staff were effectively supported to maintain their professional validation. There was an electronic reminder system in place for nurses and managers which helped with the planning of any required training towards validation.
- All staff we spoke with had been appraised and had clear goals for their development. One nurse had recently been on an advanced study day for Biologics which was her link/lead role. are genetically-engineered proteins derived from human genes. They are designed to inhibit specific components of the immune system that play pivotal roles in fuelling inflammation, which is a central feature of for example rheumatoid arthritis. This had been identified during her appraisal. They had been given time and support to fulfil the assessment to pass the course.
- A programme of staff supervision was in place for the nursing staff. This included fortnightly meetings with a manager, annual performance reviews and six monthly reviews. Managers completed announced and unannounced observation of nurses working in the patients homes. Part of the observation looked at infection control, appropriate clothing and would include a check on recording and documentation.
- An audit was undertaken by the providers Drugs and Therapeutic Committee (DTC) in June 2015 to examine nursing practices within the clinic. During this audit it was identified that nurses did not have adequate training to use the resuscitation equipment within the clinic. This was then covered in the Intermediate Life Support (ILS) training which took place in January 2016. Staff who worked permanently in the clinic had completed this training. Additional support from other nurses was occasionally provided in the clinic. However only two of these nurses had so far completed the ILS training. All staff had completed Basic Life Support (BLS). All nursing staff would eventually complete the ILS training.
- We observed nine patients receiving treatment in their homes and five patients who were attending the clinic. In every instance we saw nursing staff demonstrate a professional and thorough approach to all aspects of the tasks they were completing. This included the recording and documenting of treatment and the sharing of information with patients. All patients we spoke with said the staff were professional. One told us “they are well organised and always know what they are doing” and another said “we always have confidence in whoever comes because they are so professional and know what they need to do”. We observed nurses completing a series of checks on patients before starting treatments. This included checking symptoms, medication prescriptions and asking about any previous side effects from medicines.
- Healthcare at Home employees attended an annual national event held over three days run by the provider. They received updates on clinical and corporate progress and actions taken to improve any clinical care issues. Every nurse we spoke with had attended this event.
- Clinical assemblies were held monthly across the UK for staff to have chance to meet with executive leads. They could discuss and be updated on national issues, such as revalidation and service development.
- Staff told us that they were supported to gain their competencies in administering chemotherapy when they were ready to do so. Once they have finished gaining the competencies there was a period of supervised practice and yearly updates.

- Staff told us that prior to giving any blood transfusions in the community, on-line training had to be completed before the nurse was deemed competent. They were also assessed and observed in the community by a senior colleague.
- An induction process for new staff ensured they had the competencies and confidence to provide the care and treatment for patients in line with required practice.
- New starters spent time with their clinical manager and attended a residential training course at the providers head office training centre. They attended a corporate induction and completed all the providers mandatory training. Staff worked alongside experienced nurses and would build up the days per week they worked on their own. Two staff who had recently gone through the process said they had been well supported and provided with excellent training. The on-going support when they first worked on their own had been well organised. New staff were subject to a three month probation period which included having four, six and twelve week reviews. Competency booklets were completed throughout the induction period. It could take up to six months for all of the required competencies to be covered.
- One nurse told us that prior to starting her on call responsibilities she would have been employed for over six months and then she would join the on call roster. Healthcare at Home operate a telephone 'buddy' system for support and advice for new entrants to the roster until the nurse is confident and competent.
- We heard numerous positive comments from patients about the nursing staff. These included, "they provide an exceptional service, they are skilled and professional", "we have complete confidence in the nurses and everything they do" and "they are exceptional, everything is done exactly as you would expect it to be done."
- **Multi-disciplinary working and coordinated care pathways**
- Due to the type of service provided there were no formal links with other agencies or providers in the community but we saw that clinical managers and nurses were committed to a holistic approach to patient care. Nurses described how they would contact a patient's GP or a district nursing or safeguarding team if they needed to pass on information about patient care, treatment or circumstances. We saw an example of a concern about a patient being passed on to the GP and this being recorded in the electronic record. It was also recorded that consent had been given for the information to be passed on.
- Staff we interviewed all reported that they had no concerns contacting the consultants regarding a patient's treatment. Questions were always answered and nurses felt well supported both by the consultants and by senior colleagues.
- Nurses told us they were well supported by the office based staff. Communication was effective and information provided efficiently when requested.
- Staff commented on the good team working and support they received from colleagues
- **Access to information**
- The information needed to deliver effective care and treatment was available to staff in a timely and accessible way.
- The electronic records showed that staff recorded any information that would be required by the next nurse due to visit a patient. The records also generated emails, if required, that went to the nurse scheduling service and the patient safety team based at the head office. We observed nurses reading patients records before visiting patients to ensure they were aware of any on-going issues or concerns.
- The portable electronic devices ensured that staff could access all the information that was required. This included patient records, safety alerts, guidance and protocols and scheduling updates.
- There was good access to up to date reference sources for the nursing staff. Staff used their electronic devices to access NICE (The National Institute for Health and Care Excellence) British National Formulary guidance (BNF), report risk and also to access correspondence from Healthcare at Home relating to any practice guidance or on-going issues. They could also access

