Marie Curie

Marie Curie Nursing and Domiciliary Care Service, South East Region

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 inspection took place on 28 July 2018 and 10 August 2018 and was announced. This was the first inspection of the service since they registered with CQC in July 2017.

This service is a domiciliary care agency providing specialist nursing care. It provides personal and nursing care to people living in their own houses and flats in the community. It provides a service to people with cancer and long term medical conditions. The service regularly provided end of life care.

There was a registered manager in post. 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.

People received safe care. The provider had considered risk and there were systems in place to ensure all care provided was tailored to people's individual needs and risks. Where incidents had taken place staff escalated them appropriately and took action to reduce the likelihood of them recurring. Staff understood how to safeguard people from abuse and acted in line with local guidance when they identified concerns.

People received their medicines safely. Staff had received training in how to manage medicines and we saw evidence of staff working closely with healthcare professionals where medicines were required. Staff had strong links with local community nursing organisations which people benefited from. There was regular communication between these organisations which had helped to identify and respond to changes in people's health. Staff were trained in how to provide care in a way that reduced the risk of infections spreading.

Staff had received appropriate training and support for their roles. Nursing staff received clinical supervision and support to maintain their knowledge. Staff felt supported by management and there were systems in place to enable good communication between staff and the provider. Staff had regular supervision and appraisals to discuss their work and their performance.

People told us that staff were kind and caring and supported them in a way that enabled relatives to have breaks from their caring roles. Staff involved people in their care by offering choices. The provider asked people questions about their preferences and diverse needs so that care could be tailored around these. People told us that staff were respectful when visiting their homes and staff were knowledgeable about how to provide support in a manner that promoted dignity. Staff arrived at the times that they were expected and the provider was in the process of improving the system for receiving referrals to speed the process up for people.

End of life care was delivered in a sensitive and person-centred way. People's wishes for their end of life care were identified and reviewed regularly by staff and community healthcare professionals Changes to

people's needs were quickly identified with prompt action taken. Staff gathered important information about people's routines and preferences. People and their relatives were regularly asked about the quality of the care they received and asked if they wanted to make any changes. There was a complaints policy in place and complaints had been responded to in line with the provider's policy.

Regular checks were undertaken on the quality of the care that people received. The provider carried out a variety of checks and audits to monitor care and people and their relatives were involved of this. Staff practice was frequently observed to ensure best practice was being followed. People had consented to their care and staff understood what to do if people were unable to provide informed consent.

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.

Staff provided support in a way that mitigated risk and kept people safe.

Staff attended people's homes at the time they were expecting them. The provider had carried out appropriate checks on new staff.

People were supported by staff that understood their roles in safeguarding them from abuse. Where any incidents had occurred, actions were taken to ensure people's safety.

Important information about people's medicines was kept up to date and staff were trained in this area.

Staff understood how to provide care in a way that reduced the risk of the spread of infection.

Is the service effective?

Good

The service was effective.

People benefitted from good communication between staff and healthcare professionals. Staff responded to changes in people's health.

Information about people's needs was gathered before they received a service.

Staff had the right training and support to carry out their roles effectively.

People's nutritional needs were documented and met.

Staff understood the importance of consent and records showed this was gathered routinely.

Is the service caring?

Good

The service was caring.

We received positive feedback on the kindness of staff and saw examples of them finding ways to improve people's lives.

People's relationships and support networks were sustained and developed by the care they received.

Staff gathered information about people's religion, culture, sexuality and gender identity, they provided care which reflected these.

Care was provided in a way that was dignified and respectful of people's privacy.

Is the service responsive?

Good

The service was responsive.

End of life care was planned and delivered sensitively and in line with people's needs and preferences.

Care was person-centred and where people's needs changed, care plans were updated.

Where people had complained, the provider had responded in line with their policy.

Is the service well-led?

Good

The service was well-led.

The service relied upon strong partnership working with local healthcare organisations and the provider had systems to ensure this.

There was a plan to improve the service and develop new models of care.

People's care was regularly checked and audited and people were regularly asked for their feedback.

There were systems of communication for staff and staff told us they felt supported by management.

Marie Curie Nursing and Domiciliary Care Service, South East Region

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 inspection took place on 28 July 2018 and 10 August 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is a domiciliary care agency and we needed to be sure that someone would be in.

Inspection site visit activity started on 26 July 2018 and ended on 10 August 2018. It included reviews of records, telephone interviews with people and relatives, healthcare professionals and staff. We visited the office location on 26 July 2018 and 10 August 2018 to see the registered manager and office staff; and to review care records and policies and procedures.

