Nestor Primecare Services Limited

Nestor Primecare Services Limited t/a Primecare Primary Care - Northampton

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

Overall summary

This announced inspection took place on 18 May and 4 June 2015. Primecare Primary Care - Northampton provide dedicated support to people who are nearing the end of their lives and wish to die in their own home or in a care home.

Primecare Primary Care - Northampton provide dedicated care and support to patients who are registered with a Northamptonshire GP, are thought to be in the last eight weeks of life and wish to die in their own home or in a care home.

Summary of findings

The service dovetails with existing NHS care providers; Northampton and Kettering General Hospitals, District Nurses, GP's, Marie Curie, Hospice At Home, Northamptonshire out of hour's medical service, Macmillan and East Midlands Ambulance Service and is an integral part of the Northamptonshire End of Life Pathway.

There are three distinct aspects to the service; Advanced Nurse Practitioners based at Northampton and Kettering General Hospitals provide discharge planning and support for patients who are nearing the end of life and wish to be cared for at home or in their own care home. Advanced Nurse Practitioners and healthcare assistants provide a rapid response to people who are in their own home or care home and require support or treatment. People can contact the Primecare Care Coordination Centre 24 hours a day. Between 08:00and 01:00 the call regarding that person is passed immediately by the centre to the Primecare Rapid Response community nursing team. Out of these hours the referral is passed to directly Northampton's out of hour's medical service.

At the time of our inspection the service supported more than 90 people, and had supported over 650 to receive their end of life care in their chosen place of care. The numbers of people receiving the care from the service changed daily as people used the service when they required urgent relief of their symptoms.

At the last inspection in July 2013 we asked the provider to make improvements on the assessment of people's needs to ensure the planning and delivery of care met their individual needs. These improvements had been completed.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager understood their responsibilities and demonstrated this by managing all aspects of the service to provide a high quality service.

People were involved in choosing where they received their end of life care. When people were being discharged from hospital staff listened to what people wanted and arranged care based around their wishes and need; this included arranging equipment and care at home to ensure a persons safety and comfort.

The service was easily accessible everyone who required the end of life care. Staff responded rapidly to requests for support for people receiving end of life care at home or in a care home. People who used the service valued the caring relationship with the staff, who ensured that people received care in a dignified and respectful way. Staff were flexible in the length of time given at each visit to meet the needs of people who used the service and their relatives.

The service worked in partnership with the local end of life providers. Staff kept health professionals informed about the care that people had received to ensure that people received continuity of care.

People were protected from avoidable harm and abuse as staff understood how to recognise and report any concerns. Staff understood their role in caring for people with limited or no capacity under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

There were sufficient numbers of skilled and experienced staff to meet people's needs. All of the staff had undergone rigorous recruitment processes to ensure they had the required skills and experience to provide care to people at end of their lives. The Advanced Nurse Practitioners who prescribed medicines were qualified to practice as a Non-Medical Prescribers and attended regular professional development updates.

All staff received mandatory training, role specific training and regular updates. Staff received regular supervision and feedback on how well they were doing and how to improve their practice. Complaints were dealt with promptly and changes had been made to improve the service. Quality monitoring and people's feedback was used to monitor and improve the service.

Summary of findings

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.

People were protected from avoidable harm and abuse as the provider had suitable procedures to identify and report abuse.

Staff facilitated the provision equipment in people's homes to ensure people were cared for in a safe environment.

Staff assessed people's safety on every visit, they recorded what equipment was required and documented if these were being used appropriately.

Staff communication with other healthcare professionals ensured a safe handover and continuity of care.

There were sufficient numbers of skilled and experienced staff to meet people's needs.

All of the staff had undergone rigorous recruitment processes to ensure they had the required skills and experience to provide care to people at end of their lives.

Advanced Nurse Practitioners were qualified to prescribe medicines; they had undergone extensive training and regular updates.

Is the service effective?

Good

The service was effective.

People were cared for by staff that had received training to specifically care for people at the end of their lives.

People were cared for by staff that were supported by supervision to carry out their role.

Staff understood their role in caring for people with limited or no capacity under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People and their relatives were involved in planning their care and in particular their chosen place of care.

Is the service caring?