policies and procedures. The clinical and central pharmacists were points of contact for clinical and medicine enquiries and were available during the week with an on-call pharmacist available until 10 pm.

- **Consent, Mental Capacity act and Deprivation of Liberty Safeguards**
- People's consent to care and treatment was sought in line with legislation and guidance. Nursing staff understood the need to gain consent before commencing treatment.
- We observed written and verbal consent being sought before treatments were started and also nurses checking that consent had been previously sought and recorded.
- For example consent for treatments to go ahead was gained with the consultant prior to treatment. We witnessed a nurse checking the consent which was on her electronic tablet prior to a patient having treatment. In all the records we looked at consent had been recorded and signed by the patient.
- One staff nurse gave an example of delivering care to a patient who didn't speak English and explained that care would not be given unless an interpreter or her daughter were present.
- All staff had completed training on Deprivation of Liberty Safeguards and the Mental Capacity Act. This was part of the mandatory training for all staff.

Are community health services for adults caring?

The caring domain was inspected but not rated.

- We found that staff treated patients with compassion, kindness, dignity and respect. Through observation, and feedback from patients, we saw that staff interacted in a caring and professional manner.
- Staff communicated with patients in an effective manner that helped them to understand their care, treatment and condition.
- Staff we spoke with were well informed and aware of the emotional and social impact that the conditions they were treating could have on patients and their families. We saw that support was provided during the duration of the visit. Information was also provided which could signpost families to other support services or networks.
- **Detailed findings**

  Compassionate care
- Through observation and from talking with patients and their families we saw that patients were treated with respect and shown kindness by nursing staff and consultants. Patients explained how the consultants and nursing staff took the time to listen and understand their individual needs and situations. Patients told us the nursing staff were supportive and encouraging. We heard how patients were encouraged to maintain their independence and this was done in a sensitive manner.
- All staff we spoke with commented that they were very respectful of all patients' needs, beliefs and were very aware that they were a guest in someone's home. We observed all members of staff treating patients and their relatives with respect and dignity. All the nurses we saw working with their patients showed high levels of compassionate care.
- Treatments could take place over several hours, sometimes weekly and often over years. We observed positive relationships that had been built over time. Many patients that we interviewed spoke of how they looked forward to the nurse visiting. Some said they felt these visits were a life line especially when housebound.
- Nurses informed the patients of each procedure prior to starting and spoke with patients while treating them to ensure safety and comfort of the patient.
- Patient comments we received about nurses included many about their caring and respectful manner, "very friendly and caring", "I've seen the same nurse for 18 months now and she has a great sense of humour, I look forward to her coming" and "they are always respectful and polite and care about the job they are doing".
- **Understanding and involvement of patients and those close to them**

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- Staff communicated with patients in an effective manner that helped them to understand their care, treatment and condition.
- Through interviews and observations of patient and nurse interactions it was evident that patients and relatives felt well informed about their treatment plan, the medication they were receiving and any possible side effects that may be experienced. One patient who had recently started on a new medication regime explained how they had received a daily phone call for several days after the initial visit to check on any side effects or concerns. We were told the nurse "could not have explained everything more clearly."
- Families were often involved with the care and treatment of the patient. Nurses could train family members how to administer certain drugs as appropriate to the care plan and patients condition.
- One patient and their partner told us they felt they had been well informed from the time they saw the consultant through to meeting the nursing staff. This included receiving information. One family member told us, "I feel we have been educated as well as fully involved".
- **Emotional support**
- Staff we spoke with were well informed and aware of the emotional and social impact that the conditions they were treating could have on patients and their family. We saw that what support could be provided, during the duration of the visit, was provided. Information was also provided which could signpost families to other support services or networks.
- The physiological and psychological welfare of all patients was considered. If a nurse was concerned about a patients mental wellbeing they would either contact the patients GP or their consultant. Many of the nurses we spoke with said that the time they spent with patients and their relatives during the treatments enabled them to give dedicated time to that patient's emotional wellbeing. Some staff planning a daily caseload moved patients around in order of priority, as some patients might require more emotional support and appropriate timing of visits was important.
- Patients spoke highly of the support they got from the nursing staff and the worries that were explained or fears that were alleviated.