The inspection was carried out by one inspector, a specialist nurse and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of our planning we contacted the local authority and placing authorities for feedback on the service. We reviewed feedback from people and relatives submitted to CQC and we also checked online feedback. We reviewed notifications that the provider had submitted to CQC to identify any areas that we would need to follow up on during our visit. Notifications are information about events and incidents that providers are required to tell us by law.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke with one person and 12 relatives. We spoke with the registered manager, the regional manager, a clinical lead, two nurses and one healthcare assistant. We received email feedback from one community nurse.

We looked at the care plans for eight people, three staff files, accident and incident records, complaints and minutes of staff meetings. We looked at the provider's audits and surveys and reviewed records of staff training and supervision.

Good

Is the service safe?

Our findings

People and relatives told us that care was delivered safely. One person said, "It's definitely safe, they make me feel safe because they're so good." A relative said, "[Person] feels safe. They have always been friendly and helpful." Another relative said, "Yes, it is safe, they give him security. They give him the confidence overnight."

Staff provided support that reduced risks and kept people safe. Staff supported people in their own homes, following referrals from community nursing teams. The provider held written agreements with clinical commissioning groups (CCGs) which documented that Marie Curie staff would make use of existing risk management plans drawn up by community nursing teams. Staff provided support that managed the risks outlined to them in community nurses' risk assessments. For example, one person was at risk of pressure sores because they were cared for in bed. Community nurses had carried out a risk assessment of this risk and drawn up a plan to reduce it. The provider also kept a record of this within the person's care file. To reduce the risk of the person developing pressure sores they had an air mattress to relive pressure and creams were applied daily. The care plan also noted staff were to check the person's skin and encourage them to drink fluids and nutrition.

There was a clear process to follow if staff found risk assessments were not in place. The provider had their own risk assessment documentation which staff used if they found community nurses records were not in place. Where this had occurred, we saw evidence of staff escalating their concerns. The registered manager also discussed these issues with clinical commissioning groups (CCGs) at regular meetings. As well as the written agreements in place, the registered manager attended meetings with CCGs and the referrals teams were robust in discussing risk with community nurses before people received a service from Marie Curie. A community nurse told us, "The booking staff [at the provider's head office] are very strict about ensuring risk assessments are in place and will decline a booking if the risk assessments have not been done."

People and relatives told us that staff arrived at the time they expected them and stayed for the necessary time to meet people's needs. One relative said, "They [staff] always stay the allotted time, and sometimes they stay longer if [person] is a bit down." Management had a system to process referrals and schedule calls based on capacity in the local area and we saw that requests for daytime and overnight care were being fulfilled. Relatives told us care was arranged so their family members were cared for by consistent staff. The registered manager told us that they ensured consistency for people wherever possible and records showed people were visited regularly by the same staff. As care was provided predominantly at night, we saw that environmental risks and staff safety had been considered in each case. For example, one person lived in a poorly lit area and their care plan had guidance for staff on how to reach their property safely by ensuring they brought a torch.

At the time of inspection, the provider was in the process of making improvements to their system for receiving referrals. This was because referrals often came in requiring an urgent response and the current system did not always allow enough time. Referrals were received by a national contact centre and this meant that sometimes there was a delay in providing information about local capacity to take on new

referrals. We noted there had been two complaints in the last 12 months regarding this and the provider had responded by changing their systems and processes. Administrative staff had been recruited as part of this change and were starting in their posts the week after our visit. This was part of a nationwide improvement and had been designed to provide quicker responses to healthcare professionals when they first contacted the service. We will follow up on the impact of these improvements at our next inspection.

People were protected from being supported by inappropriate staff because the provider carried out appropriate checks on all staff. Staff files contained evidence of checks such as references, work histories, health declarations, proof of right to work in the UK and a check with the Disclosure & Barring Service (DBS). The DBS carry out criminal record checks and hold a database of staff who would not be appropriate to work in social care. We also saw that where the provider employed nursing staff, a check was carried out with the Nursing & Midwifery Council (NMC).

Staff responded appropriately to incidents. The provider kept a record of all accidents and incidents that took place and documented the actions taken in response. For example, staff arrived to support a person new to the service and identified pressure damage to their skin. Staff documented this and the person's skin was treated by community nurses. Staff documented and escalated the concern appropriately and took action to reduce the risk.

People were supported by staff who knew how to identify and respond to potential abuse. Staff had attended training in safeguarding adults and were knowledgeable about how to recognise different forms of abuse and how to escalate any concerns they had. One staff member said, "I would speak to my line manager first. If it's really serious I would call the police or out of hours social services." Records showed that where they had identified safeguarding concerns, staff had reported these and the concerns were escalated to the local authority safeguarding team.

