1st Care Nursing 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

The inspection took place on the 11, 12 and 24 August 2016.

1st Care Nursing Ltd is a domiciliary care agency registered to provide personal care and nursing care for adults and children living in their own homes. At the time of our inspection care was being provided to 53 people of whom 17 people were receiving nursing care. The service benefitted from being a subsidiary of the Active Assistance Group which provides services for adults and children with a range of physical disabilities as well as specialised services in spinal cord injury and tetraplegia and other neurological conditions such as multiple sclerosis and cerebral palsy.

The service did not have a registered manager. The domiciliary care manager was in the process of registering with the Care Quality Commission to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider did not have robust quality assurance processes in place to ensure the service maintained and improved the quality of care provided. Although staff felt supported by management, some staff told us they had not received regular formal supervision.

There were effective recruitment procedures in place to protect people from the risk of avoidable harm. Staff understood the risks and signs of potential abuse and the relevant safeguarding processes to follow. Risks to people's health and wellbeing were appropriately assessed, managed and reviewed. Accidents and incidents were recorded and monitored to identify any trends and to mitigate reoccurrence. There were systems in place for receiving, administering and disposing of medicines.

The service provided good care and support to people enabling them to live fulfilled and meaningful lives. Staff were kind and sensitive to people's needs and ensured people's privacy and dignity was respected. People had developed positive relationships with staff and were happy with the care and support they received. People were supported by skilled and well trained staff. Staff were trained and understood the principles of the Mental Capacity Act 2005 (MCA).

There was a strong emphasis on person centred care. Care plans were person centred, included people's individual preferences and needs, and contained clear guidance for staff to follow. Care plans were regularly reviewed and people and, where appropriate, their relatives were involved in the planning of their care.

People were cared for by staff who knew them well. Staff shared information effectively which meant that any changes in people's needs were responded to appropriately. People were supported to access health care services when required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were knowledgeable about protecting people from harm and abuse.

There were robust recruitment procedures in place to ensure people received their support from staff who had been recruited safely.

People's medicines were managed so they received them safely and as prescribed.

Is the service effective?

Good

The service was effective.

Staff received an induction when they came to work at the service and ongoing training to support them to deliver care and fulfil their role.

Staff had received training and had a good understanding of the Mental Capacity Act (2005).

People's healthcare needs were met and, where required, they were supported to access healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff knew people well and treated people with kindness and compassion.

Staff treated people with dignity and respect and encouraged people to maintain their independence.

People's privacy was respected.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their individual needs. People's care plans included information relating to their specific care needs and how they were to be supported by staff.

There was an effective complaints policy and procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager at the service.

Some areas of the service did not have comprehensive audits and checks in place to monitor the quality and effectiveness of the service.

Staff felt valued and were committed to providing good quality care and support to people.

There were systems in place to seek the views of people who used the service and from staff; however it was not clear how their feedback had improved the quality of the service provided.

1st Care Nursing 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 service under the Care Act 2014.

This inspection took place on the 11, 12 and 24 August 2016 and was an announced inspection. We gave the service 48 hours' notice of the inspection to ensure management was available to assist us with the inspection. The inspection was completed by one inspector and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service; this included the last inspection report and statutory notifications. Notifications are changes, events or incidents that the provider is legally obliged to send us. We also reviewed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 14 people who used the service, two relatives, eight members of staff, the domiciliary care manager and the Director of Operations for Active Assistance.

We reviewed a range of documents and records including five people's care files, seven staff recruitment and support files, training records, arrangements for medication and quality assurance information.

Good

Is the service safe?

Our findings

People using the service told us they felt safe and secure when staff visited. People's relatives also told us they were confident that their relative was safe.

People were protected from the risk of abuse. The service had safeguarding and whistle blowing policies and staff had received safeguarding training and understood the importance of protecting people and keeping them safe. Staff were able to demonstrate a good understanding of the different types of abuse and how to respond appropriately where abuse was suspected. The registered provider had access to a safeguarding team who were 'on call' 24/7 to address any safeguarding concerns and staff were aware they could contact external agencies such as social services or the Care Quality Commission (CQC) to report any concerns. One member of staff said, "If we see abuse towards [name of person] I would report it straightaway to the office and speak to the CSM (clinical support manager). We also have a safeguarding team we can call; If I had to I would contact CQC." An 'Ask Sal' poster was displayed in the office. 'Ask Sal' is a confidential helpline for people, relatives or staff to call if they had any safeguarding concerns.