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

The responsiveness of the service was inspected but not rated.

- The facilities and premises that were used were appropriate for the services that were planned and delivered. The provider was due to move to new premises at some point during 2016. This would provide an improved service for patients.
- Patients who accessed the service were able to have their consultations and subsequent treatments provided and scheduled promptly and without delay.
- Clear information was provided to patients about how to make a complaint or raise a concern. Patients we spoke with understood how to do this.
- **Detailed findings**

  Planning and delivering services which meet people's needs
- The provider, as an independent healthcare provider, did not have a formal role in the planning of local services in any of the areas it provided a service in.
- The provider had national business managers whose role included meeting with trusts and other health care providers to identify and develop services that Healthcare at Home Limited generally and Bristol particularly could potentially tender for and provide. The provider had identified there would be benefits to the community in Bristol with the provision of a PICC (peripherally inserted central catheter) line service. This was now provided from the clinic in Bristol location office, following the installation of equipment and the training of staff.
- The head office of Healthcare at Home Ltd had various boards and committees to ensure effective planning and delivery of care at a national level. Monthly

meetings were held of the board of directors, the clinical governance committee, drugs and therapeutics committee and an operational quality meeting.

- The facilities and premises that were used were appropriate for the services that were planned and delivered. However the provider was due to move to new premises at some point during 2016. The new location was planned adjacent to a provider of radiotherapy. The aim was to reduce the time between chemotherapy and radiotherapy for patients and improve treatment outcomes and patients experience. This was described by the provider as being a regional cancer centre.
- **Equality and diversity**
- A patient's individual treatment and care was planned to take into account their different needs. Staff explained how they would take account of different cultural and religious needs if this impacted on the delivery of treatment. For example the time of day they arrived to see a patient. Any particular needs around disability, age or language would be recorded in the patient records. Staff could access translation and interpreter services if this was required.
- We saw information leaflets available in different languages.
- The provider had an Equality and Diversity policy in place.
- **Meeting the needs of people in vulnerable circumstances**
- The provider did not routinely provide a service to people in vulnerable circumstances**.** We were told of two vulnerable adults who were receiving a service. We saw that appropriate arrangements were in place that were co-ordinated with the families to support these patients to receive their treatment.
- There were signs in the clinic offering chaperones for patients who required them during a consultation. The clinic staff explained how this worked. The chaperone would usually be the nurse who was working in the clinic adjacent to the consulting rooms. A patient could also choose to have a member of their family present.
- **Access to the right care at the right time**
- Patients who accessed the service were able to have their consultations and subsequent treatments provided and scheduled promptly and without delay.
- Patients we spoke with said that nurses would phone the day before with an appointment time. If traffic caused a delay the patient was informed and kept updated at all times. No patients we spoke with reported being left waiting for appointments. Patients told us that it was easy to rearrange appointments if needed and the provider was helpful and accommodating over this.
- We witnessed how one patient who was having a drug infusion was able to carry on working their normal day. The nurse was very mindful that the patient was busy and ensured that the infusion was given safely but with minimal disruption. Another patient we spoke with explained how they arranged for the nurse to visit their place of work to provide their treatment if they were unable to take time off work when their treatment was due.
- Several patients commented that they enjoyed the flexibility of the service around appointment times and the locations where the nurse would travel to provide the treatment.
- **Learning from complaints and concerns**
- Clear information was provided to patients about how to make a complaint or raise a concern. Patients we spoke with understood how to do this but none had had the need to do so.
- The provider had received few complaints. We saw evidence that complaints were responded to and lessons learnt if required. Following complaints about the delivery of medications the provider had reorganised the provision of this service. We saw that patients had been responded to promptly. Patients we spoke with said they would have no hesitation in raising a concern or making complaint if they felt it necessary but patients also told us they felt they could approach the nursing staff initially with anything they were not happy about.

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- The provider had a Patient Incident and Complaint Learning and Reporting Policy. This had been recently reviewed and also referred to the legislation around Duty of Candour.
- There was effective communication between nurses and their senior managers and those that worked in the community would see their manager on at least a monthly basis at the team meeting. During these meetings complaints and compliments were discussed and regular emails were sent to staff if anything needed to be passed on.

