Nestor Primecare Services Limited

Rozel Court

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

The inspection took place on 28 November 2017 and was unannounced. This was the first inspection since Nestor Primecare Services Limited took over responsibility for the regulated activity of personal care at Rozel Court.

Nestor Primecare Services Limited (also known as Allied Healthcare) provides personal care services for people living in an extra care housing scheme at Rozel Court. The management of the building and facilities is not the responsibility of Nestor Primecare Services Limited. The building consists of self-contained flats with some shared facilities. Nestor Primecare Services Limited has an office in the building from which they manage their service.

At the time of our inspection there were 24 people receiving personal care and support. These included people living with dementia, people with a learning disability and people with a physical disability.

The service had a registered manager. A registered manager is a person who has registered with the CQC 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 provider had arrangements in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. There were sufficient staffing levels to support people safely. Recruitment processes were in place to make sure the provider only employed workers who were suitable to work in a care setting. There were arrangements in place to store and administer medicines safely and in accordance with people's preferences.

People received care which met their needs, from skilled, knowledgeable staff who had been given appropriate training. Staff had regular supervision to help maintain and develop their skills and knowledge.

Staff were aware of the legal protections in place to protect people who lacked mental capacity to make decisions about their care and support.

Plans were in place to support people to eat and drink enough to maintain their health and welfare. People were supported to access healthcare services, such as GPs and specialist nurses.

Care workers had developed caring relationships with the people they supported. People were encouraged to take part in decisions about their care and support and their views were listened to. Staff respected and supported people's independence, privacy, and dignity.

Care and support were based on assessments and plans which took into account people's abilities, needs and preferences. The provider had a system in place to identify early signs of deterioration in people's

conditions or wellbeing.

The provider maintained an open, responsive culture and had robust arrangements in place for investigating and responding to complaints and concerns.

Systems were in place for monitoring efficiency and quality within the service so that improvements could be made.

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

Robust systems and processes were in place to protect people from the risk of abuse and from avoidable harm

The provider employed sufficient numbers of suitably qualified staff to meet people's needs. Recruitment checks were carried out to make sure staff were suitable to work in a care setting.

Processes were in place to ensure medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

People's needs were met by staff who had the appropriate skills and knowledge

Staff were trained in the Mental Capacity Act 2005 and were aware of how to apply its principles.

People were supported to access healthcare services as needed.

Arrangements were in place to support people with nutrition and hydration if needed.

Is the service caring?

Good

The service was caring.

Staff had developed good bonds with the people they cared for.

People were encouraged and supported to express their views about the care and support they needed.

Staff maintained people's privacy and dignity when providing care and treated them with respect.

Is the service responsive?

Good

The service was responsive.

People received person-centred care which met and adapted to their needs, preferences and beliefs.

People's concerns and complaints were responded to and dealt with in a professional way.

Is the service well-led?

Good

The service was well led.

The registered manager maintained an open and supportive culture and displayed clear, strong leadership.

There were effective systems in place for monitoring the quality of the service to drive service improvements.

The provider worked in partnership with professionals to deliver people's care.

Rozel Court

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 checked 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 28th November 2017 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This 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 reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with five people who used the service, two care staff, the registered manager, the field care manager and the care delivery manager.

We reviewed records which included five people's care plans, three staff recruitment and supervision records and records relating to the management of the service.

We also reviewed records relating to staffing levels, risk assessments, quality assurance and policies and procedures.

Good

Is the service safe?

Our findings

The provider had implemented robust systems and processes to protect people from abuse and support them to stay safe. The registered manager told us that they held regular meetings with the safeguarding and quality team to monitor any concerns. They also told us that they used an online portal to monitor any safety incidents and near misses.

The registered manager had policies for safeguarding and whistleblowing. They notified the local authority and the Care Quality Commission when concerns were raised about safeguarding. They worked with the local authority when conducting safeguarding investigations and recorded the outcomes using the secure portal. Safeguarding alert forms, contact details of the local authority and the number of a confidential reporting line were displayed on the staff noticeboard.