Staff had the information they needed to support people safely. Risk assessments were undertaken to keep people safe and were regularly reviewed. These assessments included potential risks such as aspiration, the removal of mucus, choking, mobility and pressure sore management and provided clear information to staff to manage these risks and support people in the safest way. People's home environment was also risk assessed for any potential hazards. There were plans in place to deal with emergencies and 'service failure plans' had been developed for each individual. Staff and people using the service had access to an out of hour's telephone service for advice and support. Staff who worked with people with complex clinical needs told us the introduction of 'Active Assistance's' management systems for care planning and risk management had greatly improved people's safety and well-being.

There were effective systems in place to record and monitor incidents and accidents. These were reported on the registered provider's on line reporting system and were monitored and analysed by the registered provider and Active Assistance's director of quality and governance. Incidents and accidents were discussed at monthly risk management meetings held by the Active Assistance group. This ensured that if any trends were identified actions would be put in place to prevent reoccurrence.

There was a robust recruitment process in place to ensure that the right staff were employed at the service. This included dealing with applications and conducting employment interviews. Relevant checks were carried out before a new member of staff started working at the service. These included obtaining references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS). Staff told us, and records confirmed, they were not allowed to start working at the service until their references and DBS checks had been completed. There were disciplinary procedures in place to respond to any poor practice by staff.

People we spoke with told us that staff arrived on time and stayed the agreed length of time. One person told us, "If they [staff] are late they let us know." A relative said, "They do notify us if there is a problem." The

director of operations told us they assessed staffing levels regularly; they said, "We over recruit on average by 20% to allow cover for holidays and sickness. We do not use agency staff". Staff told us that there were generally sufficient staffing levels to enable them to meet people's needs appropriately and that they did not feel rushed or task focussed when providing care and support. We however received feedback that occasionally on a two person visit a second member of staff had not arrived consequently placing both staff and people at risk. We discussed this with the manager who was fully aware there had been an issue and confirmed to us that this had now been addressed with staff.

People received their medication safely and as prescribed. There were three levels of medication administration: Level 1 Assistance with medication, Level 2 Administration of medication and Level 3 Administration of medication – Complex. Level 3 was where staff administered people's medicines via a specialised technique such as percutaneous endoscopic gastrostomy (PEG) feeds/medication, insulin injections and medicated dressings. Only staff who had received the appropriate training were able to administer Level 3 medicines. People's needs and level of independence in relation to their medicines were assessed and recorded in their care plans which contained detailed information and guidance for staff to follow.

All staff who administered medication had received medication training and yearly refresher training which included their competency to administer medicines being checked. Regular weekly audits were undertaken for people who were receiving specialised nursing care to ensure they were receiving their medication safely and correctly. However although the medication administration records (MARs) we reviewed for people who were receiving a domiciliary care service contained no gaps we noted that regular audits had not been carried out. We discussed this with the manager and director of operations who advised they had recently undertaken an audit following a medication error and showed us a medication audit template they had developed and would be implementing with immediate effect. Where people had been prescribed medicines on an 'as required' basis for example for pain relief, there were protocols in place for staff to follow. There were safe systems in place for ordering, receiving, storing and disposal of medicines.

Good

Is the service effective?

Our findings

Staff received supervision and had an appraisal in place and records we viewed confirmed this. However we received mixed feedback from staff regarding supervision. Although staff told us that they felt supported and could contact the office or the management team if they needed support or guidance, some staff said they had not received regular supervision. One member of staff said, "I don't get regular supervision and I just filled out a form for my appraisal no one went through it with me." The registered provider had a policy in place but this did not outline the frequency of staff supervision. We discussed the feedback we received from staff with the manager who told us the service followed CQC's guidelines but, following our feedback, would be reviewing the staff supervision and appraisal process to ensure staff had a structured opportunity to discuss their performance and development.

