Procare Community Services Limited

Procare Office

Inspection report

Church Lane
Haslemere
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

This was the service's first inspection. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- There was a strong continuous improvement and innovative practice.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountability. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However

- Staff were not always initiating the duty of candour process when things went wrong.
- Not all patients knew the processes to follow when they needed to raise a concern or complaint.
- Staff did not always receive regular clinical supervision.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Good	

Summary of findings

Contents

Summary of this inspection

Background to Procare Office

Procare community services is a subsidiary company of Procare Health Limited, the local GP federation for the Guildford & Waverley Care Commissioning Group (CCG) area in Surrey.

We inspected the Procare Office location which is a service provided by Procare Community Service limited.

It is a joint venture between Procare and the Royal Surrey County Hospital (RSCH) which was set up with the aim to help put primary care back at the heart of patient care and to help people maintain their health and independence and prevent unnecessary hospital admission. Procare holds a single contract which is a subcontract from the RSCH. The service was sub-contracted to provide adult community nursing which was part of the community health services for adults directorate.

Procare is running these services to improve the integration between GP, community and hospital services so that they work more closely together.

The service operates 24 hours a day, 365 days a year through teams of registered nurses, district nurses, community matrons, community night nursing, associate practitioners and health care assistants.

The service is run across four Primary Care Networks (PCN) and has four clinical leads/district nurses aligned to each PCN. There are two PCN's in Waverley; the community nursing teams supporting these PCN's are based in Milford Hospital, Cranleigh Hospital and Haslemere Hospital. The Procare registered office is also based in Haslemere hospital. There are two PCN's in Guildford, the community nursing teams supporting these PCN's are based in East Horsley and The Jarvis Centre.

Procare adult community nursing service provides nursing assessment, care, treatment, advice and support to those aged 18 years old and over in their own home setting. Support and care is provided to those who need this in their own homes to manage complex conditions such as mental, physical health and disability that would otherwise make the individual need a hospital admission. The provider works closely with local hospices when End of Life patients are being cared for in their own homes.

The services provided include district, community nursing and they complement the services provided by GP practices, RSCH and other healthcare organisations.

Procare does not provide inpatient beds, therapy services or podiatry services

The local community nursing teams are attached to local GP practices and are led and managed by a qualified district nurse (District Nurses are senior nurses in the United Kingdom's National Health Service who manage care within the community).

The service registered with Care Quality Commission (CQC) in July 2020 and this was the first inspection.

The service is registered to provide the treatment of disease, disorder or injury, and diagnostic and screening procedures. There was a registered manager in post at the time of the inspection.

Summary of this inspection

How we carried out this inspection

Before this inspection visit, we reviewed information we held about the service including information discussed at provider engagement meetings. Due to the service providing services within patients' homes at different location and different times, we announced the inspection 24 hours in advance so that the service could arrange interviews.

A team consisting of two CQC inspectors and a specialist advisor visited the service.

During the inspection, the team:

- Toured the Procare office and a store room at the Procare office in Haselmere
- Observed two home visits
- Reviewed 10 medicines records
- Reviewed five patients' records
- Spoke to seven patients
- Spoke to one family member
- Spoke with one community matron
- Conducted focus group meetings for 6 district nurses, 6 community matrons, 5 health care assistants
- Spoke with the director of operations
- Spoke with one associate nurse practitioner
- Spoke with one Clinical lead for Waverley
- Spoke with the deputy director of nursing
- Spoke with the service development manager-Waverley
- Spoke with Head of Nursing- Procare community services
- Spoke with staff from one partner agency
- Spoke with staff from the Community Coordination Centre
- Observed a locality meeting
- Observed a handover meeting
- Reviewed incidents and safeguarding information
- Reviewed patient complaints.

What people who use the service say

People told us staff treated them well and they feel involved in their care.

People told us staff were adaptable and very flexible.

People told us staff were compassionate, gave them good advice about their care and discussed treatment options with them.

People told us staff listened to them and told the appropriate professional when they requested change of treatment because their problem got worse; they now feel better.

A family member said they were thankful for the district nurses' input with their mother who was given two weeks to live but the input from the district nurses team and other services kept her mother alive and supported her well; everyone has been cheerful and helpful.

Summary of this inspection

People told us staff were competent and the treatment they received from staff was first class.

People told us they were not clear about how to make a complaint about the service if they needed to.

People told us they preferred to have permanent staff they were familiar with to treat them in their homes instead of different agency staff who did not know them very well to be dealing with the sensitive nature of their treatment.