Are community health services for adults well-led?

The well led domain was inspected but not rated.

- The leadership, management and governance provided assurance that the provider delivered safe, person-centred care. Leaders we spoke with supported learning and innovation, and promoted an open and fair culture.
- The registered manager, their manager and other team managers met regularly.
- There were examples of innovative and sustainable practice which supported improvement. For example planning to move the clinic to a site that had radiotherapy available and improving nurse scheduling and delivery of treatments to improve patient experience. Recent restructuring had provided better managerial support to nurse teams and to the registered manager. Healthcare at Home were working with other providers to inform the provision of healthcare in a number of areas in a white paper. Leaders in Healthcare at home and staff from the Bristol location were involved with this work.
- Staff were able to raise concerns directly with managers and through a staff survey. We saw evidence they were listened to.

  However there were areas of practice and organisation that required improvement:

- The provider did not have an immediately identifiable designated person such as a responsible officer, or the equivalent of a medical advisory committee, to give assurance to the registered manager that consultants were both competent or entitled to practice. The provider depended primarily upon consultant self-regulation, private medical insurance company assurance and NHS processes and oversight. There was no formal standard operating procedure that the registered manager could follow to ensure independent oversight of practising privileges.
- Risk was monitored and recorded within minutes and actions of various meetings. However there was not a single local risk register that provided oversight of all risk.
- **Detailed findings**

  Service vision and strategy

- Healthcare at Home Ltd's vision, purpose and mission was described as providing "inspirational healthcare in the home for millions worldwide" and by 2020 they aimed to be caring for two million people in homes across the world. The registered manager described a strategy and vision for the service at the Bristol location. We saw that there were links to the overall organisation strategy for Healthcare at Home Ltd. The strategy was called Vision 2020. The four key strands were to increase growth in the number of people they cared for, embed operational excellence and safety, to be market leaders in setting improved standards in care and service and to create a performance culture that engaged all Healthcare at Home staff. We saw practical evidence and examples of the vision, strategy and values in use. We saw minutes of meetings recording decisions about expanding, improving and relocating the services offered. Staff explained what they understood the vision, strategy and values were and how they were relevant in their work. We saw examples of work to improve the scheduling of nurses work and recently purchased equipment in place to deliver improved services. For example electronic equipment to assist the siting of PICC lines in clinic and plans for relocation.
- The provider had outlined a set of values, with quality and safety as priorities. Senior managers we spoke with explained that inspiration, collaboration, integrity and a patient focus was the value base they worked to. We saw evidence of this when we accompanied nurses into patients homes, spoke with clinical managers and the registered manager. We saw evidence that the

complaints and incident reporting process relied on staff integrity and worked. The management of clinical workload relied on individuals within teams working together. We saw several examples of this through minutes of meetings and when we spoke with staff.

- The vision, values and strategy had been developed at events held nationally primarily by senior managers with contributions from clinical staff who worked directly with patients. This had been at national clinical assemblies and in local monthly team meetings.
- The provider had used online presentations for staff to access to describe the challenges and successes of the company. Some staff we spoke had seen these and thought their work supported the overall strategy. However not all staff we spoke with were able to speak about the vision and strategy of the company in a uniform way. Key themes they spoke about were delivering good patient care and increasing the number of patients treated by 2020.
- **Governance, risk management and quality measurement**
- We saw evidence of an effective governance framework which supported the delivery of the strategy and good quality care. The provider received referrals from either NHS Trusts or Private Medical Insurance Consultants. As an independent provider, these bodies would be seen as the commissioners of the services provided. They monitored the outcomes of treatments as did the consultants. Healthcare at Home – Bristol conducted limited audits themselves, due to this being done by the insurance companies and trusts.
- Consultants prescribed chemotherapy and other treatments for staff to administer to patients. We were told that assurance they were competent and entitled to practice was given to the registered manager. Consultants did this by having their revalidation and appraisal reviewed through their employment in their NHS practice confirmed through private medical insurance companies who paid for treatments. This was then verified by the provider through their contracts with the private medical insurance companies. This process was dealt with the providers head office. There was no standard operating practice for the Bristol location to follow.
- Consultants working from the location were required to notify any concerns about their practice to Healthcare at Home Ltd. We saw evidence that the provider had recently reviewed the self-regulation process called the consulting clinic agreement (CCA) and the consultant privileges process. They had revised the methods used to verify any consultant using the clinic facilities by reinforcing the terms of the CCA in a service level agreement.
- Staff we spoke with were clear about their roles and understood what they were accountable for. The registered manager was supported by their line manager, one of two nurse directors, the clinical director other senior managers to ensure issues such as competency and entitlement to practice relating to practising privileges for consultants were monitored and assured. We also saw evidence of a current agreement called a “consulting clinic agreement” and a new draft service level agreement which was referred to as “supporting assurance for practising privileges.” We were told the documents ensured greater clarity on who was responsible for ensuring what is known in private healthcare hospitals as ‘practising privileges’ are managed The new agreement made it clearer that consultants prescribing were to ensure that patients were appropriate and fit for treatment and patients complied with treatment. However, the process still primarily relied on the insurance companies to verify competency and entitlement and consultant self-regulation. There was no equivalent of a hospital designated responsible officer (RO) who would work with a medical advisory committee (MAC) with consultant medical input to provide assurance within Healthcare at Home Ltd.
- The Bristol clinic was the registered location which contained a clinic and office for the Bristol community team. The registered manager co-ordinated services across the South, South West and South East. The registered manager reported to one of two directors of nursing who in turn reported to the operational quality meeting. The information from here was relayed to

