Newcross Healthcare Solutions Limited

Newcross Healthcare Solutions Limited (Bournemouth)

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

This was a routine comprehensive inspection, and was our first inspection of the service under its current registration. We gave the service two days' notice of the site visit, as the registered manager needed to obtain people's consent to us making home visits. We also needed to be sure the registered manager and other staff we needed to speak with would be available. We visited the office on 3, 4 and 9 May 2018, and visited someone at home on 9 May 2018.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older and younger disabled adults, and to children and young people.

Not everyone using Newcross Healthcare Solutions Limited (Bournemouth) receives regulated activity. CQC only inspects the service being received by people provided with 'personal care': help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection, the service was providing personal care to 11 people.

The service had a registered manager, who had worked for the service for several years, under its current and previous registrations. 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.

There were good links with health and social care services. These enabled people to stay at home rather than being admitted to a nursing home, or to be discharged from hospital sooner than they would otherwise have been.

The service's lead nurses had current expertise in their specialist areas.

People were treated with kindness and compassion, and their privacy and dignity was respected. Staff got to know people well and had a good understanding of the care and support they needed.

People were supported to express their views and be involved in decisions about their care. Their views were taken seriously. There was ongoing discussion between people, their relatives and the service to make sure people's care was centred on their needs and preferences.

Assessments and care plans flagged any sensory loss or communication needs.

Where the service was responsible, staff supported people to follow their interests, access the community, and develop and maintain relationships with people who mattered to them.

Consent to care and treatment was sought in line with legislation and guidance, including the Mental Capacity Act 2005 where this applied.

Risks to people were assessed and managed with the least possible restriction.

Medicines were managed safely.

People were protected through the prevention and control of infection.

People were supported to eat and drink enough to maintain a balanced diet. Where people had food and drink through tubes inserted into their abdomen, staff managed this competently, following clear directions in people's care plans.

Staff worked sensitively with people, their families, staff and health and social care professionals, to plan for end of life care.

There were sufficient care staff with the skills and experience to provide the care people needed. Only staff with the correct skills and competencies worked with people who had particular needs, such as tracheostomy care.

Staff morale was good. Staff had a clear understanding of their roles and responsibilities, and those of their colleagues. They were treated fairly and with respect, experiencing no discrimination in relation to protected characteristics such as sex, race, disability and sexual orientation.
The registered manager worked closely with the office team and maintained an overview of the atmosphere and culture in the service.

Staff said they found the registered manager approachable and that they were well supported.
They had the training, supervision and appraisal they needed to deliver effective care and support.

Staff understood their responsibilities in relation to safeguarding people and knew what they should do if they had concerns about abuse or neglect.

Lessons were learned and improvements made when things went wrong.

There was a system for receiving complaints and ensuring these were addressed promptly and thoroughly. We have made a recommendation regarding clarification within the provider's complaints policy, of CQC and other agencies' roles for managing complaints.

There were rigorous pre-employment checks before new staff were allowed to start work, in line with the provider's recruitment procedures. However, the provider's application form asked for an employment history covering only the last 10 years, rather than a full employment history. We have made a recommendation about revising the application form so it meets the regulations.

People's personal information was treated confidentially. The provider had been accredited for meeting internationally recognised standards in relation to data security and protection.

Systems operated to maintain and improve the quality of the service. These included gathering people's views of the service through ongoing discussions, and meetings for staff to provide updates and hear their views. There were regular spot checks and audits within the service and by the provider's clinical

governance team. We have made a recommendation regarding how audits feed into an action plan to drive improvements.

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.

There were enough staff with the required skills to provide the care people needed.

Medicines were managed safely.

Risks were assessed and managed. Lessons were learned from accidents and incidents.

Is the service effective?

Good

The service was effective.

Staff worked collaboratively across services to understand and meet people's needs.

People experienced positive outcomes regarding their health and wellbeing. Anything that could affect health and wellbeing was identified and acted upon.

Staff were supported through training, supervision and appraisal to provide effective care and support.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect. Their dignity and independence were upheld.

People and their relatives were involved in decisions and their views were taken seriously.

People had a regular team of staff who knew them well.

Is the service responsive?

Good

The service was responsive.