Outstanding practice

We found the following outstanding practice:

- Staff were able to present their quality improvement project ideas at the services 'Innovation Den'. This was set up to allow various teams to present ideas and projects aimed at improving patient safety and experience. Examples of projects initiated as a result of Innovation Den were, the acquisition of a hover jack (a special bed used to move patients on End of Life Care (EOL) care from one bed to the other). The community nursing kit bag, (has coloured segments to store various clinical items; red for blood related items, green for wound care and yellow for catheters, etc). The bag helped the nurses to easily identify and pick items they needed instead of carrying the whole bag to the patient's home and this helped control cross contamination.
- Procare had developed a community nursing team which started as a pilot. Because it was a successful project, it had been commissioned as two substantive posts. Two community nurses attended the ward when a patient was identified for discharge. The nurses assessed the patient and facilitated their discharge. The nurses sometimes supported and taught the patients how to self-administer their insulin therefore the patients didn't require home visits which on other occasions improved the discharge process. For example in July 2022, the community nursing discharge team reduced the length of stay for 30 patients by 1.5 days

Areas for improvement

- The provider should ensure that staff always initiate the duty of candour process when things go wrong.
- Staff should ensure patients are given information about how to complain and are supported to complain or raise concerns should they wish to.
- The provider should ensure that staff have access to regular supervision and should have clear oversight of when staff receive this.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Community health services for adults

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are Community health services for adults safe?

Good

This was the first time we rated this service. We rated safe as good.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Ninety six percent of staff had completed mandatory training; the provider's target was that 90% should have completed it. Staff received face-to-face and online training and completed competency assessments. The mandatory training programme was comprehensive and met the needs of patients and staff.

All nurses, district nurses and matrons had completed their three years validation with the Nursing and Midwifery Council to keep themselves up to date with their competencies and current regulations.

Managers had access to a training compliance dashboard which allowed them to monitor mandatory training compliance and identify and alert staff when updates were due. Staff were encouraged to ensure they complied with training requirements and were given protected time to complete training.

The service had an online system and staff could access all policies and standard operating procedures via this.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse appropriate for their role. All staff providing regulated activities completed safeguarding level one and two. The district nurses completed safeguarding level three training.

Staff kept up to date with their safeguarding training and overall, 96.7% of staff had completed this training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. Staff we spoke to were able to give examples on actions they would take if they experienced harassment and discrimination.

Good

Community health services for adults

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. At the time of inspection, we identified that the service had raised safeguarding with the local authority regarding a patient who was refusing support from staff and was self-neglecting. We saw that a network meeting was scheduled to discuss how to manage the patient to ensure they were safe from avoidable harm.

Staff knew how to make safeguarding referrals and who to inform if they had concerns. Staff we spoke to were able to state how a safeguarding referral was done. The service had a safeguarding team which reviewed Multi-Agency Safeguarding Hub (MASH) forms before they were sent to the local authority. The MASH team make assessment of an adult or a child who is at risk of abuse and decide on what to do to best protect the adult or the child.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.

Staff used infection prevention and control (IPC) measures to protect patients, themselves and others from infection. Staff followed infection control principles including the use of personal protective equipment (PPE), regular hand washing and delivered care, bare below the elbows. While on visits to patient homes, we observed that staff cleaned equipment after each patient contact.

The service carried out regular infection control audits. For example, the most recent infection control audit was a uniform audit which was done to ensure that staff wore the appropriate uniform when they visited patients' homes. The district nurses completed hand hygiene audits to ensure that staff cleaned their hands appropriately in patients' homes.

Ninety five percent of clinical staff and 96.8% for non-clinical staff had completed IPC training.

Staff told us they had enough PPE and there were always enough PPE supplies for them especially during the peak of the COVID-19 pandemic, despite national shortages. For example, district nurses did regular car boot checks to ensure staff had enough PPE in their cars.

Staff were aware of the provider's infection prevention and control policies and could access this via the online system

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

The main office was in an old building, but this was fit for purpose and well maintained. The care regulated by CQC was delivered in the patient's own home and care homes.

Staff completed risk assessments when visiting patients at home, this included lone working, moving and handling to ensure a safe environment for the staff visiting.

All staff we spoke to told us they had access to suitable equipment they needed to safely care for patients. They were aware of the process for escalating faults with the equipment and any faults reported was dealt with in a timely way.

Staff carried out safety checks of specialist equipment. The service had suitable facilities to meet the needs of patients and their families. Staff had access to suitable equipment to help them safely care for patients and could obtain

specialist equipment for patients when they needed to, by ordering these through patients' GP. We looked at the equipment available to the team, including doppler scanner, blood glucose machines, thermometers, pulse oximeter, syringe pumps, blood pressure machine and weighing scales. We found that the equipment was serviced and calibrated appropriately.