Staff showed thorough knowledge of safeguarding practices. They were able to identify different signs of abuse and actions to take if someone was at risk of harm. Staff were given safeguarding training in their induction which was supported by an online learning programme. There was a system in place for identifying if someone was being abused. Workshops and best practice meetings were held by the management team regarding safeguarding concerns.

Staff told us there were sufficient numbers of staff employed to meet people's needs and have time to engage with people. One said, "It is a pleasure to come to work." They described their workload as busy, but not pressured.

The registered manager used an electronic rostering system to ensure that all care calls were covered. Alerts were produced on the system so that staff availability and sickness could be monitored. This meant that the management team could ensure there were sufficient numbers of staff to meet people's needs.

There were robust recruitment checks in place to ensure that only staff who were suitable to work with vulnerable groups were employed. Staff files contained evidence of two previous employer references, right to work in the UK and checks with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with people made vulnerable by their circumstances.

People's care plans contained appropriate risk assessments and instructions for staff to support people to stay safe and maintain their independence. Risk assessments identified risks associated with mobility, finances, medicines, continence, health and safety, their home environment and activities. When people required specialist equipment to help them move risk assessments were in place. There was evidence that the equipment was checked each year so that it was safe to use. Care plans contained sufficient information to support staff to deliver personalised care.

The registered manager had processes in place to ensure people received their medications safely. When people received support with taking prescribed medication this was documented in their care plan. People's

Medication Administration Records charts (MARs) were accurate and clear. The field care manager had received training from a nurse so that they could assess staff competency in medication administration. Staff received regular updates and competency 'spot checks' to ensure that they were giving medication correctly. Creams and ointments were included on MAR charts and body maps were used to indicate where these should be applied. MAR charts were audited regularly and action plans were in place if errors were detected. Unused medications were disposed of safely and collected by community pharmacists.

Staff told us they had been trained to administer people's medicines and their competency had been checked "quite often". They were aware of the need to involve the person when they gave them medicines, for instance by explaining what the tablets were for. They were aware of how to administer medicines in a way that was hygienic, and what protective clothing they should wear. Staff were aware that medicines records were checked and that any gaps were followed up. This was a frequent agenda item at team meetings.

Staff followed the provider's infection control policy and used the appropriate Personal Protective Equipment (PPE) when delivering care. Staff confidently identified potential infection risks. They used appropriate preventative measures including proper hand washing techniques to protect people by preventing the spreading of infections. During a person's care call we observed staff using gloves and aprons when completing cleaning tasks and when handling a person's medication. The staff members disposed of them in the appropriate bin at the end of the call.

The provider monitored and reflected on incidents and accidents as a means of preventing future incidents and improving people's safety. One person's care plan included two incident forms for falls which had been followed up. Another person's care plan included an incident form for the failure of their pharmacy to deliver their medicines on time. This was followed up on the provider's computer incident system (CIAMS) which allowed managers to review accidents and incidents.

The registered manager told us that team meetings, workshops and staff appraisals were also used to identify areas for improvement and to develop action plans. This was confirmed by information we found in people's care plans and in staff files.

Good

Is the service effective?

Our findings

People we spoke with told us that staff provided good care which met their needs and preferences. One person said, "They're very good…I haven't had any complaints…they do the ordinary, if I don't like it I tell them". Another person told us "I'm lucky, I've got a very good carer".

The provider ensured that people's needs and choices were effectively assessed. Assessments were completed by the field care manager and people's care plans were written in partnership with them and their family members where appropriate and with people's consent. They included details about preferences for meals, social activities as well as information about their life history. There was evidence in the care plan which showed assessments had been completed with people's consent.

People's health needs were also identified and supported. One person's care plan showed they were at risk of developing a pressure ulcer. Their care plan included a body map and risk assessment so that staff could monitor their skin integrity. This was also recorded in daily care logs. The provider worked closely with occupational therapists to source equipment to help prevent pressure ulcers for people at risk of developing them.

