Harley Street Nurses Ltd

Harley Street Nurses Limited

Inspection report

12 Harley Street
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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	Inadequate
Are services safe?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

The report of this inspection was originally published on 26 May 2021. The service was rated as inadequate. Following the publication of the report, the provider requested a review of the ratings. The review of the ratings found that the CQC had made an error in following the process for receiving comments on the factual accuracy of the report from the provider. The Chief Inspector of Hospitals asked for a further review of the report and stated that this review should include additional evidence sent by the provider after the initial factual accuracy process had been completed.

The overall rating of this service remains inadequate.

Following the initial report, this service was placed in special measures. Following the review of the report, the overall rating remains inadequate. The service will, therefore, remain in special measures and will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action.

During the inspection we found:

- Governance arrangements for the monitoring and management of the service did not routinely include clinical oversight. None of the managers providing direction to, and control of, the nurses deployed by the provider were registered nurses and they did not have direct experience of providing community health services. Nor did they systematically involve clinicians with this experience to support them to oversee all aspects of clinical service delivery. The service did not use audits or data collection to monitor its performance.
- The service did not have sufficient systems for controlling infection risks. Although the service provided sufficient personal protective equipment, the service did not carry out checks to ensure that staff were using this equipment correctly.
- Staff received no supervision. Whilst staff could contact the nurse consultant, this was entirely at their own discretion. There were no systems for observing nurses' practice.
- The service did not always manage medicines well. Systems for recording medicines administration were used at the discretion of each nurse. There were no systems for reviewing medicine records or checking for medicine errors.
- Staff were required to use their own equipment to take photographs that were required as part of the clinical care. This meant records were not stored securely, under the direction and control of the provider.

However,

- Following our inspection, the service introduced weekly checks of nursing records by the nurse consultant. These checks provided reasonable assurance that risks were being managed appropriately.
- Following our inspection, the service introduced a new form for recording nursing activities and hourly observations. These records were sufficient, accurate and complete.
- The service had enough staff to care for patients and keep them safe. Staff had completed training in key skills.
- Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Inadequate 	The summary is set out on page two of this report.

Summary of findings

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Summary of this inspection

Background to Harley Street Nurses Limited

This was a focused inspection to review the domains of safe and well-led. The provider was given two days' notice of this inspection. The inspection was arranged following concerns raised, including concerns from a whistleblower.

Harley Street Nurses Ltd is registered to provide nursing care. Alongside their regulated activities the provider runs an employment business which is out of scope of the regulations. Through their employment business they provided nursing staff for other providers. In contrast the activities governed by the regulations associated with the Health and Social Care Act, and the subject of this report, require the provider to directly manage the delivery of healthcare.

Between 1 March 2020 and 28 February 2021, the service had provided nursing care to 12 patients. This work had included stoma care, palliative care, post-Covid monitoring, post-vaccine care and rehabilitation.

The service was last inspected on 4 November 2013. This inspection was not rated. The service met the standards of care required by the Care Quality Commission at the time.

The service has a registered manager in post.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the service.

Inspection activities

During this inspection we carried out the following activities:

- Visited the service's premises
- Reviewed the personnel records for two members of staff
- Interviewed the registered manager, nurse consultant and the recruitment and operational executive
- Interviewed five nurses. In addition, we received written responses to the interview questions from two nurses. A further nurse provided general written feedback.

Inspection Team

This inspection was carried out by three inspectors

Outstanding practice

We found no outstanding practice during this inspection.

Areas for improvement

The service must ensure that it assesses the risks of infection to staff and takes appropriate action to address these risks (Regulation 12(1)(2)(h))

Summary of this inspection

The service must ensure the proper and safe management of medicines. (Regulation 12(1)(2)(g))

The service must have systems in place to ensure compliance with regulations (Regulation 17(1))

The service must have systems and processes to assess, monitor and improve the quality and safety of the service (Regulation 17(2)(a))

The service must have systems and processes to assess, monitor and mitigate the risks relating to health, safety and welfare of people using the service (Regulation 17(2)(b))

The service must maintain securely an accurate, complete and contemporaneous record in respect of each person using the service, including a record of care and treatment and decisions taken in relation to care and treatment (Regulation 17(2)(c))

The service must maintain secure records of care and treatment. This includes the secure storage of photographs taken for clinical purposes. (Regulation 17(2)(c))

The service must ensure that people employed by the service receive appropriate support, training, professional development, supervision and appraisal (Regulation 18(2)(a))

Action the service should take to improve:

The service should ensure that staff know who the safeguarding lead is. The safeguarding lead should ensure they are familiar with the policies and procedures of the local adult safeguarding board.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires Improvement	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Inadequate

Community health services for adults

Safe	Requires Improvement
Well-led	Inadequate

Are Community health services for adults safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. During the inspection, we reviewed the employment records for two members of staff. Both these records showed that the staff had completed all the training that the service designated as mandatory. This included training on health and safety, safeguarding adults and children, fire safety and moving and handling. During interviews, staff confirmed that they were up-to-date with their mandatory training.