We saw that all sterile supplies including single use dressings were stored correctly and packaging was intact. Staff monitored the temperature in the treatment room and temperature readings were clearly logged. There was evidence of good stores and stock management.

Staff managed and disposed of clinical waste safely. Clinical waste was collected by the local council from patients' homes. All staff had sharps bins which they used when they visited the patients in their own homes. Patients with a known need would have their own sharps bin. The sharps bins were sealed once filled and transported in a rigid transport container to the base for disposal. The boxes were signed and dated.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed comprehensive risk assessments for all patients on referral, removed or minimised risks and updated their care plans. Staff identified and quickly acted upon patients at risk of deterioration. Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately to other services such as GP, hospital, mental health services and other services. Staff reviewed these regularly, including after an incident or if their health deteriorated. Staff knew about and dealt with any specific risk issues including risk of falling, sepsis, and pressure ulcers.

Staff shared key information to keep patients safe when handing over their care to other teams. We observed detailed handover meetings between staff which included all key information to ensure patients' needs were met. We observed that staff discussed patients in a dignified way. All district nursing teams had daily telephone handover calls and face to face handover meetings.

Patients considered to be at high risk of pressure ulcers were seen within the policy guidance. District nurses' records showed that nurses assessed risks using recognised tools, such as skin integrity assessments and frailty scores. Staff photographed patients' wounds and shared the pictures with the team in handover and with the tissue viability team and GP to help track how pressure ulcers were healing.

The service had a lone worker policy and had clear guidelines to support staff who were lone working. Staff entering patients' homes carried smart phones, tablets and had access to out of hours support or emergency help if necessary. Staff who needed urgent assistance whilst on visit could ring the emergency Community Co-ordination Centre (CCC) number and use a code word to alert the CCC staff they needed help. The CCC staff monitored the systems and ensured that staff had checked out at the end of their shift. Staff used emails via Electronic management Information System (EMIS) to check in and out at the district nurses' hub when staff had safely completed their visits. Where there were potential risks, such as high risk of aggression staff visited in pairs.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff to keep patients safe.

Good

Community health services for adults

We reviewed the nursing and support staff vacancies. The service did not have vacancies for district nurses and nurses because the provider had taken steps to recruit nurses to fill the vacant gaps.

The provider told us they had an agreement with their local university where nurses already employed by Procare enrolled with the university to train to become district nurses. Following completion of their studies they came back to work for Procare. For example, Procare recently trained seven district nurses and four pre-registered nurses in consolidated practice who would be starting work as district nurses and community nurses respectively from September 2022. This process helped the provider to fill most of the nursing vacancies they had.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. Procare is part of the first wave of community nursing teams across England to adopt the safer staffing tool for community nursing which is due to be rolled out.

The service had a low vacancy rate at the time of inspection because management focussed on recruitment and retention and reduced the number of staff vacancies. However, despite a positive recruitment campaign for their community nursing team, the provider continued to have some vacancies within their community matron team and night service. Two of their recent appointees had withdrawn which resulted in having two vacancies within the community and district nursing teams.

All staff leaving the service were offered exit interviews, the main themes identified were retirement, career progression or moving out of area. The provider has improved their staff retention over the year by developing a recruitment and retention strategy. The provider learned from the feedback they received and changed the management style and structure, which helped to reduce the turnover rate from 20% to 3% within one year. For example, the community matrons told us they were proud of how they worked together and engaged in the frontline role as district nurses. They worked part clinical and part managerial and believe it was the right thing to do which helped improve staff availability and retention.

The service had low and/or reducing turnover rates. The overall turnover rate was 3% for the past year.

The service had high sickness rates. The overall sickness rate was 5.71% for the past one year.

The service had low and/or reducing rates of bank and agency nurses.

Managers made sure all bank and agency staff had full induction and understood the service. Managers ensured that all agency compliance forms were completed, and the agency provided evidence of training to the provider. All agency staff were put on two shadow shifts, completed Procare medicines management training and EMIS training before they started working with patients. Managers monitored agency staff to ensure they were competent, and managers assessed their competencies. The service used agency staff to provide support when needed. However, the manager told us the provider had taken a decision to reduce the use of agency staff from September 2022.

The manager told us they were able to adjust staffing levels daily according to the needs of the patients. For example, the provider worked collaboratively with a local hospice which provided them with nursing staff when they found it difficult to find cover for shifts during the COVID-19 period.

Staffing risks were discussed during quality review and managers meetings. Managers updated the service risk register and indicated registered nurses' vacancies as their main risk.

Good

Community health services for adults

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could easily access them.

District nurses completed care plans for each patient according to their needs. All staff had access to the patients' electronic record when they visited the patients. All medication administration charts were left in the patients' home and once completed they were uploaded onto the electronic patient record. To ensure clear communication with the patients, carers and other agencies there was a communication sheet left with the patient. Care plans were comprehensive and easily accessible.