Good

The service was caring.

People who used the service valued the caring relationship with the staff.

Staff listened to what people wanted and provided care around their wishes.

Staff always ensured that people received care in a dignified and respectful way.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their end of life care and in particular their chosen place of care.

Summary of findings

People had ready access to staff who provided a rapid response service to people in need of symptom control.

Staff were flexible in the length of time given at each visit to meet the needs of people who used the service and their relatives.

Complaints were dealt with promptly and changes had been made to improve the service.

Is the service well-led?

Good

The service was well led.

The service promoted a person-centred culture.

The service worked in partnership with the local end of life teams.

The service had a registered manager who understood their responsibilities and demonstrated this by managing all aspects of the service to provide a high quality service.

Quality monitoring was used to drive improvement.

People's feedback was used to monitor and improve the service.

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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.

The inspection took place on 18 May and 4 June 2015. The inspection was announced; the provider was given 48 hours' notice because the location provides a rapid response service throughout the county of Northamptonshire; we needed to be sure that someone would be in. The inspection was undertaken by two inspectors.

We reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider and the local authority safeguarding team.

Primecare Primary Care provide dedicated care and support to patients who are registered with a Northamptonshire GP, are thought to be in the last eight weeks of life and wish to die at home or in their own care home.

The service dovetails with existing NHS care providers; Northampton and Kettering General Hospitals, District Nurses, GP's, Marie Curie, Hospice At Home, Northamptonshire out of hour's medical service, Macmillan and East Midlands Ambulance Service and is an integral part of the Northamptonshire End of Life Pathway.

During our inspection we spoke with four relatives of people who had used the service and five staff and the registered manager. We also looked at records and charts relating to 10 people and two staff recruitment records. We also spoke with a Consultant in Palliative Care medicine, three district nurses, the GP Out of Hours services, four senior staff at Northampton and Kettering General Hospitals, one person from the community end of life team, and the managers of two care homes.

We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Good

Is the service safe?

Our findings

People were cared for by staff that had undergone rigorous recruitment processes to ensure they had the required skills and experience to provide care to people at end of their lives. The provider had ensured that all references and checks had been carried out and the Advanced Nurse Practitioners (ANP) were registered with the Nursing Midwifery Council and had completed competency tests.

People were protected from avoidable harm and abuse as the provider had suitable procedures to identify and report abuse. Staff received support from the manager when raising safeguarding alerts. Training records showed that staff had received training in safeguarding vulnerable adults, and this was part of a rolling programme that ensured an annual update. The deputy manager was the designated lead for safeguarding.

People received care in their homes where the staff had ensured the appropriate equipment had been provided. Staff ascertained people's preferred place of care whilst they were in hospital and facilitated the equipment required to maintain a safe environment in their own home or a care home, such as the provision of pressure relieving equipment to protect people's skin integrity.

Once at home people had ready access to Advanced Nurse Practitioners (ANP) for support and symptom management which was delivered as a rapid response service in addition to people's own GP or District Nurses. The safe and continuation of care depended upon the clear communication between the ANPs, the GPs and District Nurses. All of the District Nurses told us that the communication from the ANPs was excellent, one District Nurse told us "they [ANPs] tell us who they have visited and the care they gave, handover any changes in people's conditions, it is invaluable".

People's needs were regularly reviewed so that risks were identified and acted upon as their needs changed. People's risk assessments were included in their care plan and were updated to reflect pertinent changes and the actions that needed to be taken by staff to ensure people's continued safety. These contained action for minimising potential risks such as risks associated with the management of medicines.

People were prescribed and administered medicines by Advanced Nurse Practitioners who were qualified to practice as a Non-Medical Prescribers and attended regular professional development updates. People were prescribed medicines that provided relief of their symptoms in line with the national End of Life guidelines and local palliative care guidelines. The manager attended regular palliative network meetings where any changes in the local medicines guidelines were discussed and updated. The ANPs also accessed the palliative care formulary guidelines via the specialist website for further guidance.

People's assessed needs were safely met by sufficient numbers of skilled and experienced staff.