Systems were in place to ensure people received their medicines safely. Due to the nature of the service, staff did not usually administer people's medicines. Staff usually provided overnight care which meant regular medicines had been administered before their visits. We noted that care plans contained detailed information about people's medicines and important information about them, such as dosages, medical conditions and any allergies people had. Where people were prescribed 'as required' (PRN) medicine there was guidance for staff on when and how to administer it. Community nurses and relatives told us that where staff had administered PRN medicines, they had kept medicine administration charts (MARs) up to date.

People were protected from the risk of the spread of infection. All staff had undergone training in infection control and people told us that staff regularly washed their hands and used personal protective equipment (PPE), such as gloves and aprons, when providing personal care or carrying out clinical procedures. Management checked infection control as a part of observed practice and staff were given PPE to take with them to people's homes to use if community nurses supplies were not in place. Staff were knowledgeable about how to reduce the risk of infection spreading when supporting people in their homes. One staff member said, "We remember the basics like wiping the kitchen down after making drinks and we have gloves with us which we wear for things like washing and personal care."

Good

Is the service effective?

Our findings

We received positive feedback about the way staff communicated with each other and relevant professionals to provide effective care. One relative said, "[Person] is looked after extremely well, the whole team seem to be well organised. And they communicate effectively with the community nurse if there are any issues." Another relative told us, "One hundred percent. The staff are brilliant, I can't fault them. They always tell me if there any problems."

People's health needs were met because staff worked effectively alongside healthcare professionals. People who received a service were already under the care of community nurses and the staff worked closely with them to meet people's needs. People's care records showed regular communication with community nursing teams where needs had changed. For example, one person's needs had recently changed and their GP had made changes to their medicines. We saw this information was shared with the provider and the person's care plan was updated. Community nurses gave us positive feedback on the communication with staff. The registered manager regularly attended meetings with clinical commissioning groups (CCGs) and showed us examples where they had escalated issues identified with people's care to encourage improvements to local services.

The provider ensured staff had a good understanding of people's needs before providing support to them. People's needs were thoroughly assessed and records showed that when new referrals came in, important information about people's medical conditions, care needs and personal preferences were gathered. Staff told us that the strong links with community nurses meant they could always access information when necessary. One staff member said, "We are given a sheet with what we need to do and I always sit down and have a chat with the family. If we're ever not sure or things have changed I can always ring the community nurses and they're really good."

Staff had the right training and support to carry out their roles. One person said, "The staff are absolutely super with everything." A relative told us, "Staff definitely understand [person]'s care needs. Everybody is well trained, and absolutely brilliant. I feel confident that I can go to sleep, and that he will be well looked after." Staff told us they attended mandatory training courses in areas such as safeguarding adults, health and safety and infection control. The provider kept a record of staff training and this showed staff were up to date in these areas. Staff completed some training as e-learning but the provider also arranged regular face to face training for staff. For example, we saw evidence of a recent 'Person-centred Practice Framework' training session that was based on a recent model of holistic care planning. Staff were knowledgeable about how to provide individualised care to people and their relatives when we spoke with them.

Training was tailored to the needs of the people that staff supported. People using the service had a variety of clinical needs that required support from trained nurses. Nursing staff had regular clinical supervision meetings where they kept themselves up to date with current practice. One nurse told us, "Last week I did syringe driver and oxygen training." A syringe driver is a specialist device for providing injectable medicines in measured doses over a period of time. Records showed that staff had regular clinical supervision and the feedback from community healthcare professionals about the competence of nursing staff was positive. A

community nurse told us, "In my experience they are knowledgeable and the nurses are competent in identifying when symptom control by injectable medication is required."

People's nutritional needs were met. Information about people's dietary needs was documented in their care plans. For example, one person was at risk of choking due to difficulties swallowing. To manage this risk, they had fluids that had been thickened and needed to maintain a safe posture when swallowing. Their care plan clearly documented this with information on how fluids should be thickened and details about how to position the person when they had a drink.

People had consented to their care. People's consent was sought when they started to receive care and this had been documented. Relatives told us they always observed staff asking for permission before providing support to people and records showed this was considered as part of care planning. For example, one person sometimes found verbal communication difficult due to their medical condition. Their care plan recorded that they used gestures to consent when they could not do so verbally. A diary entry showed staff had documented where the person had used this gesture to give consent to care.

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. At the time of our inspection, all people using the service were able to provide consent to their care. We discussed the MCA with the registered manager and they gave an example of where they had worked with healthcare professionals to establish a person's mental capacity to consent to care. Staff had received training in the MCA and record showed training was up to date in this area.