When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely on the EMIS which was password protected and all staff accessed the records using their password.

All care records we reviewed were completed to a high standard. They were accurate, holistic and contained detailed information about visits/appointments, physical health checks, plans for dietary needs, health promotion, and support with self-management of conditions.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines. Most medicines were prescribed by patient's GP and stored in their own homes. Medicines charts were stored in patients' homes and a copy was uploaded onto EMIS.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Review of medicines records showed clear review processes were in place, they were up to date and held appropriate information. For example, we reviewed 10 medicines records and saw that staff followed the correct procedure and practices for prescribing and administering medicines. Medicines records were accurate and kept up to date.

Staff stored and managed all medicines and prescribing documents safely. There were protocols in place regarding storage and management of medicines at the service. For example, we found that patients had locked safe boxes in their homes where their medicines were stored including controlled drugs.

Staff followed national practice to check patients had the correct medicine when they moved between services. The electronic recording and reporting systems allowed access to GP records, ensuring that the most up to date and accurate information was available. National guidance for medicines management was followed.

Staff received safety alerts from the local NHS Trust. Staff learned from safety alerts and incidents to improve practice. These safety alerts were reviewed at clinical governance meetings and disseminated to the community teams.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicine on their physical health according to NICE guidance. The protocol ensured staff documented any side effects or allergic reactions in patients' records. Other aspects of patient's physical health were only dealt with if deemed necessary at the time of a visit or if a call was received that indicated possible health problems, at which point the GP or emergency services were called.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff recognised and reported incidents and near misses appropriately using the organisation's online incident reporting system and in line with the provider's policy.We reviewed incidents and the top three incidents reported consistently were pressure ulcers, safeguarding and medicines.

Clinical leads discussed the necessary corrective and preventative actions following investigation of incidents in monthly clinical governance meetings. These actions were discussed with staff during monthly leadership meetings, locality meetings, patient safety meetings, monthly and daily handover meetings and daily huddles. There were clear actions from meetings and managers had a tracker in place to ensure actions were followed through.

Managers took part in serious incident investigations and made changes based on the outcomes. Managers and clinical leads were trained to undertake investigations. For example, staff told us clinical leads took special interest in dealing with Root Cause Analysis (RCA) to understand the root cause of incidents and used the themes from RCA for example pressure ulcers to develop quality improvement projects.

Managers shared learning from incidents through learning bulletins sent out to staff each month. Recent learning from incidents included how to document incidents appropriately, photographing wounds to share with appropriate professionals and ensuring early onward referral of patients to the appropriate teams. Staff received feedback from incident investigations via email.

The most commonly reported incidents were pressure ulcers, and staff were clear about which of these needed to be reported. When an incident report was completed regarding a pressure ulcer the severity was graded and tissue viability nurses and managers were contacted to look at the incident.

We reviewed incident reports across the district nursing teams and saw evidence of shared learning and changes made to ensure the improvements. For example, following an incident regarding a leg ulcer, the service simplified the wound care audit which was completed monthly and reviewed after three months.

It had been recognised from the root cause analysis presented at the patient safety panel that staff had not always initiated the duty of candour. As this was identified as a theme, a quality improvement project was initiated, and a programme of support and training was put in place for staff to understand that it is okay to say 'sorry'. When an incident had caused moderate harm or above for example, a category 3 pressure ulcer, this then triggered the statutory duty of candour which was followed by staff. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Patients and their families were involved in the investigation of incidents. Managers and clinical leads supported staff after any serious incident and staff accessed debriefs after significant incidents including expected deaths.

Good

Community health services for adults

Are Community health services for adults effective?

Good

This was the first time we rated this service. We rated effective as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

The provider had processes in place to ensure protected characteristics under the Equality Act 2010 was considered when making care and treatment decisions**.** For example, the provider ensured that staff developed care plans which were tailored to patients' needs.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All staff could access policies on the provider's intranet.

The organisation gave staff tablets and laptop computers to enhance the delivery of effective care as staff were able to input records in patient's homes and check on the most up to date patient records and clinical tests.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff were aware of patients' specialist nutrition and hydration needs. The staff encouraged the patients with their nutrition and hydration during visits.

Staff may ask the patient or carer to complete nutrition and hydration charts as part of their ongoing care. Staff used the malnutrition universal screening tool (MUST) a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a nationally recognised tool (Pain Score) and gave pain relief in line with individual needs and best practice. Patients told us they received pain relief soon after requesting it.

Staff administered and recorded pain relief accurately.