Safeguarding

Staff had a limited understanding of how to protect patients from abuse. Staff had completed training on how to recognise and report abuse. The service had a policy on 'Safeguarding Service Users from Abuse or Harm'. However, staff were not aware of who the safeguarding lead was in the organisation. We interviewed the person identified in the policy as being the safeguarding lead. Their explanation of how they would respond to safeguarding concerns was not consistent with the policy or national guidance. This meant it was possible that the service would not respond to safeguarding concerns in accordance with the local safeguarding procedures.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. During all visits to patients, staff wore face masks, face shields, aprons and gloves. This personal protective equipment (PPE) was provided by the service. The service had a general infection prevention and control policy. The service had also introduced infection prevention and control guidance for use during the Covid-19 pandemic. This document had been updated in November 2020. However, there were no systems in place for the service to check that staff were compliant with requirements for infection control. For example, the service did not carry out spot checks to ensure that staff were complying with the policy and using the PPE correctly. This meant that they did not have assurance that risks were being appropriately addressed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. When working in patients' homes, staff had a designated room or area to store their records and any items they needed in the provision of care and treatment. The service provided most equipment the staff needed, such as blood pressure machines, oximeters and equipment for monitoring blood glucose levels, although the service did not provide cameras for staff to record wound care. Staff used their own cameras for taking clinical photographs. Staff said they checked the equipment before they used it. The service replaced blood pressure monitors, blood glucose measuring devices and pulse oximeters twice

a year. The service also provided staff with a rudimentary record sheet for noting when devices had been changed. Staff managed clinical waste well. Staff said that, when necessary, patients had a yellow clinical waste bin in their home for the disposal of items relating to blood and wound care. This bin was collected by a clinical waste contractor or returned to the GP practice.

Assessing and responding to patient risk

Following this inspection, the service made improvements to its systems for assessing and managing risks. During the inspection we found that some patients had risk assessments that were provided by the hospital when they were discharged. All staff said that if they were aware of risks increasing, or that the patient's condition was deteriorating, they would contact the patient's consultant immediately and arrange an ambulance if necessary. However, at the time of the inspection, there was no oversight of the nurses' practice to ensure that risks were being appropriately assessed and managed. Immediately after our inspection, the service introduced a weekly review of nursing records by the nurse to ensure that there was oversight of how risks were managed. These records included a daily update of the patients presentation in relation to risks identified in the care plan.

Nurse staffing

The service had enough nursing and support staff with qualifications, skills, training and experience. We reviewed the records of two registered nurses who provided care and treatment to patients in the patients' homes. Both records showed that the nurses' registration with the Nursing and Midwifery Council was up-to-date. Application forms and references showed that both members of staff had experience of working in this field of nursing. Records also showed that managers had received certificates from the Disclosure and Barring Service before the employee was confirmed in post. The nurse consultant interviewed all applicants to discuss their experience and assess competency for the role. When staff joined the service, they completed an induction checklist to show they had been provided with key information relating to the role. However, the managers of the service had not carried out any visits to patients' homes to observe the quality of nurses' practice since April 2019, two years before the inspection. Whilst the service had introduced a system of reviewing nurses records shortly after the inspection, there was still no direct observation of nursing practice to assess nurses' competency. Staff were employed on a sessional basis, depending on the needs of patients. One member of staff said they visited their patient for one or two hours each day. Other staff said they completed 12-hour shifts at their patient's home.

Quality of records

Immediately after this inspection, the service introduced sufficient procedures to ensure that staff kept detailed records of patients' care and treatment. All staff said they kept records each time they visited a patient. The service provided staff with a 'patient's folder' containing a set of blank forms such as a sheet for the patient's personal details, daily nursing documentation, observation charts and medication charts. Records completed for one patient after 20 March 2021, showed that staff completed a comprehensive daily review of the patient's presentation. Staff also recorded hourly observations and repositioning. The service had a privacy notice for patients providing details of policies on data protection. Legal requirements relating to data protection were also included in the contracts held between the service and the nurses. However, the storage of information relating to patients' care and treatment on nurses' personal telephones or electronic tablets meant that the service had insufficient assurance of the security of this data.

Medicines

Inadequate

Community health services for adults

The service did not have systems and processes to safely administer, record and store medicines. All nurses administered medicines to patients. The records were kept at the patients' homes. Three nurses said they recorded administration of medicines on a drug chart, although this was not included in the nursing records. However, whilst the nurse consultant checked nurses' competency in administering medicines during a telephone interview, there were no observations or oversight of nursing practice. Overall, this meant that the service had no systems for checking that medicines were being administered correctly as prescribed, or identifying any medicine errors.