The provider delivered a comprehensive induction programme for staff as well as annual updates. A 'care coaching' system was used by the provider to help staff develop. Staff received a 'care coaching passport' which recorded training they had received in specific areas. The registered manager told us that they completed regular spot checks and supervisions for staff as a way of "seeing them through [the] journey" in a supportive way.

The registered manager told us that "open and honest conversations" were an important part of supporting staff between appraisals. Staff could access online learning to achieve care competencies. We found certificates of proficiency in staff files which evidenced this. Unmet competencies were flagged on the electronic system and face to face training was provided if needed. This system ensured that only competent staff provided care for people with specific needs. Bespoke training was provided for staff so that people's specific needs could be met.

Staff told us they had training in the Mental Capacity Act 2005. None of the people they supported had been assessed as lacking capacity, and one staff member told us they would like to have refresher training in this area if that changed. Staff told us they always sought consent "at every stage". If people declined support one day, they would try again the next. Staff told us they would report it to their manager if they saw that a person's ability to make their own decisions had deteriorated.

At the time of the inspection the service was not supporting anyone who required help with nutrition. The registered manager told us that training around nutrition support was available for staff if needed and that food and fluid charts could be included in people's care plans if needed.

Staff worked effectively with different professionals to meet people's needs. Care plans contained evidence

of contact with social workers, GPs and nurses. The registered manager told us that staff also worked with housing colleagues to ensure people's accommodation needs were met.

If people were admitted to hospital, a care passport was used to share relevant information with health professionals, with the person's consent. Health professionals were required to complete this before the person was discharged. Senior staff would also complete assessments in hospital before people returned home, so that they could ensure a safe discharge for the person and prevent them being re-admitted to hospital. This assessment also included the provision of suitable safety equipment. This meant that people received the care and support that they needed, at the right time.

The service had some involvement with supporting people to lead healthier lives and to have access to healthcare and ongoing support where appropriate. One person told us that they were supported by staff to attend the dentist "they came with me to the dentist…I can't go out on [my] own".

The registered manager told us that staff worked with healthcare professionals such as occupational therapists and district nurses in order to assess and plan to meet people's needs. Records showed that staff assisted people to access appointments and worked with occupational therapists and community nurses if needed.

Good

Is the service caring?

Our findings

People we spoke with told us that they had good relationships with the staff who cared for them. One person told us staff were "all very caring, always willing to do anything I need". Another person said that staff worked hard to meet their needs and to get to know them. They said, "Anything I wanted they would get me…very friendly, I know them all now."

Staff told us they had developed good bonds with people who used the service. One staff member said, "I have not been here as long as everybody else, but I'm doing all right." Staff described caring interactions with people which showed kindness and respect for people's individuality. They put people at their ease and developed a rapport. One said, "It is their home, after all." Staff described how they provided emotional support when needed by sitting with people and making time for them. They also had good relationships with people's families.

People who used the service gave positive feedback about the way staff interacted with them. Several people had developed personable relationships with staff. One person told us "They make you feel good, they chat and smile and generally cheer you up…they're always here when they should be". Another person said "I'm lucky, I've got a very good carer…I talk to her about all sorts of things".

People felt that their needs were being met. One person told us that the provider had worked with the housing agency to prepare their flat for when they were discharged from hospital. They told us that when they returned home "It was as if I hadn't been away…I'm very happy with what I've got". Care plan records showed care plans were reviewed with the person. People had choice as to which pharmacist supplied their medicines.

Staff told us they encouraged people to express themselves and guided them to speak with the manager if they had problems. When the field care manager needed to talk with a person who was living with autism to get their feedback on the service, they took a member of staff who had developed a good rapport with the person. They responded better with a familiar member of staff present, and the manager got better feedback as a result of thinking creatively about how to engage with people.