Some patients had access to syringe drivers for symptom control, specifically when patients were coming towards the end of life. Staff told us they visited patients who were on syringe drivers daily. Pain relief was administered and recorded accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff participated in relevant national clinical audits and repeated audits to check improvement over time. For example, senior managers did lots of benchmarking against national standards.

Managers ensured staff understood information from the audits and this was shared in local team meetings and on the staff intranet.

Managers used the results to improve care and treatment and patient outcomes. For example, a clinical audit completed recently by the manager identified that the clinical team did not routinely complete baseline observations on patients during their initial visit. The manager shared the findings and lessons learned with the teams. As part of the improvement plan, the managers ensured that the district nurses supported the teams to carry out the baseline observations for patients during their first visit. Staff improved their performance on their ability to carry out baseline observations for patients on their first visit as a result of the training they received.

District nurses carried out wound care audits to ensure that wounds were being recorded on their wound care assessment sheets. The nurses updated the care plans regularly to ensure that wounds were healing.

The anticipatory care matrons collected qualitative measures to see if the patient felt they had an improvement in their ability to function independently. This was measured at the beginning and end of their episode of care. The results were encouraging.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff and agency staff full induction tailored to their role when they started work and supported staff to develop through yearly, constructive appraisals of their work. Information provided by the provider showed that appraisals were happening regularly and in line with the organisation's policy. For example, 93% of staff had received appraisals in 2021.

Managers supported and offered staff training to develop in their roles through constructive clinical supervision of their work. For example, the professional nurse advocates provided training and restorative supervision to the district nurses.

Staff told us they received standard individual or group clinical supervision from the clinical leads.

However, clinical supervision audits identified that supervision had slipped a bit and staff did not always receive regular supervision.

The clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us managers discussed their training needs with them during their supervision.

Staff reported feeling well supported in their roles and discussed their training needs with their line managers who supported them with their development and clinical practice.

Staff spoke positively about learning and development opportunities within the provider organisation. Staff we spoke to were very complementary of the provider and praised the provider for the level of training and specific clinical training outside of the organisation that would help improve and advance their clinical skills.

Managers made sure staff received any specialist training for their role. The provider had a clear pathway for nurses to progress from band three to band 8A and for associate matrons to become advanced care practitioners. For example, at the time of inspection, a band three nurse was going through the registered nurse apprentice programme to join the team as a Band 5 nurse after completion with clear onward route for progression following this

The provider had a sponsorship programme to train nurses at the local university to become district nurses and work for Procare when they completed their training. For example, seven district nurses who had completed their training with the university would be starting work in September as well as four student nurses. There were 84 students who would experience community nursing as part of the provider's rotation programme next year. If the provider had vacancies, when the nurses completed their training, the provider would consider their application for a role in the community nursing team. Managers identified poor staff performance promptly and supported staff to improve. For example, staff members who made medicine errors were taken through a development process and would repeat their medicines competency training to improve their knowledge in medicines administration.

Managers made sure staff attended team meetings or had access to minutes when they could not attend.

Staff in all the teams felt able to raise any concerns or questions they had with the team leaders. Less experienced staff were supported to develop their skills, and staff said they were never asked to perform interventions that were beyond their limit of competence.

Multidisciplinary working

Staff and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other relevant agencies outside the organisation.

The district nurses described effective multidisciplinary and integrated team working. Procare hadtwo district nurses that worked with the CCC and urgent response teams to take and triage referrals. The district nurses referred patients to other specialist teams as needed and vice versa. Some of the specialist teams were physiotherapy, podiatry, occupational therapy (OT), crisis response, discharge to assess and hospital discharge teams with palliative care. Staff sometimes carried out joint visits to patients' homes. For example, during our inspection, we saw evidence of joint working with tissue viability clinics where patients received support for leg ulcers or wound management and a diabetic patient with pressure ulcer could be referred to the podiatry team or crisis response team.

Good

Community health services for adults

Staff held regular effective weekly multidisciplinary meetings to discuss patients and improve their care. These meetings had a structured agenda and minutes were recorded and uploaded on to the electronic record system. For example, the head of CCC met the head of nursing from Procare each month to have discussions to improve patient care.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service provided relevant information and encouraged patients to live healthier lifestyles. The service took steps to involve patients and carers in monitoring their own health and implemented procedures to enable them to manage their health and wellbeing and to maximise their independence. For example, staff developed personalised care plans with patients who wanted to lead healthier lifestyles. Staff were proactive in encouraging patients to make healthy lifestyle choices. However, staff could only give advice to the patients during their visit to the patient's home. Staff offered support and onward referral where appropriate and if the patient wanted this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff supported patients to make informed decisions about their care and treatment. Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Patients consented to treatment based on all the information available. When patients could not give consent, staff made decisions in their best interests, and they considered the patient's wishes, culture and traditions, and recorded this in the electronic record. The district nursing teams would also seek the support of the mental health team for guidance in these cases.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff involved the Multidisciplinary Team (MDT) and made decisions in their best interest, considering patients' wishes, culture and traditions. Staff clearly recorded consent in the patients' records.

