Network Healthcare Professionals Limited

Network Healthcare Professionals Limited - Liverpool

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 inspection took place on 25 November 2015 and was announced. Network Healthcare Professionals Limited - Liverpool, provide personal care to people with complex needs who live in their own homes. At the time of our inspection, four people received support from this service. The agency has an office in Liverpool city centre.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

We were told people received support that maintained their safety. Staff were knowledgeable regarding safeguarding and knew how to raise concerns when necessary.

Risk assessments had been completed to ensure the environment was safe and in areas, such as mobility and scalds.

There was an accident policy and a contingency plan in place to ensure the service could continue in the event of an emergency.

Medicines were managed safely and staff were trained to administer them as they were prescribed.

Not all safe recruitment practices were clearly recorded in staff files to ensure only suitable staff were employed to work with vulnerable people. There were appropriate numbers of staff available to meet people's needs.

People were supported by staff who knew them well. Staff were trained in a variety of areas and were able to effectively support people who may display behaviours that challenge.

Staff told us they were well supported, received an annual appraisal and were able to speak to the manager at any time.

Consent was sought from people in areas, such as finances, administration of medicines and care planning. When people were unable to consent, the principles of the mental capacity act were followed to ensure care was provided in people's best interest.

People were supported by external health professionals to maintain their health and wellbeing. People's nutritional needs were met by staff that supported people to shop and prepare meals based on individual preferences. Staff were aware of people's needs and what support they required regarding their nutrition.

People told us staff were kind and caring their approach and had a good understanding of how to communicate with people who used methods other than speech.

Care plans were detailed, specific to the person and reflected people's choices and preferences.

We were told people's privacy and dignity was protected and care plans we viewed and staff we spoke with reflected this.

When able, people were involved in planning their care. For people unable to be involved, relevant others were consulted to ensure planned care was appropriate to meet people's needs.

Care files included information regarding people's social history, preferences and choices, which enabled staff to provide support based on the person's wishes. Staff we spoke with knew people they supported well.

People were supported to engage in activities that were meaningful to them and were supported to access advice and support from relevant health professionals in order to maintain their health and wellbeing.

Quality assurance systems were in place to monitor the quality of the service, such as surveys, audit's, spot checks and staff suggestion forms. People told us they were able to raise any issues with the manager and knew how to make a complaint should they need to.

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 received support that maintained their safety, by staff that were knowledgeable regarding safeguarding and knew how to raise concerns.

Not all risks had been assessed to ensure people's health and safety was maintained. Medicines were managed safely by trained staff.

Procedures were in place to ensure the service could continue in the event of an emergency.

Safe recruitment processes were not always clearly recorded in staff files.

Appropriate numbers of staff were available to meet people's needs.

Is the service effective?

Good

The service was effective.

People were supported by well trained staff who knew them and their needs well.

Staff felt well supported, received an induction, annual appraisal and were able to raise concerns with the manager at any time.

Consent was sought from people in line with the principles on the Mental Capacity Act 2005.

People were supported by staff and external health professionals to maintain their health and wellbeing.

People's nutritional needs were met by staff that provided support with shopping, meal preparation and nutritional intake.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring in their approach.

Care plans were detailed, specific to the individual and reflected their preferences.

Staff protected people's privacy and dignity when supporting people.

Is the service responsive?

Good

The service was responsive.

Relevant people were involved in the developing care plans to meet people's care needs.

Care files included information regarding people's history, preferences and choices and people were supported to engage in activities meaningful to them.

People had access to advice and support from relevant health and social care professionals in order to maintain their health and wellbeing.

Summary of findings

Is the service well-led?

Good

The service was well-led.

Feedback regarding the management of the service was positive and people told us they were able to raise any issues with the manager.

Quality assurance systems were in place to monitor the quality of the service and encourage improvements.

There was an open and person centred culture within the service.

Not all notifiable incidents had been reported to CQC.

Staff were aware of whistleblowing arrangements and told us they would report any concerns they had.

Network Healthcare Professionals Limited - Liverpool

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 25 November 2015 and was announced. We gave 48 hours notice because we needed to ensure that the registered manager would be available to answer any questions we had or provide information that we needed.