People were able to gain a rapid discharge service from hospital as staff were based at the Northampton General Hospital and Kettering General hospital every week day to facilitate discharges. People cared for at home anywhere in the Northamptonshire area had a dedicated team of staff whose role was to respond to people's symptoms at end of life. The staff based themselves in areas around the county so that they would be as close to people to cut down on travel time. People could contact the dedicated Primecare Care Coordination Centre 24 hours a day. Between 08:00and 01:00 the call regarding that person was passed immediately by the centre to the Primecare Rapid Response community nursing team. Out of these hours the referral was passed to directly Northampton's out of hour's medical service. The Rapid Response team rota (showing mobile numbers for staff on duty) was shared with all providers of end of life care across the county.

People were protected from out of date practice as there were appropriate arrangements for them to be kept updated through close contacts with the local NHS policies and procedures used by Northamptonshire Healthcare NHS Foundation Trust. Any changes in practice, equipment or safety alerts were updated through regular professionals meetings. For example, where the local Trust had introduced 'safer needles' out in the community, the staff had changed their practice to ensure that people would receive the same level of care from them as the they do from the District Nurses. The manager responded to and acted upon national Clinical Alerts sent to her daily via the Primecare "Clinical Alert Cascade" system. These included field safety, drug and equipment alerts. Actions taken were reported on monthly.

Good

Is the service effective?

Our findings

People received care and support from care staff that had received the training they needed carry out their roles and ensure that the support provided was in people's best interest. The registered manager and care staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately. There was a Mental Capacity Act policy and procedure for staff to follow to assess whether people had the capacity to make decisions for themselves. Where people were not able to make decisions for themselves meetings with their family representatives and the GP were arranged to make a decision on their behalf and in their best interests. The registered manager told us that there was no one receiving care with a DoLS in place and that everyone had been assessed for their capacity to consent to personal care needs and treatment as required. Staff were able to describe the use of mental capacity assessments and the appointment of an independent mental capacity advocate where appropriate.

Staff received training that ensured they had the knowledge and skills to carry out their role. All of the Advanced Nurse Practitioners (ANP) and Health Care Assistants (HCA) received mandatory training, role specific training and regular updates. For example we saw that the HCAs Care were trained using the Skills for Health' competency documents specifically for end of life care. The ANPs also continued their professional development to maintain their nurse prescribing and were trained to verify a person's death. All staff received yearly training on syringe drivers from the staff at the local hospice. There was a clear training plan which demonstrated that all staff would be receiving regular training in the future.

People were cared for by staff that were supported to carry out their roles. All new staff underwent a period of close supervision and all staff had regular supervision, we saw that they received feedback on how well they were doing and how to improve their practice. All staff had annual appraisals which covered their future development. The call handlers in the national call centre were monitored for their performance and advised where they could improve their practice.

People and their relatives were involved in planning their care and in particular their chosen place of care. When people were identified by hospital staff as requiring end of life care, they referred them to the Primecare Primary Care staff who would facilitate their wishes as to their choices of end of life care. The palliative care team at one hospital told us "the service is very good, we work closely together". The link nurses also liaised directly with the health care professionals who were to be involved in a person's care in the community. The District Nurse teams told us that the communication between the link nurse and themselves was "excellent". We saw that in the year from April 2014 to March 2015 staff had facilitated the discharge of 453 people needing end of life care at home or in a care home. These people were referred to them by clinical staff at Northampton General Hospital and Kettering General Hospital.

People received their care at home by accessing the service by phone as and when they required a rapid response for symptom control; they had been given a contact number to call when the need arose. We spoke with one relative who told us "the nurses were on call for extra help… they gave us everything we needed". Staff in care homes also accessed the service, one manager told us the ANPs were "incredibly helpful" as they had assisted them with providing symptom control for their resident.

People were assessed by the District Nurse team for their risk of not eating and drinking enough. Staff at the service followed the plan of care set by the District Nurse team and provided feedback to them if a person's needs changed. Staff followed national end of life care guidelines to ensure that people continued to eat and drink for as long as possible.

Good

Is the service caring?

Our findings

Relatives of people who had used the service told us that they had valued the caring relationship with the staff. One relative told us "My father had a good relationship with the nurses, they would sort dad out and they would provide emotional support for me and my family". They told us about an occasion that the nurse had stayed with them until their care worker from another agency arrived to provide support. Another relative told us that the care the nurses provided was "as important to me as it was for my husband".

