Interserve Healthcare Limited

Interserve Healthcare - Greater Manchester

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?	Good

Summary of findings

Overall summary

Interserve Healthcare Greater Manchester is a community healthcare service and provides nursing and personal care and support across Manchester and Lancashire. The service is based in Rochdale and offers support to adults and children living in their own homes. At the time of our inspection the service was providing support for 21 people.

The current provider registered with the Care Quality Commission in March 2015. This is the first inspection for Interserve Healthcare Greater Manchester.

This was an announced inspection which took place on 24 and 27 October and 3 November 2016. In line with our current methodology we contacted the service to tell them of our plans to carry out a comprehensive inspection. This was because the location provides a domiciliary care service and we needed to be sure that either the registered manager or another manager was available to support the inspection.

The service had 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.

Staffing arrangements had improved offering people better continuity of care so that their care and support was not compromised.

People and their relatives, where necessary, were involved and consulted with about the person's care and support needs. Staff had received training on the Mental Capacity Act 2005 and were aware of the importance of seeking people's permission before carrying out tasks.

Suitable arrangements were in place for the management of people's medication. Systems were in place to check that people's medicines had been administered as prescribed.

We found that effective recruitment procedures were in place and followed to help ensure staff were suitable to work with vulnerable people. Staff were supported in their role through induction, training, supervision and appraisals. Records to show what training had been completed did not fully reflect what we had been told.

People knew what procedure to follow if they had any complaints or concerns.

Staff we spoke with had a good understanding of people's needs and preferences. Care files provided sufficient information to guide staff in meeting their needs and wishes. People told us staff were kind and caring and treated them with respect. Staff told us how they maintained people's dignity and spoke about

people in a warm and caring manner.

People told us they felt safe with the staff that supported them. Staff had completed training in how to safeguard people from abuse and knew the action they should take if they had any concerns.

We found potential risks to people had been adequately assessed and planned for so that people were protected from possible harm or injury. Where necessary the registered manager had notified CQC of events or incidents that occurred in the service in accordance legal requirements.

Systems were in place to monitor and review the service provided and opportunities were provided for people to comment about their experiences.

Information about people stored electronically in the office. Computers were password protected which ensured that information was kept confidential.

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.

Staffing arrangements had been improved to help ensure the service people's care and support was not compromised. Relevant recruitment checks were completed prior to new staff commencing work ensuring they were suitable for the position.

The management of people's medication was safe. Suitable arrangements were in place to ensure the premises and equipment were suitably maintained so that people and staff were not placed at risk of harm.

Systems were in place to protect people against abuse. Risk assessments were in place to guide staff helping to ensure the health and well-being of people was protected.

Is the service effective?

Good

The service was effective.

Staff received the induction, training and supervision they needed to help ensure they provided effective care and support.

People were involved and consulted with about their needs and wishes. Staff received training on the Mental Capacity Act 2005 and recognised the importance of seeking people's permission before carrying our tasks.

People who used the service received appropriate support to ensure their health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

Staff we spoke with had a good understanding of people's needs, wishes and preferences. Staff told us how they maintained people's dignity and spoke about people in a warm and caring manner.

People told us staff were kind and caring and treated them and

their family members with kindness and respect.

People's records were stored securely so that people's confidentiality was maintained.

Is the service responsive?

Good

The service was responsive.

Systems were in place for reporting and responding to people's complaints and concerns.

Prior to support commencing people's needs were appropriately assessed so that an informed decision could be made about whether the service could meet their needs.

Each person had a plan of care which directed staff in the care and support people wanted and needed. Information reflected their individual needs, wishes and preferences.

Is the service well-led?

Good

The service was well-led.

The service had a manager who was registered with the CQC.

Systems were in place to monitor and review the service provided and opportunities were provided for people to comment about their experiences.

Staff were aware of the whistle blowing procedure and told us they would not hesitate to raise any issue they had.

Interserve Healthcare - Greater Manchester

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Prior to the inspection we considered information we held about the service, such as notifications received from the provider. We had also asked the provider to complete a 'Provider Information Record' (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make and helps to inform some of the areas we look at during the inspection. This was provided prior to the inspection.

This inspection was announced and carried out by an adult social care inspector. The inspection took place on the 24 and 27 October and 3 November 2016. The provider was given 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure that either the registered manager or another manager was available to support the inspection.

As part of the inspection we spoke with a nurse, two support staff, the team leader and the registered manager. We also contacted the relatives of three people and two health care professionals who commission packages of care with the service to seek their views about the service. Comments received have been added to the report.