People received holistic, individualised care. Care plans were comprehensive and addressed people's needs.

People were encouraged to pursue interests and keep in contact with people who mattered to them.

People and their relatives were supported to make decisions about end-of-life care

Is the service well-led?

Good

The service was well led.

There was a positive, person-centred, open and inclusive culture. Managers and staff promoted equality, diversity and human rights, and prioritised safe, high-quality, compassionate care.

The registered manager and senior staff were available, consistent and led by example.

Staff communicated well with each other and with people and their relatives. They had a good understanding of each other's roles.

Newcross Healthcare Solutions Limited (Bournemouth)

Detailed findings

Background to this inspection

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

This was a routine comprehensive inspection. We gave the service two days' notice of the site visit, as the registered manager needed to obtain people's consent to us making home visits. We also needed to be sure the registered manager and other staff we needed to speak with would be available. The inspection was undertaken by an adult social care inspector.

Inspection site visit activity started on 3 May 2018 and ended on 9 May 2018. It included visiting a person and a relative in their own home and speaking with a person who came to the office. We visited the office location on 3, 4 and 9 May 2018 to meet the registered manager, office staff and care staff, and to review care records and policies and procedures. We spoke with two care workers, two registered nurses, six other office staff, and the registered manager. We reviewed: five people's care records; six staff recruitment, training and supervision records; and other records relating to the management of the service, such as accident and incident records.

Before the inspection we reviewed the information we held about the service. This included incidents they had notified us about and a Provider Information Return. A Provider Information Return is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also obtained feedback from three professionals who had contact with the service.

Good

Is the service safe?

Our findings

People and their relatives told us they trusted the staff who worked with them. A relative commented that it had taken time to build this trust owing to their family member's complex needs and past history with previous services. Staff understood their responsibilities in relation to safeguarding people and knew what they should do if they had concerns about abuse or neglect. The registered manager had attended training provided by local statutory services in relation to manager's responsibilities for safeguarding adults. Information about whistleblowing and referring safeguarding concerns was displayed in the office.

The provider's recruitment procedures included rigorous pre-employment checks before new staff were allowed to start work. The service recruited only staff who were experienced in care work. Checks were made with the Disclosure and Barring Service to establish whether candidates had a criminal record or were barred from working in a care setting. References were obtained from previous employers, including seeking the reason why staff had left their employment. However, the provider's application form asked for an employment history covering only the last 10 years, rather than a full employment history. We drew this to the registered manager's attention during the inspection. They referred this to their human resources and recruitment teams.

We recommend the provider revises their application form for staff who work in their regulated services, to require a full employment history as required by Schedule 3 to The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient care staff employed to provide the care people needed. A person told us they liked their staff, and their care records reflected a regular team. Other people's care records also reflected a consistent staff team. A relative said staff always turned up on time. The registered manager, coordinators responsible for organising rotas and staff who oversaw care packages confirmed there were enough staff to cover people's care. Plans were made to cover contingencies such as extreme weather; people had continued to receive the care they needed during snow and ice earlier in the spring. On occasions where gaps in rotas could not be covered by the service's staff, the service used agency staff from the provider's employment business who had the necessary competencies.

There was a central out-of-hours on call service for people who used the service, their relatives and staff, to contact for advice and support or in emergencies. Staff and people we spoke with all confirmed they had received the support they needed if they had used this.

There were arrangements to ensure that only staff with the correct skills and competencies worked with people who required these. For example, feeding tubes (known as PEG tubes) inserted directly into the abdomen require skilled care that would traditionally have been delivered by registered nurses. The service employed registered nurses who delegated these tasks to care staff with the appropriate skills and training, having assessed that they were competent to perform them. A relative told us staff never performed these tasks unless they had the required competencies. The provider's computer database did not allow staff to be allocated to care packages if they did not have the right competencies, or their training or competency

checks were out of date. This included annual checks of competence in handling medicines.

Risks to people were assessed and managed with the least possible restriction. People's individual risks were assessed and addressed in care plans. These were particular to the person and included issues such as moving and handling, choking, vulnerability to pressure sores and the use of bedrails. These were reviewed at least monthly, or more often if there were changes in someone's situation. There were also environmental risk assessments for each person, identifying potential hazards for people and staff, such as household pets, visitors to the household and potential fire risks.