other committees for example the quality committee which in turn reported to the Healthcare at Home board. We saw evidence of issues discussed and recorded at all levels of the organisation which were initiated in nurse team and clinical meetings.

- There were two committees that oversaw the patient incident and complaints process, the operational quality group (for reports arising from operations) and the clinical governance committee (for reports arising from clinical issues).
- The registered manager ensured oversight of the nurse teams in the South region through nine clinical managers who supervised 134 nurses in seven teams. There had been recent increase in clinical managers which provided improved supervisory ratios. The register manager was also supported by a non clinical senior operations manager. The registered manager spoke daily through a conference call with clinical managers about nurse and patient issues that might affect the service. We observed one of these meetings. The clinical managers also met with the registered manager monthly to discuss a range of issues including incident reporting, clinical governance and lessons learned and shared. Clinical managers also met with nurses in the area they were responsible for. We observed one of these meetings and saw minutes where actions were recorded and outcomes.
- **Leadership of this service**
- The registered manager had the capability and experience to lead the staff working from the Bristol location effectively. We saw evidence for this in records of appraisals and one to one meetings, and in minutes of meetings. This was also demonstrated in managerial and nurse team meetings we observed where the registered manager and others encouraged appreciative, supportive relationships among staff. We also saw evidence that individual clinical managers understood the challenges to good quality care and identified the actions needed to address them. Nursing staff told us that leaders were visible and approachable.
- **Culture within this service**
- The culture of the service centred on the needs and experience of people who used the services. There were options for patients to have treatment at home or at the Bristol clinic and a range of times and dates of treatment were offered. The focus helped people to continue living in their own homes and was embedded in the culture of the services.
- Staff told us their managers were visible and approachable. All of the staff we spoke with felt well supported in their roles. Staff told us that clinical leaders were approachable, friendly and professional. Staff spoke of an honest and open culture with good relationships between nursing staff, consultants and office support staff. Staff we spoke with described being respected and valued. Senior managers had recently supported the move to increase time for professional support to nurses through one to one meetings and professional development. There were good induction programmes for new workers and those who were planning to take on new skills.
- Staff said they felt well supported in relation to the lone working arrangements they usually operated under. They were provided with monitoring devices which could provide information about their location. Staff were clear about the process they were to follow if they required support from colleagues. We were told the on-call arrangements worked well and that when management support was required this could be accessed.
- **Public engagement**
- We saw that patient's views and experiences were gathered and acted on to shape and improve the service. A programme of surveys called the 'patient voice' was in place. The most recent results showed 98% satisfaction across all elements of service provision.
- There was a procedure in place to organise on-going nursing surveys of the patients they provided treatment to. For example certain patients were to be asked for formal feedback after four months and thereafter on an annual basis. Different procedures were in place depending on the level of service and the treatment being provided.
- **Staff engagement**
- Staff we spoke with described feeling engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. We saw

evidence that Healthcare at Home employees attended an annual national event and received updates on both corporate and clinical progress to date and the actions taken to improve any clinical care issues. There was an annual Clinical Conference for all clinical staff where national issues, performance and updates were provided by senior managers, together with an awards ceremony. Clinical Assemblies were held each month across the United Kingdom for staff to have chance to meet with senior managers and clinical leads and to discuss and be appraised of national clinical issues for example, Revalidation and changes to CQC compliance.