During our visit to the agency office we looked at three care files, three staff recruitment files and training records, the management and administration of medication for one person as well as information about the management and conduct of the service.

Good

Is the service safe?

Our findings

We were told the service currently supported 21 people, both adults and children, with complex care needs. Support was generally provided during the evenings and overnight, providing respite for family members.

Prior to this inspection we had been made aware by people who used the service or their relatives of their concerns in relation to inconsistent staff cover, the turnover of staff and the lack of continuity. These concerns were looked at as part of this inspection.

Some of the people we spoke with confirmed these concerns. One person told us they had raised concerns due to shifts not being covered, particularly at short notice. They felt the service had not always had effective contingency plans in place and therefore at times their relative had been cared for by staff that were not always familiar with their needs and on occasions no cover had been provided at all. Similar concerns were raised with us by another relative who said that issues usually arose when regular staff were off sick and the service struggled to cover shifts. Both people told us that more recently staffing arrangements had improved. A third relative did not raise any issues and spoke more positively about their experience. They told us, "We have continuity, it's always the same carers and they never let us down."

Feedback was also provided from healthcare professionals who oversee the care received by some people who use the service. One professional told us that safeguarding concerns had previously been raised due to ineffective staffing arrangements, particularly when cover was needed at short notice due to sickness absence. They said that due to the complex needs of people their care and safety could potentially be compromised. We were told that as a result of some of the concerns some packages of care had been transferred to other care providers. However we were told there were currently no outstanding issues.

We discussed this with the team leader during our visit to the service. We asked what procedures staff were expected to follow if they were to be absent from work. The team leader told us that contingency plans were in place which required staff to notifying the office of any absence as early as possible so that cover could be arranged. Office staff would check with staff when they were able to return to their normal duties so that all necessary shifts were covered. A copy of the sickness absence procedures was also detailed in the staff handbook for staff to refer to.

We also discussed people's comments with the registered manager. They acknowledged that if staff called in sick and had not notified the office in good time then finding cover could at times be difficult. We were told that a recruitment consultant had been appointed to support the service. Their role was to ensure that sufficient numbers of staff were available to support the service and where necessary additional recruitment was undertaken. We were told the service strived to offer continuity of care for people. The registered manager said that when planning people's care packages a core team of staff was identified and trained to meet their specific needs. This helped to ensure appropriate cover was provided at all times, including leave and sickness.

We looked at what systems were in place to safeguard people from abuse. We asked the relatives of people

if they thought their family members were kept safe. Relatives told us, "Oh yes, I feel [relative's name] is very safe with the carers", "I trust them [staff] to look after [relative's name]", "I can relax when the care staff are around", "Yes, I feel [relative's name] is safe with the carers" and "I feel [relative's name] is safe, the staff are very good and clearly know what to do".

We saw that policies and procedures were available to guide staff in safeguarding adults and children from abuse. This was supported by a programme of training. Staff spoken with and records seen confirmed that training had been provided. Those staff we spoke with were aware of the signs of abuse, what they would do if they witnessed it and who it should be reported to. Staff were confident that if they raised any concerns with managers they would be dealt with appropriately. One staff member spoke about the whistleblowing procedure (reporting poor practice), and knew they could contact outside agencies if they felt their concerns were not listened to. A copy of the whistle blowing procedure was also included in the staff handbook which was provided to all staff.

We looked at what checks were carried out when recruiting new staff to the service. We found a safe system of recruitment was in place. We looked at three staff files. The staff files we saw contained an application form including a full employment history, interview questions and answers, health declaration, at least two professional references and proof of identity which included a photograph of the person. We saw that checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. Professional registration with the Nursing and Midwifery Council (NMC) was also checked where necessary. These checks should help to ensure people are protected from the risk of unsuitable staff.

Staff were provided with a handbook which included policies and procedures such as confidentiality, code of conduct and performance management. This information informed staff what was expected of them in their roles.

We looked to see if there were safe systems in place for managing people's medicines where the service was responsible for administering them. We saw a detailed policy and procedure was available to guide staff and training was provided. Nursing staff also completed competency assessments of staff to ensure they understood the procedures and were seen to administer medication safely. Records seen and staff spoken with confirmed what we had been told.

Where people were supported with their medication this was recorded in their care files. We found that people records clearly showed the level of support provided and what was required of staff, particularly where someone required rescue medication due to a medical condition or received their medication via a PEG (percutaneous endoscopic gastrostomy). This is a feeding tube placed through the abdominal wall and into the stomach allowing nutrition, fluids and/or medications to be put directly into the stomach. This helped to ensure people were kept safe and their individual needs were met.