Good

Is the service caring?

Our findings

People and relatives told us that people were supported by kind and caring staff who they got along well with. One person told us, "I can only praise them all. Very friendly, very kind and very helpful." A relative said, "They are most definitely kind and caring. They have a laugh whilst the carer is doing her jobs. And the carer always respects [person]'s preferences." Another relative said, "The carer was really good at talking to her when she felt anxious. The carer really tried to calm her."

Staff found ways to improve the lives of people and their relatives. A relative told us, "They always give me the advice I need. I could not survive without them." Relatives gave us positive feedback about the caring approach of staff. Everyone we spoke with told us that staff made them feel valued and exceeded their expectations. They gave examples of staff staying longer than the contracted time where people were unwell and said staff regularly prepared drinks for them and their family members, to enable them to have breaks from their caring roles. Staff were equally as committed to improving people's lives and gave us further examples. One nurse told us, "We were supporting a person whose relative had not come to terms with their prognosis. They didn't understand risks relating to their nutrition and they were in denial. We spent time with the relative talking to them about choking risks and arranged a meeting with their GP to talk about the condition and ensure they got long term support."

People were enabled to sustain relationships and support networks. The service provided by Marie Curie was flexible and was often used to provide relatives with breaks from caring for loved ones. The feedback from relatives on the impact this had on their lives was very positive. One relative described the service as 'invaluable' and another described how they were able to 'switch off' when staff were with their family member. We saw that information was gathered about people's living arrangements and any existing support in place so that care could be planned around that. This helped to ensure care could be timed so that it would have the most benefit to people and their relatives. We also saw examples where relatives were given support to understand and come to terms with the prognosis of loved ones.

The provider gathered information about people's culture, religion and sexuality. At assessments people were asked about these areas of individuality to identify if they had any specific needs staff needed to be aware of. For example, one person was born outside of the UK and this had been captured in their care plan. Staff had completed training in understanding diversity and the provider took this seriously by commissioning and participating in projects in this area. For example, the provider told us in their PIR that they had recently participated in a project to identify the impact of terminal illness on people and relatives that identified as lesbian, gay, bisexual or transgender.

Staff involved people in their care. People using the service were at advanced stages of their medical conditions and we saw examples where people were unable to communicate verbally and needed support to make choices. For example, one person's care plan detailed how they used particular gestures to indicate 'yes' or 'no' and staff were to follow these to enable the person to choose drinks. Another person's care records had lots of information from a relative detailing drinks and flavours that they liked, as they were unable to eat solid foods. Staff were knowledgeable about how to enable people to make choices and they

understood the importance of doing so. One staff member told us, "People's independence is important so we make sure we give advice and help people make decisions. One patient points to things to tell me what they want and I make sure to give them enough time."

Relatives told us that staff were respectful of people's privacy and dignity when providing support in their homes. They told us that staff ensured personal care was carried out in private and staff were mindful of ensuring curtains were closed. Staff were knowledgeable about how to provide care in a way that promoted people's dignity. One staff member said, "I always ask permission before I do anything. I do things like making sure people have a sheet covering them, I treat them as I would wish to be treated."

Good

Is the service responsive?

Our findings

People and relatives spoke highly of the respect, skills and sensitivity shown by staff who were providing personalised end of life care. One person said, "Even just coming to give me a shower, it's so important to me." A relative said, "They've always helped him through difficult moments." Another relative said, "They have been very good. They listen and understand his routine." Another relative told us, "They do everything for him that hitherto he would have done for himself."

End of life care was planned in a holistic way. Care plans showed that information about people's preferences with regards to end of life care were gathered and documented. Where these changed, reviews were carried out and care plans were updated. For example, one person's needs had recently increased due to a deterioration in their condition. Records showed staff liaised with community nurses who identified that this person no longer wished to be admitted to hospital if they deteriorated further. This information was added to the person's care records as well as an update to the medicines care plan to show that anticipatory medicines had been prescribed. Anticipatory medicines are medicines prescribed to ensure that people are comfortable and pain free at the end of their lives.

Another person had a very detailed care plan which provided detail on how to ensure they were comfortable. This included tasks such as ensuring the person had moisture in their mouth by using specialist sponges. The care plan provided information on when and how to use these and a nurse was knowledgeable about this when we spoke with them. Staff had received training in end of life care and anticipatory medicines. Nursing staff were also knowledgeable about palliative medicines and were assessed as competent to administer these if community nurses were not present when they were required.