- **Innovation, improvement and sustainability**
- We saw that senior managers and staff were working at continuous learning, improvement and innovation. For example Healthcare at Home Ltd had been significantly involved in an independent white paper called "building the case for clinical care in the home at scale". They had worked with other NHS bodies and other providers of healthcare, for example King's College Hospital and Macmillan cancer support. The paper looked at developments to services and potential changes to health care delivered at home. The Bristol location was involved and had informed contributions to this work. They had assessed the potential impact on the quality and sustainability of five service models, home cancer care, end of life care, and home treatment of long term conditions, timely discharge from hospital and the use of virtual wards. The five types of service were discussed in response to a document called the Five Year Forward View produced by the NHS in October 2014 which looked at how services might be delivered in future.
- We saw plans that Healthcare at Home- Bristol were planning a move to a new location in partnership with a provider of radiotherapy to reduce the time between chemotherapy and radiotherapy for patients and improve treatment outcomes and patients experience. This was described as being a regional cancer centre.
- Following problems with delivery of certain medications for patients the provider had improved the service. Fourteen days before delivery of the medication patients were offered choice of delivery day, then ten days before delivery a reminder was sent and further reminders at two days before treatment time. Then a four hour time slot was given to patients. Finally the day before the delivery patients were given a two hour time slot with a final confirmation of delivery within 20 minutes.
- During our visit healthcare at home were scheduling nurse visits to patients the day before the visits were due. We saw project plans to improve their system so that nurses would know two or three weeks in advance. This was hoped to improve patient experience and better manager resources.
- The provider was working to deliver electronic prescriptions which would reduce the occurrence of poorly completed or incorrect prescriptions which delayed safe and effective care. They were also developing a new service to be able to site peripherally inserted central catheters or lines which enabled drugs to be given that needed to go into particularly large veins.
- There was an assurance system and service performance measures, which were reported and monitored. We saw that action was taken to improve performance. For example when there had been delays in delivery of critical medications to patients the provider returned the control of the service to an in house system. Consultants who referred patients to the provider were responsible for monitoring the outcome of treatments. We saw evidence that the provider monitored some quality indicators. They did this through numbers of adverse events recorded, electronic patient records audits, numbers of infections for example in peripherally inserted central catheters or PICC lines and directly observing practice of nurses.
- There were arrangements for identifying, recording and managing risks and actions that need to be taken. Risk was recorded centrally at the providers head office and held by the clinical governance committee. Risk associated with local service delivery at the Bristol location was monitored through minutes of meetings and specific agenda items. For example incident reporting or patient scheduling for nurse visits. The registered manager and the senior clinical manager told us they were developing a local risk register so that risk could be assessed and monitored more easily. There were no dates planned for completion of this work.

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- The structure of departmental or divisional governance arrangements were clear. There were clear lines of accountability including responsibility for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line. For example staff were able to describe the process of information that flowed from the nurse facing the patient to the relevant level in the organisation. The registered manager and others were able to describe the roles of committees that provided governance and assurance to the board. Some committees had been recently started and because of this some minutes were not yet available. Feedback from people who used services was discussed at divisional and Board meetings.
- Quality and risk information about the community services for adults was reviewed at divisional and board level and we saw records that assurance was provided about the quality of information being considered. The majority of meetings relating to medication and pharmacy issues were held at the providers head office with information being cascaded down to the clinic locations. The lead pharmacist attended the clinical meetings including the Drugs and Therapeutics Committee. The patient's safety meetings always included a section on medicines. The latest minutes showed there had been discussion and feedback on the new incident reporting system in relation to medicines and also a plan to introduce a medicines newsletter later in 2016.

Outstanding practice and areas for improvement

Outstanding practice

We considered the opportunities for nursing staff to undertake training and the development of specialist skills to be outstanding.

The electronic records system used by nursing staff and across the organisation provided an outstanding system for the monitoring of patients care and communication between professionals.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should complete formal risk assessments for gas cylinder storage and handling. Suitable arrangements should be put in place for tracking cylinders from the point of receipt to their return empty to the supplier.
- Nurses should monitor and record the temperatures of the fridges used to transport medication.
- The provider should have an identifiable designated person such as a responsible officer, or the equivalent of a medical advisory committee, to give assurance to the registered manager that consultants were both competent or entitled to practice..
- The provider should complete a risk register that relates solely to the registered location in Bristol.