Incidents

The service did not manage patient safety incidents well. Following the inspection, the service provided an example of a report managers had written relating to a member of staff who contracted Covid-19 whilst working for the service. The report provides a narrative of conversations between the nurse and the managers, confirming that the employee was asymptomatic. The report does not consider how the nurse contracted Covid-19, whether personal protective equipment was being used correctly or whether any other measures may have prevented the incident. There was no evidence to indicate that the service learned from safety incidents or shared any learning from incidents with staff to improve practice when things went wrong.

Safety Performance

The service had some systems in place to improve safety. After the inspection, the service provided evidence of clinical governance meetings. At a meeting in December 2018, the service had reviewed its health and safety policies. Health and safety policies were reviewed following the outbreak of Covid-19 in March 2020 and again in September 2020.

Are Community health services for adults well-led?

Inadequate

Leadership

Leaders did not have the clinical skills and experience to run the service. Registration for the provision of nursing care means that nurses must be working under the direction and control of the registered provider. None of the managers required to provide direction and control were registered nurses and did not have direct experience of providing community health services. The service deployed a nurse consultant to interview applicants for nursing posts, but, at the time of the inspection, they had no role in the provision of care and treatment. Following the inspection, the service provided evidence to show that the nurse consultant had begun to review nursing notes each week. Staff said they had regular contact with the registered manager and the recruitment and operational executive. However, whilst the registered manager had a post-graduate qualification in psychology, neither the manager or operational executive had a clinical background and they were not able to provide guidance on clinical matters.

Vision and Strategy

The service had a vision for what it wanted to achieve. The service was committed to providing high quality, value for money services for its patients.

Culture

Inadequate

Community health services for adults

Staff provided mixed feedback when asked whether they felt respected, supported and valued. Most staff said they had regular communication with the service and they found this helpful. Staff said they valued being allocated to the same patient for the duration of that patient's care. This enabled staff to build good relationships with patients and ensure continuity of care. Some nurses said the service had been very supportive, particularly during the pandemic. However, other staff said the lack of supervision or any oversight of their work left them feeling unsupported and vulnerable.

Governance

Leaders had some effective governance processes but there was a lack of comprehensive oversight of the service. The service had reasonable procedures in place for the recruitment of nurses. The registered manager, the co-founder of the organisation, the recruitment and operational executive, the person responsible for wages and finance and the 'on-call' executive met each morning for a handover meeting to discuss administrative matters. These staff also attended a quarterly governance meeting. At each clinical governance meeting, managers considered a particular theme such as health and safety, patient involvement and the skills mix within the team. In February 2021, the service had responded well to a complaint from commissioners by introducing a new form for nursing records and a system that involved the nurse consultant reviewing nursing records each week. However, during our inspection, there was no evidence of audits or data collection. Recommendations from clinical governance meetings were not always implemented, Nursing staff rarely attended the clinical governance meeting. The nurse consultant had only attended one clinical governance meeting. That meeting had taken place after the inspection. Nurses did not receive supervision. Nurses did not meet to discuss clinical matters. During the inspection, we raised these concerns with the provider. They said that the nurse consultant had previously carried out announced and unannounced visits to patients' homes to check the work that nurses were doing. However, these visits had not taken place since April 2019, almost two years before the inspection.

Management of risk, issues and performance

Leaders and teams had some systems to manage risks and performance effectively. For example, the service had completed an organisational risk assessment to manage the risks associated with the Covid-19 pandemic.

Information Management

Managers did not collect reliable data about the service. The service did not use data to make decisions and improvements.

Engagement

Leaders engaged with patients to seek feedback and engaged staff to discuss administrative matters. The registered manager telephoned patients to seek feedback. The service also received feedback by email from patients and their families. Staff said there was frequent communication with the service, although this mainly related to administrative matters. There were no staff meetings to discuss clinical practice or service development.

Learning, continuous improvement and innovation

Managers were committed to providing good quality services but there was little evidence of a pro-active approach to learning and improvement.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Nursing care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** • The service did not assesses the risks of infection to staff and takes appropriate action to address these risks • The service did not ensure the proper and safe management of medicines

Regulated activity	Regulation
Nursing care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** **• The service did not ensure that people employed by the service receive appropriate support, training, professional development, supervision and appraisal**

Regulated activity	Regulation
Nursing care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance** **• The service did not have systems in place to ensure compliance with regulations** **• The service did not have systems and processes to assess, monitor and improve the quality and safety of the service**

This section is primarily information for the provider

Enforcement actions

- The service did not have systems and processes to assess, monitor and mitigate the risks relating to health, safety and welfare of people using the service
- The service did not have systems to ensure the secure storage of all records relating to care and treatment