Medicines were managed safely. With the provider's support, the service had overhauled its medicines management. The provider's clinical governance team checked medicines administration records (MAR) to verify they had been written correctly. This included amendments when prescriptions changed part way through the month, for example, if someone started a course of antibiotics. There were clear instructions for the administration of as required and topical medicines, such as skin creams. Where the format of a medicine was altered, such as crushing a tablet, a pharmacist was consulted to ensure this was safe. There was an isolated incident where one person had a skin cream prescribed towards the end of their medicines cycle, but it was not recorded on their MAR. The registered manager investigated this when we drew it to their attention and arranged for it to be corrected.

People were protected by the prevention and control of infection. Staff received training in infection prevention and control. We observed staff washing their hands correctly and using personal protective equipment such as disposable gloves. Staff confirmed personal protective equipment was always available when they needed it.

Lessons were learned and improvements made when things went wrong. Staff reported accidents and incidents to the office, where they were logged on the provider's computer system. The system allocated severity ratings and the branch management team reviewed each incident to ensure appropriate action had been taken. For example, for medicines errors action was taken according to the level of severity, from reflection through to disciplinary action. The system allocated a score to the staff involved, which affected the risk rating and action taken after subsequent medicines errors within the year. There was additional oversight by provider's clinical governance team to establish any developing trends.

Good

Is the service effective?

Our findings

There were good links with health and social care services. These enabled people to stay at home rather than being admitted to a nursing home, or to be discharged from hospital sooner than they would otherwise have been. The service's lead nurses had previously worked in hospitals involved in people's care. This helped them identify the professionals they needed to liaise with regarding people's care. For example, a lead nurse had convened a multidisciplinary meeting that had resulted in the person's GP and other professionals agreeing actions to improve the whole family's experience. The lead nurses had already known some people before they came to use the service, and so had a particular understanding of the complexities of their care. Care workers worked alongside hospital staff when people were still in hospital, under the supervision of the lead nurses, to ensure care could be provided immediately the person was discharged. During this time the lead nurses assessed staff as competent in providing aspects of care, such as tracheostomy care. As a result, a child who had spent their whole life in hospital was able to be discharged sooner than would otherwise have been the case.

The service's lead nurses had current expertise in their specialist areas of paediatric palliative care and gastrostomy (tube) feeding. They drew on this to deliver training to staff in relation to people's particular needs, and to assess staff competence. A relative said they valued the care workers always informing them of any concerns or changes so they could contact the doctor or other health professionals for their family member.

The service liaised with other services to ensure people received the care they wanted and needed, in a safe way. For example, staff had seen how someone enjoyed and benefited from using a hot tub but had not been able to assist them with this, because professionals had deemed it unsafe. The service explained to the person's professionals what staff had observed. The professionals had recognised the benefits for the person and had undertaken a risk assessment, which meant Newcross staff were now able to support the person to do something they enjoyed and that contributed to their sense of wellbeing.

Care was assessed and planned with the involvement of people and their relatives. Assessments and care plans were comprehensive and person-centred. They were regularly reviewed in consultation with people and their families. There was ongoing discussion between people, their relatives and the service to make sure people's care was centred on their needs and preferences.

The service supported staff through training, supervision and appraisal, to deliver effective care and support. All of the staff we spoke with told us they felt well supported in their work, received regular supervision and were encouraged to undertake the training they needed. The provider supported its nurses to maintain their registration with the Nursing and Midwifery Council, through meeting the training requirements and arranging for the necessary reflective discussions. Key training for all staff was undertaken at induction and updated at intervals thereafter, through a combination of DVD and face-to-face learning.

People were supported to eat and drink enough to maintain a balanced diet. Many people had food and drink through tubes inserted into their abdomen, as they were unable to swallow. The staff who supported

them were competent to do so and ensured they had sufficient food and fluid. There were clear directions in people's care plans and records for when and how much they should consume, and staff records of food and fluids given were consistent with these. Another person chose to have a limited diet. Staff had established that this had been the case for many years prior to the onset of the person's dementia.