We reviewed the medication administration records (MAR) for one person completed in August and September. We found records were not always completed in full to demonstrate medication had been given as prescribed or if not given then a code detailing why this had not been used. We were told and records showed that MARs were brought into the office each month and checked by the care co-ordinator. Any issues identified were addressed with the relevant staff member.

We looked at three people's care records. Each contained risk assessments that guided staff on what action they might need to take to manage and minimise areas of risks so people were kept safe. Risk assessments

we saw included moving and handling, tracheostomy and suction, feeding tubes and medication. We were told and records showed that information was reviewed twice a year or more frequently if needs changed.

We also saw that a general risk assessment was completed which explored risks around the persons home and fire safety. Individual personal emergency evacuations plans (PEEPs) had also been completed. These provided information for staff about how they should support people in the event of an emergency.

Whilst the servicing of equipment in people's own homes, such as wheelchairs and hoists, was the responsibility of the local authority commissioners the team leader told us that they would liaise with the relevant contractors to ensure the servicing of equipment was completed when required so that they were safe to use. This helped to ensure people were not at risk of harm.

We saw there was an accident procedure in place. A record was made detailing the accident/incident, action taken and outcome. Records had been reviewed by the quality manager and signed off once agreed relevant action had been taken. This additional check helped to review if any themes were occurring and if additional action was required.

The service had an infection control policy which provided staff with guidance on preventing, detecting and controlling the spread of infection. This included the use of personal protective equipment (PPE) including disposable gloves and aprons. We were told that as part of the programme of training staff completed infection control training. People's relatives we spoke with confirmed that staff had access to PPE and that it was used.

Good

Is the service effective?

Our findings

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

The team leader told us that no-one was currently being deprived of their liberty. We were told if the service felt a person was being deprived of their liberty they would liaise with the local authority so that the necessary authorisation is sought from the Court of Protection. Where any restrictions were in place we were told people had capacity to make decisions for themselves. Where the service supported children, the parents advocated on their behalf. We saw on one person's file they communicated with others using 'non-verbal communication'. Guidance for staff on how best to communicate with the person was detailed on their care file. This enabled them to be involved in making decisions for themselves.

Staff spoken with said they had undertaken the MCA e-learning training and completed a workbook to check their understanding of the Act. Staff spoken with gave example of how they sought people's consent before providing care or when caring for children, parents were consulted with. This was confirmed by those people we spoke with.

During the inspection we looked at how staff were supported to develop their knowledge and skills. We asked the relatives of three people if in their view staff were competent in meeting their relative's needs. Comments received included; "They do a good job", "Training always seems to be available", "They know what they need to do, they have training so they have the right skills." However concerns were raised by one of the healthcare professional we spoke with about whether some staff were suitably trained and competent in meeting the complex health needs of people, particularly when they were asked to provide cover at short notice, as they felt some staff had not completed the specialist training to meet people's complex needs.

Records we looked at showed that when new staff started working for the organisation they received a comprehensive induction, covering all aspects of their role and responsibilities. This included the completion of all mandatory e-learning training. We were told that training had to be completed before new staff were 'signed off' to work with people. We were told e-learning training included, roles and responsibilities, medication, health and safety, medication awareness, first aid, development of children and young people, safeguarding adults and children and moving and handling. This helped to ensure that staff were equipped to carry out their role. Evidence of induction was seen on the personnel files for new staff we looked at. Additional face to face training was also provided in moving and handling and first aid. Mandatory training was said to be updated annually to ensure staff were aware of current good practice. Staff spoken with confirmed what we had been told.

One staff member we spoke with told us that new staff had a mentor who would support them. Shadowing

shifts were also provided, the number of shifts varied depending on how confident the new staff member felt. This was confirmed by two of the relatives we spoke with. One relative told us that a new staff member for their family member was quite inexperienced, additional shadowing sessions were agreed to help them learn their role. Other comments included; "They [staff] care about what they are doing" and "One person is training up tomorrow night." Staff also said, "They don't push new staff into doing things too soon".

We were told that staff also received training in specific areas of care and support people needed. This included spinal injury, tracheostomy and PEG (feeding tube). Staff spoken with, who offer this level of care and support, confirmed they had undertaken this training, that assessments of competency had been completed and that courses were frequently made available should staff require further training. Training records for those staff spoken with confirmed what we had been told.