People were cared for by staff who had the skills and knowledge to meet their needs. Staff had undertaken an induction programme when they started work at the service and were supported to obtain the knowledge and skills they needed to provide good care. The induction period for staff recruited to provide specialist nursing care was longer to ensure staff fully understood the clinical needs of the people they were supporting. The director of operations told us that nurse's employed by the Active Assistance Group provided 'in house' training on anatomical dummies and staff were 'signed off' once they had demonstrated they were clinically competent. Staff would then be required to undertake shadow shifts and work with the clinical trainers before being formally signed off as fully competent to deliver care to people.

Staff told us the training they received was good and they had received appropriate training to enable them to deliver good care. One member of staff told us, "Training is brilliant I enjoy the training." Another member of staff said, "I do training twice a year, the general training update as well as the complex training. I've also met with the care services manager recently to be shown how to use a new form of vent and to receive an update on suctioning." Training records confirmed staff had completed the registered provider's mandatory training and had received yearly refresher training. People we spoke with were complimentary about the quality of the staff and felt they were competent to carry out their role. This showed us that people were supported by staff that had the skills and knowledge to meet their needs and ensure their safety.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS). The 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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had received MCA training and understood the key principles of the MCA. Staff were aware that people had to give their consent to care and had the right to make their own decisions. One member of staff told us, "People's capacity is assessed and recorded on their care plans, my job is to promote independence and empower people to make their own decisions; I cannot dictate what they should do but I would encourage them to make a different choice if I thought their safety was at risk. If I thought they were at risk I would call the office or out of hours line."

People were supported, where required, with their nutritional needs. Where required staff helped people to shop and prepare their meals. One person told us, "They [staff] cook what I want and [name of staff member] cooks meals from scratch."

People's healthcare needs were met. Where required people were supported to access healthcare professionals such as GP and hospital appointments. One person told us, "The carer reminds me of my medical appointments." Staff told us if someone was unwell or they noticed deterioration in their health they would inform the office and if required contact the emergency services or arrange an appointment for the person to see their GP.

Good

Is the service caring?

Our findings

People we spoke with were highly complementary of staff and told us that staff were kind and compassionate. Comments included, "Amazing support, fantastic team most of the time;" "I'm glad I've got them;" "They are absolutely wonderful;" "They are very courteous;" and, "I couldn't have better care." Where possible people were supported by the same staff team who knew them well which ensured consistency and continuity of care. During our visit to a person's home we observed friendly and caring interactions between people, their relatives and staff.

People were involved in their care planning and were able to express their views and opinions. One person told us, "I have a written care plan, my views are listened to and things are reviewed one to two times a year." Another person said, "The manager will pop round and review every couple of months." People's preferences were recorded in their care plans. Where appropriate staff had discussed people's likes and dislikes with relatives so they could ensure they provided care which met people's individual needs. Staff told us that in addition to the information contained in people's care plans they had time to build positive relationships with people which enabled them to increase their understanding of their needs. Staff we spoke with were able to describe people's preferences, personal histories and interests. This showed us that they knew people well.

People's dignity and privacy was respected and staff demonstrated a good understanding of privacy and dignity. Feedback from people included, ""I am treated with respect all the time;" "I'm certainly treated with respect;" and, "I like my own space and they [staff] give me privacy but are always within earshot in case I need them."

People's independence was promoted and staff encouraged people to do as much as they could for themselves where they were able to. For example one member of staff described how they supported people to wash independently as much as they could so they did not lose their independence to undertake this task. We noted a compliment received by the service which stated, 'Thank you for all your kindness to [name of person]. You helped them to maintain their independence which was most important to them. They were able to remain in their own home which held so many memories for them; you are a credit to the care industry.' Comments from people we spoke with included, "The service helps me in ways I couldn't do without;" and, "It [the service] allows me to remain independent in my home." The director of operations told us, "1st Care is about providing care to people in their own home and to keep them as independent as possible. We are not risk adverse, people's lifestyles are different and we acknowledge that."