Consent to care and treatment was sought in line with legislation and guidance, including the Mental Capacity Act 2005 where this applied. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The children whose care we considered were young children, whose parents gave consent for them. The registered manager and care staff recognised adults should be presumed as having capacity to make particular decisions unless there were grounds to doubt this. They acknowledged that people were able to make own decisions even if these did not appear wise. The service had participated in a best interests meeting for someone who lacked the capacity to manage their finances and whose relative oversaw this.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion, and their privacy and dignity was respected. In all of the face to face and telephone interactions we observed, staff were respectful towards people and their relatives. Similarly, when staff talked about people with us and with each other, they did so in a way that valued the person. People and relatives told us that staff treated them and their homes with respect. One said that on the few occasions care workers left things in a way that was not to their preference, they had raised this with them and with the registered manager and lead nurse. The issues were resolved promptly.

Whilst most people who used the service had extensive care needs, their independence was upheld as far as possible. Care plans emphasised what people were able to do. A person told us they were pleased with their care and support, staff neither doing too much nor too little for them.

Staff knew and understood people well. They told us in detail about people, relatives and their preferences. People had a regular team of staff and their care records contained information about their personal histories, interests and hopes. Staff worked shadow shifts with people before being responsible for care, and took on responsibility only once people and their relatives agreed to this. A relative said they were always consulted before new staff came to shadow shifts with their family member. They valued speaking with staff who knew their family member particularly well, finding reassurance in sharing their observations with them.

Staff understood how people communicated. There was clear information about this in people's care plans. For example, some people used eye-gaze boards connected to computers to speak, and others communicated through gestures. Staff were able to tell us about the subtleties of this.

Staff at all levels showed concern for people's wellbeing in a caring and meaningful way. They responded promptly when people were worried or upset. For example, a relative talked about an incident when their family member had become agitated. Another family member had contacted the office, and someone from the office turned up within a short time. The relative had not expected this but felt reassured by it.

People were supported to express their views and be involved in decisions about their care. Their views were taken seriously. For example, a relative told us how staff respected their and their family member's wish that staff did not wear uniforms when they took the person out. The registered manager and a field team leader independently told us how they worked with people and relatives to accommodate their wishes about which staff worked with them, whilst upholding staffs' human and employment rights. One family had specific wishes about how staff communicated with them and which parts of the house they had access to. Clear guidelines about this were set out in the person's care plan.

People's personal information was treated confidentially. The provider had been accredited for meeting internationally recognised standards in relation to data security and protection. Care records were kept in paper form and on a computer system. Staff who used the computer system had password-protected access to this. Staff were aware of the need to uphold confidentiality and this was evident when they spoke

with us. For example, a member of staff checked that they were allowed to share information about a person's care with us before doing so.

Good

Is the service responsive?

Our findings

People and their relatives were positive about the care they received from the service. Comments included: "Newcross – I can't fault them" and "Now I can see the light at the end of the tunnel".

People and their relatives were actively involved in planning and reviewing their care. Their needs and wishes were reflected in comprehensive, individualised care plans. For most people who used the service, staff worked alongside relatives to provide care. For example, a relative organised moving and handling for the family and private carers specific to their loved one's needs, which staff also attended. This was in addition to the service's moving and handling training for staff. Care plans clarified responsibilities where these were shared, specifying boundaries as to what staff were and were not able to do.

The service worked to meet the Accessible Information Standard. This was introduced by the government in 2016 to make sure people with a disability or sensory loss are given information in a way they can understand. Assessments and care plans flagged any sensory loss or communication needs. For example, where people used eye-gaze boards to communicate, their care plans detailed how staff should support them with this. No-one whose care we tracked needed information in an amended format.

Where the service was responsible, staff supported people to follow their interests, access the community, and develop and maintain relationships with people who mattered to them. For example, one person was particularly keen to go on walks and have coffee out, as part of their daily routine. Care workers supported them to do so, and the person told staff how they valued the freedom this gave them. Another person who needed staff on hand at all times was keen to develop their social life and make new friends. They worked with the service to devise staff guidelines so they could have the privacy they wanted when they were entertaining, whilst staff were readily on hand to provide care if needed.