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act training was not a statutory training requirement within this service but was covered as part of safeguarding training and the compliance rate was 96% across the community teams.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are Community health services for adults caring?

Good

This was the first time we rated this service. We rated caring as good.

Good

Community health services for adults

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff treated patients with compassion and kindness and were passionate about delivering care to patients. Staff were discreet and responsive when caring for patients, respecting their privacy and dignity. We observed home visits where district nurses spoke kindly and respectfully to patients. We spoke with seven patients following the inspection and they were very positive and complimentary about the staff and care they received.

Staff took time to interact with patients and their family in a respectful and considerate way. For example, patients we spoke with said they appreciated the care they received from the district nurses and the healthcare assistants because they had good treatment results for their leg ulcers and other ailments.

Patients said staff treated them well and with kindness and staff supported them to address their individual needs.

Staff followed provider policies to keep patients' care and treatment confidential. All patients were seen privately in their own homes. Staff told us they were very particular about the privacy and dignity of the patients they supported and would only speak about patients' care to carers and family members if patients gave consent. Patients' care records were stored manually in the patients' homes and documents were scanned onto electronic records in the Procare office. We saw that staff had completed Information Governance and Data Security training which confirmed that staff were aware of the importance of keeping information about patients confidential.

At handover meetings, staff discussed the psychological and emotional needs of patients, their relatives and carers. Carers assessments were completed when required. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they relate to their care needs. For example, staff respected the religious and cultural beliefs of a patient who was on palliative/ End of Life Care (EOL) care and ensured their religious and cultural needs were met. Staff offered regular daytime and evening slots to patients, or they were flexible and adaptable depending on the needs of the patients or commitments of registered nurses and the district nurses. For example, one patient told us they requested additional visits in the mornings if necessary and the service sent out staff to visit them same day. However, one patient told us sometimes their treatment was provided by agency staff who did not know them well and therefore were not familiar with their treatment. They preferred to be treated by permanent staff who had visited them for a while, knew them well and understood their treatment better.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients emotional support and advice when they needed it. For example, people we spoke with told us staff were non-judgmental, were very approachable and were good listeners. Staff we spoke with told us they provided emotional support and advice to patients when they were distressed. Patients said staff recognised that ailments could be painful, and they were sympathetic and thoughtful.

Good

Community health services for adults

Staff undertook training in breaking bad news and demonstrated empathy when having difficult conversations. Patients told us staff demonstrated empathy when having difficult conversations with them

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients confirmed that staff referred them to other agencies when required. For example, one patient told us when their ailment became worse, the district nurses referred them to other professionals who listened to them and gave them further treatment which made them feel much better.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients understood their care and treatment. Staff explained the treatment progress and changes to their treatment to the patients. Patients told us they were kept up to date with their treatment.

Staff communicated with patients, families and carers in a way they could understand, using communication aids where necessary. For example, we saw evidence that a patient who had a sight impairment and therefore preferred to communicate verbally had their choice and preference met using verbal information. Staff supported the patients to give informed consent about their care during their initial assessment and during subsequent visits. We saw evidence regarding discussions about their impairment and personal choices.

Patients and families could give feedback on the service and their treatment and staff supported them to do this. Staff regularly asked patients for feedback which they entered on their iPad. Patients gave positive feedback about the service. Staff also left leaflets for patients and families to complete and staff collected them later.The provider had re-introduced the friends and family test from April 2022. In July 2022 they received 101 responses. 79 people said the care they received was very good, 18 people said the care was good and four people said the care was neither good nor bad.

Staff supported patients to make advanced and informed decisions about their care.

Are Community health services for adults responsive?

Good

This was the first time we rated this service. We rated responsive as good.

Planning and delivering services which meets people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population

Good

Community health services for adults

The community nursing teams worked closely with the urgent community response team which is part of the adult community services division of the Royal Surrey Foundation Trust. Their aim was to meet the needs of the local people and focused on improving the efficiency and quality of patient pathways by bringing existing services together. The CCC team was made up of a group of staff from different community teams including two district nurses from Procare who received referrals from a range of sources including GP, acute settings and social care.

The CCC worked with other organisations to quickly respond to changing service pressures such as hospital admission avoidance.