We were told that competency assessments were completed by the branch nurse. Their role was to oversee the clinical needs of people and staff. This post was currently vacant however a nurse had been appointed to work one day in the office and during the evenings so that competency assessments could be carried out. These assessments explored areas of practice including medication and PEGs and checked staff understanding of the procedures in place as well as observations of practice to check staff knew what was expected of them so people were kept safe.

Staff spoken with told us "They are really good at providing training", "If you need anymore, they will always provide it" and "Yes, I feel equipped to do my job". All the staff we spoke with said the service continually provided training opportunities to staff and at no time had they felt compromised when providing care to people.

Systems were in place with regards to supervision and team meetings. We saw records to show and staff confirmed that individual meetings were held with their care co-ordinator. Staff we spoke with said that full team meetings were not generally held due to the times staff worked and the different locations. However staff said that 'peer group support meetings' were held so that those staff who worked with the same clients, had an opportunity to meet and discuss their work. Any clinical issues raised through individual or group meetings were discussed with nursing staff. All the staff we spoke with felt supported in carry out their role.

We asked staff how they helped people meet their nutritional needs. We were told that food hygiene training was provided as part of the induction programme and updated on an annual basis. This was confirmed by those staff we spoke with. As people lived in their own homes or with family support, they could eat what they wanted. We were told that some people received their nutritional intake through a PEG tube. We saw clear guidance on individual care records about how this was to be provided. Additional monitoring records were completed, such as tube cleaning and rotation records and feed and water charts. This helped to ensure people's nutritional needs were safely met.

Care records we looked at showed that people's specific health care needs were monitored. This helped to ensure any changing needs could be quickly responded to. Information about people's health needs were recorded and showed they had access to a range of health care professionals when needed.

Good

Is the service caring?

Our findings

People who used the service were very complimentary about the staff from Interserve Greater Manchester. All the people we spoke with said they had a good relationship with staff. Their comments included, "Very caring", ""The carers are kind and caring", "We're very happy with the service", "They are good at looking after [relative's name]" and "Staff are well mannered and polite."

All the people we spoke with told us staff always treated their family member with dignity and respect when offering care and support. We were told that staff were also considerate to other family members within the home. People told us, "They are respectful to [relative's name] and us as a family, they appreciate our family time" and "Staff are always polite and respectful to all members of the family."

The parents we spoke with told us that staff support was provided for their child to attend school. This enabled them to take part in social and educational opportunities, promoting their independence.

Staff we spoke with were able to show that they knew people who used the service well. Staff spoke sensitively about the people they supported. They told us how they considered people's privacy and dignity. We were given examples about how care interactions were explained and discussed before being provided, so the person was aware of what was happening.

We were told that some staff had worked with people for many years and had good working relationships. One person said, "They are like part of the family." Staff were described also described as "punctual and reliable."

Care records we looked at explored the best ways of speaking with people, particularly those who did not communicate verbally. Information was seen on one file which included Makaton information. Makaton is a language using signs and symbols to help people to communicate. Staff told us that training was available to enable them to communicate better with the person.

We were told that people had access to specialist equipment where needed. This helped to promote people's independence and keep them safe.

Electronic records were kept in the main office with regards to people's care and support. Computers were password protected which helped to ensure confidentiality was maintained. We were that people had a copy of their care plan.

Good

Is the service responsive?

Our findings

We looked at the assessment process when people were referred to the service and how their care was planned for. We were told that when packages were referred to the service limited information was provided about the needs of people. The service would make arrangements to carry out their own assessment so that further information could be gathered. Following the assessment an internal meeting was held involving office staff, the community matron and care services manager. During these meetings, consideration would be given to the resources required and whether sufficient numbers of staff were available with the skills and competencies needed.

We were told that where possible staff would be matched to people so that their skills could be best utilised. Any new staff would have a period of shadowing existing staff, providing them with an opportunity to be introduced properly to people. Once staff with the relevant skills and experience had been identified a 'meet and greet' visit would take place prior to support commencing. The relative of one person told us, "New staff are always introduced to us before doing shifts."

The complex health needs of some people or children meant they were not always able to contribute to the development of their care plan. Staff would consult with their relatives so that relevant information could be sought. Family members we spoke with said they had access to care plans and had been involved in reviewing and updating information to make sure it reflected their relative's needs and wishes. Two people told us, "We have an open relationship and there's good communication between us" and "Yes there are regular meetings so we can discuss things."

One healthcare professional we spoke with said that care packages they were involved with had recently been formally reviewed involving all relevant parties such as schools and the parents of the young people. Any queries raised had been responded to. This showed that the service acted and listened to people so that the service provided met their needs and wishes.