The Accessible Information standard is a framework for providing information to people with a sensory impairment or disability in a way that they can understand. The field care manager told us that they had spent time explaining information to people who needed support and that written information had been provided in large fonts or braille for people with visual impairments. This showed that the service was compliant with the Accessible Information Standard.

Care plans made clear where people were able to be independent, for instance one person's plan stated staff should observe them taking certain medicines, but assist them with others.

Staff told us they were aware that confidential information should not be recorded in people's daily logs of care, as they could not be certain who might have access to the logs.

Staff gave us examples of how they respected people's privacy and preserved their dignity. These included making sure people were covered during support with personal care, and allowing people as much time as they needed in the bathroom.

Good

Is the service responsive?

Our findings

People's care plans contained detailed and specific information about their care and preferences. For instance there were mobility risk assessments which took into account their physical attributes. Where people were at risk of poor skin health, there were instructions in the use of barrier creams and equipment such as pressure relieving mattresses.

Care plans contained summaries of the support people needed during timed visits and detailed plans around specific needs. These included mental capacity, communication, mobility, nutrition, continence, medication, skin care, washing and dressing, finance, sleeping and breathing needs.

The provider's computer based scheduling system was used to make sure staff were assigned to calls who could support the person according to their needs and in line with their preferences.

Where needed, there was training specific to people's needs and conditions. The provider checked care workers delivered care and support according to people's needs by means of spot checks, reviews, supervisions, and feedback from people.

In one person's case the provider had made recommendations about the furniture in their flat to help them be as independent as possible when moving about. Arrangements could be made if people needed to have their care plans in braille or other languages.

Records showed people received care and support according to their care plans, such as records of blood sugar levels where the person was living with diabetes. Daily logs of care delivered showed that two care workers attended if they were needed to support people according to their needs.

The provider had an "early warning system" which prompted care workers to be aware of and report risks to people's health and wellbeing. This included changes to their skin health, behaviour, appetite and breathing. Staff explained to us how they used the early warning system, for instance if they spotted damage to a person's skin. This process was integrated with the computer based system for recording and managing accidents and incidents. Together with the scheduling system this demonstrated how the provider used technology to sustain a high quality of service.

Staff said they spoke regularly with visiting nurses, operational therapists and other healthcare professionals to share advice about people's care and make sure it continued to meet their needs. If they saw that people's needs had changed, they spoke with their manager about it. There was a staff handover at the start of each shift where care workers exchanged information about people's care, such as new signs and symptoms, recent falls and GP or other healthcare professional visits.

Staff had arranged activities, such as a charity coffee morning, to help maintain people's wellbeing. They were planning a Christmas event, and were planning to engage with local charities to plan future events. The management team had spent time with people, finding out their preferences and supporting them to

maintain friendships. The registered manager told us that they were exploring the possibility of local authority funding for a shopping service to enable "freedom of choice" for people.

People were supported to maintain their faith and spirituality. Care plans included faith cards which contained details about people's beliefs and cultural practices. The registered manager told us "we adjust [the length of] care calls so people can go to the church or mosque". This meant that people's individual beliefs were supported and respected.

There was a copy of the complaints process in people's care files. The provider had a target to respond to complaints within 28 days. However, the provider tried to deal with concerns promptly so that they did not become complaints. Staff told us people were able to raise concerns informally. One staff member told us, "People just say if they want changes."

At the time of our inspection, there was nobody receiving end of life care, although the registered manager told us they had supported people who wished to stay in their own home in their last days. The service worked closely with the district nurse team and other medical professionals when developing a care plan for end of life care. They notified the housing provider so that if necessary they could get additional equipment quickly for people at the end of their life. A care worker had been given an internal recognition award for their sensitivity when supporting a person and their family as they passed away.

Good

Is the service well-led?

Our findings

The provider had a clear corporate vision: to be the choice of care that gave people the freedom to stay in their own home, working in partnership with the NHS and local authorities. People living at Rozel Court understood the scope of the service provided by Allied Healthcare. The format of the extra care housing scheme meant that the provider could encourage positive team work among staff because they were working in the same building. There were regular internal awards to recognise good staff performance, with the registered manager frequently nominating local staff for regional awards. Staff we spoke with described good, effective team working.