The inspection was undertaken by one adult social care inspector. Before our inspection we reviewed the information we held about the service. This included a review of the Provider Information Return (PIR) which had been completed by the provider. The PIR 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 looked at the notifications the Care Quality Commission (CQC) had received about the service.

During the inspection we spoke with the registered manager and two members of care staff. After the inspection, we spoke with two health and social care professionals, two care staff, one relative and one independent mental capacity advocate (IMCA) on the telephone. An IMCA supports and represents people in the decision making process if they lack capacity to make decisions themselves, in line with the mental capacity act 2005 (MCA).

We looked at the care files for three people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service.

Good

Is the service safe?

Our findings

Relatives and health and social care professionals we spoke with, told us people received support from the service that maintained their safety.

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. Staff we spoke with were able to explain different types of abuse, potential signs of abuse and how they would report any concerns. Staff told us, and training records confirmed that staff received safeguarding training to make sure they were up to date with safeguarding procedures. There was a safeguarding policy in place and staff signed to confirm that they had received the staff handbook which alerted staff to their responsibility to read the safeguarding policy. The manager had a safeguarding log; however no referrals had been required at the time of inspection. Local safeguarding procedures from surrounding local authorities were available for staff to refer to.

We looked at how risks to people had been assessed in order to maintain their health and wellbeing. We saw risk assessments had been completed in areas such as mobility, transfers and scalds. However, one care plan evidenced that a person was at risk of developing a pressure ulcer and risk management measures had been implemented, such as regular repositioning support and pressure relieving equipment. There was however, no risk assessment within the file to evidence this had been accurately assessed. The manager agreed to ensure a relevant risk assessment was completed.

Effective processes were in place to protect people from risks relating to their environment. For instance, the service ensured that electrical and mobility equipment were checked for safety, smoke alarms were monitored and flooring and lighting were checked to ensure they did not pose any risks. The service was not responsible for maintaining these checks as they provided support in people's own homes; however they monitored the checks and contacted the landlord if there were any concerns. The manager told us, and staff confirmed that contact numbers for relevant maintenance personnel were available in people's homes.

Care files we viewed contained a copy of a contingency plan that had been developed to ensure people's needs could continue to be met in the event of an emergency, such as a fire or flood.

There was an accident policy in place which had been reviewed in February 2015. There had been no accidents reported for this service.

We looked at how medicines were managed within the service. Staff we spoke with told us they received regular medicines training and the training records we looked at confirmed this. There was a medicines management policy in place to guide staff and covered this areas such as storage, administration and actions to take in the event of an error.

Relatives and health professionals we spoke with told us medicines were administered by carers as they were prescribed and are stored safely in people's homes. We viewed completed medicine administration records (MARs) for two people who staff administer medicines for. These records were pre-printed and supplied by a pharmacy; people's allergies were recorded to prevent people receiving medicines they may be allergic to. The records showed that medicines collected from the pharmacy were checked and receipt confirmed on the charts and all medicines had been signed for when given. Count sheets were in place for boxed medicines such as paracetamol, which enabled an accurate balance to be maintained. Records also reflected when creams were administered.

Medicine audits (checks) were completed by the manager every six months and covered aspects such as staff training, competency checks, storage, administration and records. Actions requiring improvement were identified. Team leaders also completed monthly medicine audits for each person supported. These checks were detailed and ensured the MAR chart was completed accurately, medicines required as and when were given and recorded correctly and reasons for variable doses were noted. Ordering and storage were also checked to ensure people had an appropriate supply of their medicines available when required.

We looked at how staff were recruited to the service. We saw four personnel files and evidence of applications forms, references and Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list

Good

Is the service safe?

for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. All files viewed contained a DBS check; however the date the DBS check made was not recorded on all files, so we could not see if this was completed before a person started in post. The manager agreed to record the issue date of DBS certificates for any new staff recruited.

All staff files contained photographic identification of the staff member. One file however, did not reflect that when convictions were evident on a person's DBS certificate, all potential risks were assessed. The manager explained the process that would be followed and this was reflected in the recruitment policy. This included a discussion with the potential employee, previous employers if applicable and risk management measures would be put in place, such as no lone working. The manager agreed to ensure this process was recorded for relevant staff members and advised it had been completed for current staff, but not clearly recorded. Since the inspection the manager has updated their pre-employment checklist to ensure DBS issue dates are recorded and has developed a DBS risk assessment tool and shared copies of these with us.