Relatives told us that the nurses listened to what their relative wanted and provided care around their wishes. One relative told us "they understood what mum needed, they were kind and stayed until the treatment worked." We spoke with staff who told us they were proud to work for the service and told us that the service was a "patient driven – nurse led service". We saw many recorded examples of the nursing staff staying with people to ensure that the treatment they had given to alleviate their symptoms had worked. Relatives told us of their appreciation of their care one said "my husband received fabulous care and attention". All of the relatives we spoke with told us that they would recommend the service to others.

Relatives told us that they appreciated the time the staff to listen to them and gave them the confidence to care for their relative at home. One relative told us that "nothing was too much" and that the nurses "really listened to what dad wanted". We saw that on 54 occasions in the last year the nurses at the hospitals had provided people with a same day discharge home. This included arranging equipment and care to ensure that their wishes to be cared for at home were met. In these instances the Rapid Response service Health Care Assistants provided the care for people as there was no time to arrange for outside agencies to provide care. In the feedback given to the service we saw that people had appreciated the time that staff gave them, one relative told the service "The speed you got everything set up for us to leave Northampton Hospital .Our father wanted to be home and you helped make that possible."

Relatives told us that the staff had always ensured that their relative had received care in a dignified and respectful way. When people had died, in most cases the ANPs verified people's death and provided information to relatives on how to proceed with registering the death and how to contact their undertaker.

Good

Is the service responsive?

Our findings

People and their relatives were involved in planning their care and in particular their chosen place of care. Where people chose to receive care in a care home the staff liaised closely with care home to ensure that they had all the information, medicines and equipment needed to care for the person at end of their life. The manager of one care home told us "they [staff] were very helpful, they supported staff, helped with the medicines and treatment plans".

People had used the service to access a rapid response for symptom management. Whenever people required care for the relief of symptoms such as anxiety, pain or breathlessness and were not able to have their District Nurse or Doctor attend, staff at the service provided Advanced Nurse Practitioners (ANP) to attend to their needs. People and their relatives had one number to call for all of their concerns; the number went to a centralised call centre where non-clinical staff took the details and passed these onto the ANP on duty. District Nurses told us that staff provided an excellent service, one District Nurse told us "they [staff] provide high quality care, the [nurses] are well trained and highly motivated". One relative had fedback to the service; they told them "I would like to thank you for all the help you gave me during my father's illness and subsequent death. You were always there during the evening that seemed to be the time when my father was the most agitated and I wanted your help". After people had received their care the ANP's contacted the GP's and District Nurses to provide feedback on the care that had been provided, the District Nurses told us that the communication between the District Nurses and ANP's was excellent.

People benefited from the effective communication of the service with other health professionals. Where people were already at home, or in a care home and receiving end of life care from their GP and community nurse team, they may not always have be known to the service. During the night some of these people required treatment for their symptoms. Staff worked closely with the Out-Of-Hours (OOH) GPs who described the service as "Absolutely excellent, it works really well for the mutual benefit of all, with the welfare of the patients at the heart of it all". The GPs were able to refer people directly to staff for a rapid response for people who required urgent symptom management. The staff described the close working relationship to be very beneficial as they were able to access GPs at short notice after normal opening hours, weekends and bank holidays and GPs had access to ANPs who were experienced end of life care practitioners.

Anyone in Northamptonshire receiving end of life care had access to the service. The manager had gone to great lengths to build relationships with healthcare professionals to ensure that they had access to their rota, which provided them with staff names and mobile numbers to be contacted in the event that people required urgent symptom control. The rota was distributed weekly to places such as accident and emergency departments, out-of-hours GPs, ambulance services, hospices, district nurses and the 111 service. The feedback from these services about the information was that it was "invaluable", and health professionals told us that "the service went out of its way to be accessible to people who may need the rapid response." People received their care promptly because the staff responded promptly to requests from health professionals.