The registered manager was aware of their legal obligations with respect to protecting the human rights of staff, and had supported staff members where it had proved necessary.

Rozel Court was managed by the provider along with other extra care housing schemes and a home care agency as their "Southampton Branch". This meant both managers and staff had a wider network of support within the provider's organisation. They described the Southampton Branch as "a big, supportive family". The registered manager was supported in the location by a field care manager who had responsibility for the day to day care and safety of people at Rozel Court.

The management team held daily informal meetings or 'huddles' which were used to identify daily actions

There was clarity of responsibility based on clearly defined roles and process maps. This meant staff knew what to do and how to do it. The registered manager told us they recruited staff according to clear job descriptions. Interviews were competency based and included scenarios which allowed interviewers to judge how candidates would react in different circumstances.

Where information was stored on computers, access was controlled by passwords. Access was arranged so that staff accessed information relevant to their role. Care workers were authorised to access information such as policies and to use an online chat forum to engage with their peers in the organisation. If computers were left unattended there was a "time out" function which reduced the risk of inappropriate access to data. Arrangements were in place for staff who did not have their own computer or suitable hand held device to access the provider's systems.

There were various ways the management team communicated with staff. These included emails, a regular newsletter and team meetings. Team meetings took place every three months, and were arranged to accommodate difficulties staff might have attending, such as taking account of night shift workers and those with family caring responsibilities. Staff were involved in the development of the service by means of a staff survey which was followed up by focus groups locally and at a regional level. The provider also made sure that staff were made aware of the outcome of any investigations into accidents or incidents.

The provider engaged staff by means of individual goals in their personal development plans. Each staff member had three identified goals, and they reviewed progress towards achieving them through regular

supervision and appraisal meetings. For more senior staff it was usual for one of their goals to be related to acting as a care coach for junior staff. This was a means of involving and sharing the provider's vision throughout the organisation.

The provider engaged people who used the service by means of a quality survey, six monthly care plan reviews, and telephone and face to face contact as needed. If the person was not able to take part personally, the provider engaged with a family member or other advocate.

There were effective systems in place to drive improvements and address issues. Feedback from the quality survey was analysed at a local, regional and national level. This meant the registered manager was able to compare local results with wider trends. The survey included coverage of staff skills and punctuality, dignity, care tasks, and consistency of care workers. If there were individual comments by people, these were sent anonymously to the registered manager by email. The registered manager had responded to individual comments by changing rotas and schedules so that the service responded better to people's individual needs.

Staff told us they were confident about raising concerns with their manager. One care worker said they were "not afraid to talk to anyone" if they had concerns. They were aware of the provider's policy for whistle blowers, and said they had a good relationship with the local management which gave them confidence to raise concerns if necessary. Training had reinforced the provider's policy and there were contacts elsewhere in the organisation where they could raise concerns if necessary.

The provider had successfully encouraged staff who transferred from the previous provider of personal care at Rozel Court to adopt the more efficient computer based process and systems. As one of the provider's larger branches, Southampton was chosen to pilot the provider's "one best way" system to standardise processes and procedures and promote best practice within the organisation. This meant that people benefitted from improvements in a timely way.

By law, a provider must inform CQC of any significant events by sending a notification. The provider had sent notifications to the CQC of important events.

We observed staff arranging appointments with healthcare providers, such as GPs and district nurses. There was a positive working relationship at all levels with the housing provider at Rozel Court. Care quality supervisors went to the local hospital to make sure the service was prepared to meet people's needs when they were discharged. The provider worked closely with occupational therapists to make sure people had the right equipment to maintain their independence, and with district nurses and older people's nurses with the purpose of reducing GP visits. There were regular meetings with the local authority to discuss and anticipate trends in social care needs, typically over the next six months.