While the service did not have a separate End of Life Care (EOL) service, the service had a very good relationship with a nearby hospice. Staff we spoke with had good understanding of how to care for a dying person and explained how they would meet the physical comfort, mental, emotional and spiritual needs of the patient. We saw completed Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. All ReSPECT forms we saw involved the patient and their families.

The CCC staff checked and ensured that all patients had been seen as scheduled. Staff told us the team for Waverley received approximately 15-20 referrals per day.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Patient's individual needs were recorded within their electronic care records. Records were person centred and holistic and included patients' wishes when appropriate.

Patients were seen in their own homes and staff were flexible with appointment times to meet patient preferences. Patients told us staff were flexible and adaptable.

The service had access to a translator service if required. For example, the provider had access to language line (Language translation service agency that provides a wide range of interpreting, translation and localisation agency services). Staff talked with patients, families and carers in a way they could understand, using communication aids and made reasonable adjustments where necessary. Staff completed training in equality, diversity and inclusion and had a good understanding of this.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Most patients' referrals were received through the CCC which allocated referrals to the appropriate teams. The CCC managed all referrals on Electronic management Information System (EMIS). The CCC had a web-based system for all phone calls where patients could make contact directly with community nurses (CN) and during emergencies. Some referrals were received through calls, GP made referrals through EMIS and some referrals were received through emails. The system allowed the community nurses to view the patients' GP record to determine if the patient required a same day urgent visit. The team triaged the referrals and chased any missing information. The team decided on the most appropriate team to see the patient especially if a patient presented with an urgent clinical health need which could lead to further deterioration in their needs or left them at risk of admission to hospital.

Good

Community health services for adults

Patients identified as being at highest risk were prioritised for visits that day.

The on call clinical lead covered the CCC during weekends and bank holidays to ensure continuity of care.

The urgent response team took patients from district nurses to free up their time or were asked to shadow visits to improve their skill set.

All referred patients received a holistic assessment of their specific health needs and they created an individualised mutually agreed treatment care plan where needed.

Learning from complaints and concerns

It was not very easy for people to give feedback and raise concerns about care received even though the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Not all patients knew how to complain and didn't feel confident to raise concerns if they needed to. For example, two patients told us they did not know how to complain and did not have access to leaflets which directed them to who to complain to if they needed to complain. Staff told us most patients did not like using Patient Advice and Liaison Service (PALS) even though staff put leaflets which signposted patients to how to make complaints to PALS in the patients' homes. Staff told us patients told them they preferred to speak to someone directly to get their complaints resolved instead of using PALS.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

We saw that complaints were a standing agenda item during team meetings and were routinely discussed with clinical leads and the nursing team in monthly leadership meetings and through quarterly clinical governance meetings. The service investigated identified trends and themes in relation to concerns and took action to resolve these.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Are Community health services for adults well-led?

Good

This was the first time we rated this service. We rated well-led as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Good

Community health services for adults

Staff told us they could approach senior leaders at any time to raise concerns or receive support. Mangers supported staff to develop their skills and take on more senior roles**.**

Senior managers got involved during the periods of short staffing during the pandemic and supported the team to continue to deliver care.

Feedback received from staff was positive about the support and guidance they received from the leadership team.

The leadership team supported staff member's professional development. We were able to meet with nurses who were being supported in their training to develop into the band six district nurse role. Staff felt leaders supported their career development.

Senior managers we spoke with developed staff internally and supported an initiative to support the recruitment and retention of staff including registered nurses. The organisation had links with local universities to provide associate nurse apprenticeships. The organisation had members of staff in the process of completing the district nurse additional training.

The manager told us they felt supported by their manager and was aligned with a professional coach that supported in their role.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. For example, the main strategy for the provider was workforce recruitment and retention strategy and this was discussed at governance meetings?

Staff understood and worked within the vision and values of the service. These were aligned to job role descriptions.

Culture

Staff we spoke to felt respected, supported and valued. They were focused on the needs of patients receiving care.

The service had an open culture where people using the service and staff could raise concerns without fear.

The service promoted equality and diversity in daily work and provided opportunities for career development. Staff told us they felt "proud" to work for the service and had opportunities for progression. For example, one member of staff told us the provider gave them a chance to progress form an associate nurse practitioner to become a qualified nurse.

Managers ensured there were enough staff who responded to patient contact, provided support and guidance or responded to any concerns raised.

Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian (FTSuG). Staff followed the provider's speak up policy. Staff confirmed they were aware of how to contact the FTSuG and how to access the service. For example, one issue raised with the FTSuG related to increase in fuel cost and its impact on staff and delivery of care.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountability and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a defined governance structure to ensure quality and compliance in clinical community services and across the wider business. Our findings from the other key questions demonstrated that most governance processes operated effectively at team level, that risk was managed well, and managers had systems in place to adequately monitor staff performance.