People received the care they required as staff were flexible with the time they spent with each person to meet their individual needs. We saw evidence in records and feedback from relatives that healthcare assistants would stay for long periods at short notice to provide care and comfort. Nursing staff stayed with people to provide treatment and ensure that the treatment was effective. Some families found that they could not cope with looking after their relative at home, the nursing staff helped to assess and find alternative suitable care places. For example the staff arranged for one person to receive their care in a nearby hospice at short notice, as the family were unable to cope.

People were assured that the service provided care in keeping with the whole of the end of life healthcare community. The service worked closely with the health professionals that cared for people at end of life in the whole of Northamptonshire such as the hospital and community palliative care teams, end of life care teams and community teams; they worked together to develop the new guidelines for caring for people during the last eight weeks of life. We saw evidence of meetings to develop the guidelines and the input that the service had provided.

People who received the service had fed back verbally and relatives sent cards and letters to feedback their views on the service. The manager had over a number of years tried many methods in obtaining feedback but found that formal

Good

Is the service responsive?

surveys and letters did not yield any response. The manager had found that when they called relatives a number of weeks after the person had died to ensure they were coping, that relatives would provide feedback without prompting. This unsolicited feedback was used to inform the service of their performance.

People had their comments and complaints listened to and acted on, without the fear that they would be discriminated against for making a complaint. A complaints procedure was available for people who used the service explaining how they could make a complaint. People said they were provided with the information they needed about what do if they had a complaint.

Good

Is the service well-led?

Our findings

The service promoted a person-centred culture by being an effective rapid response service. Staff at all levels understood their roles and responsibilities in providing end of life care to people at a time when they needed it. Staff received development in their roles for example being involved in the update of documentation and palliative care practice in end of life forums and networks within Northamptonshire. Everyone we spoke with about the service commented on the excellent communication; the District Nurses and the GPs found this to be useful in maintaining continuity of care for their patients; relatives told us they found this to be invaluable as they knew when the nurses would visit and explained the care they provided.

The manager's attitude towards sharing the information on the rotas had ensured that anyone who was providing end of life care would have access to their rapid response service to provide symptom control. The manager had told us "we don't want anyone to need us, and not be able to reach us".

The service had a registered manager that had been in position since 2010; they understood their responsibilities and demonstrated this by managing all aspects of the service to provide a high quality service. They had developed effective working relationships with the local general hospitals, the out-of-hours GPs, the community healthcare teams, the ambulance service and care homes. They had improved the end of life service in the community by working closely with these organisations to develop systems that ensured people received a rapid response to their immediate need when they require it. For example a Standard Operating Procedure had been agreed between the service and the ambulance service; where an ambulance was called to a person receiving end of life care, the crew would now consider the service as one of their options for providing for people's needs, instead of taking them to hospital.

The service worked in partnership with the local end of life teams by providing training to all levels of staff that provide care at end of life. For example in Northampton General Hospital the staff provided end of life care training to the ward managers and in the community, the nurses provided training to staff in care homes alongside the community end of life care team.

Staff had secure access to people's records and updated these after each visit. The records were kept on computers that also contained shared drives. The manager ensured that the shared drives contained the policies, procedures and clinical guidance for staff to access at any time.

Where there had been any incidents or complaints the service used the experience to change practice and improve the service. For example where there had been an incident concerning medication, all staff had changed their practice to place themselves in an environment where there would be no distractions whilst drawing up the medications.

There were regular audits, these were used to drive improvement; The provider carried out quality monitoring of calls in the call centre, they looked at the answering times and listened in to the calls to measure the quality of the information provided. The results of these audits were fed back to individual call handlers and to the service manager. The results showed that the quality of the calls had remained high and continued to improve.

Further quality monitoring of staff performance such as the documentation, the timings of visits and communication relayed to GP and District Nurses were carried out during staff supervisions and appraisals, which were planned and carried out regularly. Where there were issues identified during supervision these were monitored and the manager worked with the person to improve their practice.

Nurses' registrations and prescribing competencies were checked for validation monthly. Audits of training and yearly updates were closely monitored by the provider via a central database, audit and quarterly quality assurance meetings; they were able to provide the manager with trend analysis required to identify any specific training needs.

Feedback about the service from relatives was collated continuously and a six monthly review of the compliments and complaints was completed and included in the quality reports to the commissioners.