People's diversity needs were respected and included in their care plan. The manager told us that if required staff would support people to access religious support and access churches in the local community.

People were provided with information on advocacy services. An advocate supports a person to have an independent voice and enables them to express their views when they are unable to do so for themselves. The manager told us that no one was currently accessing advocacy services.

Good

Is the service responsive?

Our findings

The service was responsive to people's identified needs. Prior to people using the service an assessment was undertaken to identify people's needs and whether these could be met by the service. For people with clinical needs their assessments were undertaken by specialist assessors. The director of operations told us, "We really look at the clinical needs [of people] before we make a decision on whether we can meet them. If there was a clinical need we weren't sure about it would go to the director of quality for further consideration." Information from the assessment process was used to develop people's care plans. People and, where appropriate, their relatives and health and social care professionals were involved in the planning and review of their care and support needs.

Care plans we looked at were person centred and included detailed information about people's needs and how they wished to be cared for. Care plans were reviewed regularly or sooner if people's needs changed. We noted that any changes to care plans were clearly highlighted to enable staff to easily identify where changes had been made. Staff providing clinical care told us that there were always thorough handovers between shifts and, where appropriate, with relatives. Daily communication books were also updated with relevant information. This meant that there was up to date information available for staff to ensure people's needs were met.

Staff we spoke with were very knowledgeable about the people they supported and were aware of their likes and dislikes, interests and health and support needs. During our inspection we saw examples where people had been supported to pursue their hobbies and interests. This meant a personalised and responsive service was provided which met people's individual needs.

Staff who provided clinical care told us there were thorough handover meetings between shifts which, where appropriate, included relatives. There was also a communication book which all staff used to communicate important information to each other. Staff working on the domiciliary part of the service told us that people's records were always updated after each visit. This showed that there was good teamwork within the service and that staff were kept up-to-date about changes to people's support needs.

The service had a clear policy in place for dealing with complaints. People told us they knew how to make a complaint if they needed to. The service had received three complaints in the 12 months prior to our inspection. Records confirmed these had been dealt with appropriately in line with the service's policy and procedure.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection the service did not have a registered manager in place. The last registered manager left in January 2016. The domiciliary care manager at the service was in the process of submitting a registered manager application to the Care Quality Commission.

There were quality assurance systems in place to review and improve the quality of the service provided to people. However some of these systems such as medication audits for people receiving a domiciliary care service had only recently been introduced and had not yet been embedded in the service. We also noted no formal audits had been carried out such as the auditing of daily records to check that the care provided to people was meeting their needs as outlined in their care plan. In addition no formal observations were being undertaken of staff practice for domiciliary care staff. We discussed this with the manager who told us they were aware this aspect of the service required improvement and that they would be addressing this to ensure robust systems were put in place.

Annual staff surveys were undertaken by the registered provider. We saw the results of the staff survey carried out in 2015. A total of 41 responses had been received. Whilst issues raised by staff had been noted, no formal analysis had been undertaken or action plan developed. For example, 19% of respondents had indicated they had received no supervision or appraisal and only 58% of respondents felt any concerns raised would be effectively dealt with by management. Staff we spoke with told us they had not received any feedback following staff surveys. This meant that we could not be assured that the registered provider used staff feedback to make improvements to the service.

People's views were sought about the service. People told us staff sought their feedback and were invited to complete an annual survey. We looked at the client survey undertaken in 2015; 20 responses had been received. We noted an action plan had been developed following issues raised by people and included the action to be taken and the date for the action to be completed by. However, all the people we spoke with did not recall receiving any information from the service, for example actions taken following surveys.

Staff were positive about their roles, clear on their responsibilities and enjoyed their work. They shared the registered provider's vision to provide good quality care to people. Regular staff meetings were held for the clinical staff. A member of staff told us, "We work long shifts so the team cannot always attend meetings but we always get copies of minutes if we are unable to get to meetings." The manager confirmed to us that no staff meetings had taken place for domiciliary care staff and advised regular monthly meetings were to be scheduled with effect from September 2016.

People's confidential information was stored safely and securely in the office when not in use but was accessible to staff when needed.