Care was planned around people's individual needs, routines and preferences. Care plans contained enough information for staff to provide the right care, based on people's needs. For example, one person used equipment to move themselves in bed and required items within reach of them which was documented in their care plan. The community nurses carried out regular reviews and these were attended by Marie Curie staff when it was appropriate.

The nature of the service meant care was often scheduled on an ad-hoc basis, or the provider carried out one-off visits of care. This meant it was not always appropriate for the service to be involved in reviews of care packages. However, people and relatives were contacted before each visit and regular surveys were carried out. We also saw evidence of Marie Curie staff contributing to and attending community nurse reviews. Where people had been receiving regular support from staff we saw evidence of staff emailing about changes to people's needs which were updated within care plans. People also benefitted from strong links between staff and the community nursing teams who provided regular updates and informed the provider of when things had changed.

People and relatives were given opportunities to make changes to their care. There was a complaints policy in place which informed people of how to raise any concerns and what their expectations should be regarding timescales for a response. Every relative we spoke with told us they knew how to complain and

felt confident that any issues would be addressed by management. There was a record of all complaints received which documented the actions taken and the responses. Records showed complaints had been investigated appropriately and responded to in line with the provider's policy. The provider tracked complaints in a way that meant they could monitor them and identify any patterns or trends to learn from in order to improve the service.

Good

Is the service well-led?

Our findings

People and relatives told us that the service was well-led. One person said, "They are well organised. They called us to see how we were getting on." A relative told us, "They are very well organised. We have been extremely well looked after." Another relative said, "Yes, they are on the ball, all joined up."

The provider had strong positive links with stakeholders that were improving services for people. Staff routinely worked alongside community health services to provide care that was tailored flexibly around existing support networks that people had in place. People's records contained evidence of strong communication and links and staff told us they had good relationships with community nursing teams in each area where they provided care. Healthcare professionals spoke positively about their strong integration with the service in individual people's care and as organisations. A community nurse told us how their service had won an 'Excellence in End of Life Care' award, which was assisted by their strong relationship with Marie Curie. They told us, "We have a very good working relationship with excellent Marie Curie nurses working as part of our team."

There was a commitment to drive improvement both in the service and within the sector. The provider had introduced a pilot for a new type of service within one geographical area that they worked in. This was a new type of model for the service as it was a daytime service, whereas other areas only provided overnight care. We spoke to the nurse who was the lead in this area and they were positive and enthusiastic about developing a new service to help people and their relatives. They told us how they worked alongside community nurses, relieving their workload as they were able to carry out some clinical procedures on their behalf, enabling local community services to increase capacity and reach more people. This service was receiving positive feedback from people, relatives and healthcare professionals.

People were involved in the running of the service. One person said, "They're always on the end of the phone and sometimes they call me." People and relatives told us they received regular calls from the provider to check if they were happy with the care that they received. The provider carried out regular surveys to gather people's views and records showed the most recent surveys had been positive. Staff also had regular spot checks that included observed practice and people's feedback was also gathered as a part of this process.

There were a variety of checks and audits in place to monitor the quality of the care that people received. The provider carried out audits of areas such as medicines, documentation and staff practice. Where improvements were identified, these were actioned. For example, a recent documentation audit had identified improvements to the way personal information was documented and stored to ensure its' safety. In response, new communication sheets and guidance for staff were drawn up and disseminated amongst the team.

Staff were supported and involved in the running of the service. One staff member said, "The manager has common sense. They are nice to people and have the right ethos." All staff we spoke with spoke highly of management and they level of support they received. Staff told us they could contact management whenever they needed and received regular calls to check their wellbeing and identify if they needed

support. Regular meetings took place in each region and minutes of these were documented. Records showed meetings were used to discuss a wide variety of issues and pass on important messages. We saw that staff also used meetings to make suggestions to improve people's care. For example, a recent meeting had been used to discuss people's gender preferences for the staff that supported them. Staff discussed approaches and why this would be important to people, sharing their experiences.

Staff were kept informed of changes to the service through newsletters. The registered manager told us it could be a challenge reaching all staff as some did not work for the service regularly and it was not possible for every staff member to attend every meeting. To reduce the impact of this, the provider had recently introduced a newsletter called 'In The Loop' which provided local updates on the service being provided by Marie Curie. The latest edition had been used to welcome new staff, provide information on training courses that were taking place and provided updates from each area within the region.

Management understood the responsibilities of their registration. Providers are required by law to notify CQC of important events such as deaths, serious injuries and allegations of abuse. Due to the nature of the service that was provided, staff were often present at the end of people's lives. We found that where required, CQC had been notified of deaths which had helped to inform our planning for this inspection.