The service used technology to ensure staff received timely care and support. Most people who used the service required constant care, so staff generally spent their whole shift working with them rather than travelling from person to person. When they arrived on shift and finished a shift, staff used a telephone log system to clock in and out. This flagged up to the office, or out of hours to a central team, if a member of staff had not arrived within 15 minutes of their staff time. Action was taken accordingly to ensure the person received their care. A relative told us they were informed if staff were going to be late and that care was never missed.

The service was aware of its role in supporting people to die with dignity and in comfort, when the time came. Some people who used the service, including children, were receiving palliative care, although the service had rarely cared for anyone right at the end of their life. Staff worked sensitively with people, their families and their health and social care professionals, to plan for end of life care. The service thoughtfully supported its staff during the time they were attending people with palliative care needs.

There was a system for receiving complaints and ensuring these were addressed promptly and thoroughly. People had information about how to raise complaints and concerns. A relative told us they felt able to

voice any issues and that these were dealt with properly. The provider's complaints policy gave the managing director's contact details in the event people were not happy with the resolution of their complaint. The policy also said people could contact a local inspector for CQC but did not make it clear that CQC does not have powers to investigate or resolve complaints, although it does welcome feedback about people's experience of services. The policy did not give details of other organisations people could contact, depending on how their care was funded.

We recommend the provider reviews their complaints policy to clarify its reference to CQC and also to incorporate organisations with powers to resolve complaints.

Good

Is the service well-led?

Our findings

The registered manager worked closely with the office team and maintained an overview of the atmosphere and culture in the service. Staff had a clear understanding of their roles and responsibilities, and those of their colleagues. Comments included: "Everyone knows each other's roles and what should be happening", "It's very well defined, who does what" and, "Everyone's so friendly in the office – you all just matter." There was a shared sense of ownership of the service, illustrated by the whole office team seeking to hear what had been discussed at inspection feedback. A relative and all the staff we spoke with said communication within the service was good. We observed that throughout the inspection staff communicated readily and openly with each other.

Staff said they found the registered manager approachable and that they were well supported. They had supervision meetings every two or three months with more senior staff. These provided a supportive forum in which they could discuss their work, the impact it had on them and any further support they needed. Staff felt they could approach the registered manager and office team informally whenever they needed. Counselling had been arranged for staff dealing with particularly challenging situations.

Staff morale was good. All of the staff we spoke with were positive about working for the service. Comments included: "I think I've found my dream job. It's a mixture of everything. It's never boring" and "I really, really like the open communication here". They also spoke with pride about working for a provider they perceived as having a good reputation. For example, a member of staff had encountered the provider in a previous role and told us they only countenanced working for them because of the provider's reputation. Staff told us they were treated fairly and with respect, experiencing no discrimination in relation to protected characteristics such as sex, race, disability and sexual orientation. Staff had training about equality and diversity training when they joined the service.

The registered manager felt well supported by their organisation's management and clinical governance teams. They networked with managers of the provider's other services, and also had contact with similar services provided locally by other providers. In addition, they encouraged their staff to work in partnership with other organisations, such as hospital and community health teams.

Systems operated to maintain and improve the quality of the service. People's views of the service were gathered through ongoing discussions about care, including care plan reviews. The computerised database flagged actions that were required, such as care plans due for review, and staff supervision and training that was falling due. Medicines and care records were audited monthly by senior staff. Any issues, such as omitted records or signatures, were logged on the provider's database and were followed up. There were also spot check observations on staff; these were announced to people and their families, but not to the staff themselves. The provider's clinical governance team were proactive in their oversight of the service, reviewing incidents that had been logged on the database for appropriate follow up and for developing trends. Whilst audits took place to ensure the service continued to operate safely, effectively and responsively, it was not always clear what audits were taking place at a higher level and how these fed into an action plan to drive quality improvement.

We recommend the service reviews the programme of audits that take place within the service and by the provider's management and clinical governance teams, identifying how these support it to provide a safe, effective, caring and responsive service, and feed into an action plan to drive quality improvements

Staff meetings took place from time to time for staff to discuss the care packages they were working within. The frequency of these meetings depended on the particular care package. Staff received updates in relation to the service, care plans and the views of people and their families. They were able to discuss openly their reaction to this news and their ideas for improving care. The provider's regular staff bulletins also included updates for staff, such as results from clinical governance audits and experiences from recent CQC inspections.