Staff at all levels were clear about their roles and accountability and told us they had opportunities to meet with their manager to discuss and learn from the performance of the service. For example, the manager told us the leadership structure within the organisation had enabled the district nurses to have senior oversight over the other nursing staff.

Managers had robust governance processes to track staff in their use of infection prevention and control measures, Managers told us they were assured that staff who were engaged in field visits were delivering safe care to patients.

The service improved service quality and safeguarded high standards of care with quarterly clinical governance meetings chaired by the clinical leads.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had the following on their risk register; high petrol prices impacting community nursing service, reduced staff in the CCC resulting in high number of urgent referrals being missed or delayed leading to deterioration, dopplers not being completed as SIGN (Scottish Intercollegiate Guideline Network) guidelines required, demand exceeded community nurse capacity, and Disclosure and Barring Service (DBS) checks for existing staff not being renewed in line with policy.

Managers reviewed their corporate and clinical risk registers weekly and updated progress and associated actions. The risk register included an action plan to increase recruitment and ensure the service continued to have the capacity of staff employed with specialist skills to safely deliver the treatments offered, to ensure that staff were supported with means of commuting to work, district nurses provided training for the teams to complete dopplers in line with SIGN guidelines and the managers were working with the Royal Surrey who managed the services Human Resources to ensure DBS were renewed for all staff. The manager was following up on 12 outstanding DBS checks with the Royal Surrey at the time of inspection.

The service had a business continuity plan to deal with emergencies. For example, they had plans to deal with emergencies such as adverse weather conditions and flu outbreaks. The service had an effective contingency plan during the COVID-19 pandemic and adjustments were made to the operation of the service as a result. For example, we saw procedures had been put in place for staff to wear face coverings while walking in the corridors of the office premises.

Information Management

Staff collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Data or notifications were consistently submitted to external organisations as required.

The provider had an intranet and document sharing platform which provided a central point for access to policies, incident reporting and other support services and platforms. This was also used as a central information sharing platform where staff received weekly newsletters and manager cascades on their phone and iPad.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Leaders and staff actively and openly engaged with patients and staff. The service had established links with local commissioning groups, the community, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. For example, the provider engaged in two daily calls with their local hospice.

The service held regular team meetings which demonstrated that line managers updated their staff with information such as but not limited to, service updates, incidents, audits and outcomes, compliments and complaints and lessons learned. For example, the manager told us they attended monthly clinical governance meetings to have wider learning. They also attended patient safety panel meetings which was chaired by the head of nursing. An external person from the Integrated Care board (ICB) was always present at the meetings to challenge processes where necessary. Staff told us that they were happy with the amount of communication received from the senior leadership team about changes within the organisation and knew where to access additional information if needed.

The service had undertaken a staff satisfaction survey in 2021 and the results showed that staff felt supported and engaged in their role and the provider had a positive and an open culture. However, staff felt overwhelmed with workload. The provider relaunched their Friends and Family Test (FFT) and linked it to Healthwatch. The provider centrally collated feedback from patients and families and the 2021 results showed that patients and families were happy with the support and care they received.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Good

Community health services for adults

The service was committed to improving services by learning from when things went well and wrong and promoting training. All staff were given opportunities to feedback ideas for improvement and their ideas were taken forward to management. For example, the provider used Innovation Den which was for teams to present ideas to management about quality improvement projects to improve patients care. Some of the projects that the Innovation Den supported were, hover jack bed (A special bed to move patients on EOL care from one bed to the other), community nursing kit bag (has coloured segments to store various clinical items; red for blood related items, green for wound care and yellow for catheters, etc). The bag helped the nurses to easily identify and pick items they needed instead of carrying the whole bag to the patient's home and this helped control cross contamination.

The provider had developed a community team and commissioned two substantive posts where nurses assessed patients and facilitated their discharge. Nurses taught the patients how to administer their insulin and therefore the patients did not require home visits which had helped reduce the length of stay in hospital for 30 patients by 1.5 days.

Managers noticed through the process of reviewing incident reports that staff were not adequately describing wounds, so the clinical lead created a wound care document to act as a quick reference guide or refresher course for new starters. This document was rolled out to all staff and uploaded onto their computer tablets.

The provider had four clinical leads who had completed the Professional Nurse Advocate (PNA) accredited programme which is driven by the NHS and had therefore become an accredited PNA. The PNA's role is to facilitate Restorative Clinical Supervision (RCS) with the aim to offer staff a safe environment to process experiences, reflect constructively, study options and increase level of resilience. For example, one PNA told us she led and supported the nurses in practice and encouraged the nursing teams to lead on quality improvement which in turn helped improve patient care.