We looked at the care records for three people. These were held electronically in the office. These provided good person centred information about the individualised support people wanted and needed. We saw that information into people's specific medical conditions had also been clearly detailed in their care records. This information helped staff to have a better understanding of the person's condition and the treatment and support they required.

We looked at what system were in place for the reporting and responding to people's complaints and concerns. People we spoke with were asked if they had raised any issues or concerns with the service about the support they received. We received a mix response.

A health care professional said there concerns had not always been responded to effectively and had therefore escalated it to a more senior manager, when issues were then resolved. The relatives of two people and a healthcare professional said they had raised issues of concern with the service, particularly in relation to staffing. One person said, "I've had a couple of meetings with [registered manager] and she gets

things sorted" and "Dealt with quickly and professionally." A further professional and a third family member said they had no issues or concerns about the service provided. The relative of one person added; "Never had occasion to raise any concerns, but when I have rang them [the office] they have been prompt to answer" and "If I didn't feel they were up to the care then I wouldn't let them in."

We looked at the complaints procedure. This outlined the process for responding to and investigating complaints. It gave contact details of people within the service who would deal with any complaints and the timescale for response. It also gave contact details for other organisations that could be contacted if people were not happy with how their complaint had been dealt with. Electronic records were held of any issues brought to the attention of the service and any action taken, where necessary. Records showed that concerns people spoke about during the inspection had been raised with the agency and records showed what action had been taken. This helped to demonstrate issues were taken seriously and people were listened to.

Good

Is the service well-led?

Our findings

The service had a manager who was registered with the Care Quality Commission (CQC). The registered manager was supported by the team leader and three care co-ordinators. The service was also in the process of recruiting a branch nurse, whose role would be to oversee clinical areas and support qualified staff.

We asked people's relatives and healthcare professionals their views about the management and conduct of the service. We received a mixed response regarding the management and coordination of staff supporting those people with complex packages of care. Some people felt that sufficient importance had not always been given ensuring reliable and consistent staffing were provided so that this did not impact on the quality of care provided. However they told us more recently this had improved.

One healthcare professional said managers and staff kept them informed and monthly updates were to be provided regarding those they were involved with. Staff also spoke positively about working for the service. Their comments included; "They [office staff] are very supportive", "Good with clients and staff" and "Really supportive as a team."

We looked at what opportunities were made available for people who used the service and their families to comment on the service provided. In addition to the review meetings we were told that quarterly questionnaires were distributed. Responses were forwarded to the head office, once analysed a summary was sent to the branch office along with any actions required.

We saw that prior to support commencing, people were provided with information about the service. Brochures included specific areas of support such as; children and young people with complex care or care at home. These provided general information about the larger organisation and what people could expect to receive.

We looked at how the management team monitored the quality of the service provided. The service used 'people planner' which enabled them to monitor areas such as staff recruitment and the completion of mandatory training. We were told that co-ordinators were also to complete 'spot checks' of staff to check they were completing the tasks expected of them. Other checks were completed by branch staff with regards to care records being accurate and complete, the recording of medication administration and checks to ensure bed rails and hoisting equipment were in good working order. Any issues identified were raised with individual staff members or referred to relevant professionals so that appropriate action could be taken.

We were also told that the service had previously been providing a considerable number of 'pop in' calls. It had been acknowledged that the service had at times experienced difficulties in staffing these visits and had therefore ceased providing this service. This meant the number of care hours had considerably reduced releasing staff to support other packages of care.

In addition to the office checks the community matron carried out clinical audits of the service and the care service manager had oversight of any complex care issues. They liaised between the CCG (clinical commissioning group), community matron and families to check the service was providing the agreed plan of care. Further auditing and checks were also completed by the chief nurse in relation to clinical governance and the quality manager who had oversight of all areas of the service. Reports were completed and any actions identified were planned for. These were kept under review to ensure that action required had been taken.

All the staff we spoke with were aware of the whistle-blowing procedure (the reporting of unsafe and/or poor practice). Staff we spoke with were confident that any concerns raised would be listened to and dealt with. They also knew they could contact people outside the service. One person told us, "I would feel confident raising any issues and it being dealt with appropriately." We were also told that if staff wanted to raise any issues confidentially they could also contact am independent peer support person who worked outside of the branch. Having a culture of openness where staff feel comfortable in raising concerns helps to keep the young people safe from harm.

Before our inspection we reviewed our records and saw that events such as accidents or incidents which CQC should be made aware of had been notified to us.