We looked at staffing within the service. The manager explained that most people they support received 24 hour staff assistance and staff rota's we viewed showed that these staffing levels were consistently maintained. Additional staff were provided on particular days each week to enable people to access the community for activities. Relatives and health professionals we spoke with told us staff were always available to provide support to people. For those that did not receive 24 hour support, we were told staff always arrived on time. Staff we spoke with told us there was always enough staff to meet people's needs and that only staff who knew people's needs well would cover in the event of sickness or holidays.

Staff told us they had access to a good supply of gloves and aprons in each person's home in order to prevent the spread of infections.

Good

Is the service effective?

Our findings

Relatives and health care professionals we spoke with told us they were happy with the service provided. An advocate, who represented the views of some people using this service, told us they had no problem with the support offered to people and that staff knew people they supported, "Inside out." Staff we spoke with agreed that they knew people's needs and preferences well.

All people we spoke with told us staff were helpful and knowledgeable regarding the needs of people they supported. One person told us staff were particularly effective at supporting people who displayed behaviours that may challenge. One care file we viewed contained very detailed information to guide staff how to support a person to manage their behaviours and this support had been agreed by the person.

Staff told us they felt well supported and trained to meet people's needs and carry out their roles and responsibilities effectively. Staff told us they would never be expected to support a person alone that they did not know. Most staff we spoke with had worked with people they were supporting for a number of years. When people receiving support came to Network Healthcare Professionals, a number of staff transferred from their previous provider in order to continue providing continuity of care to people in their new homes.

We looked at how staff were trained within the service. Most training was delivered through DVD's which staff watched and then completed an assessment to ensure they understood the information. Staff told us some training was delivered "face to face", such as manual handling and that they refreshed all training every year. The training matrix we viewed showed that most staff had completed recent training in areas such as safeguarding, food hygiene, fire safety, medicines, infection control and health and safety. Training delivered to enable staff to meet people's specific needs was also evident, such as epilepsy, basic life support, dementia, mental capacity and deprivation of liberty safeguards. The Mental Capacity Act 2005 (MCA), is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Deprivation of liberty safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We looked at how staff were inducted into their job role. Staff told us that induction included completion of all mandatory training courses prior to supporting people. Staff also shadowed a more experienced member of staff in order to get to know the needs of people receiving a service. The manager told us, and staff files confirmed, that they only recruit staff with at least 12 months social care experience to ensure staff have the necessary knowledge and desire to provide high quality care to people. Staff files contained a set of scenario questions completed as part of induction, providing the manager with an understanding of how staff would respond in certain circumstances. All staff we spoke with told us the induction was sufficient and prepared them for their role. The manager showed us a new induction pack in place for any new staff, which covered the requirements of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers should adhere to in their daily working life.

Staff felt well supported in their role and told us they could contact a team leader or the manager at any time if they needed to. Staff told us they received formal supervision occasionally but stated they received informal support from team leaders and the manager on a daily basis. Staff also told us they could have a formal supervision whenever they wanted one and were happy with this. The manager regularly visited staff whilst they were supporting people and this provided an opportunity to raise any issues. Staff told us they received an annual appraisal and these were evident within staff files.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). During discussions with staff they told us they always asked for people's consent before providing support. Care files we viewed showed that when able, people had been consulted regarding their support and consent was given in areas such as care planning, administration of medicines, support with finances and consent to receive support from male carer's.

When people lacked capacity to give consent, an independent mental capacity advocate had been involved to represent people and be their voice when decisions needed to be made. We spoke with an advocate who represented people using this service and they told us staff

Good

Is the service effective?

always considered people's consent. They told us staff acted in the best interests of the people they supported and also described situations when staff had acted as a good advocate for people.

One care file we viewed showed that when a person had lacked the capacity to make a specific decision, relevant people had been involved in the decision making process in their best interest. This meant that the service was working within the principles of the MCA.

People were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, community psychiatric nurse, district nurse, advocate, dietician, tissue viability nurse and diabetic nurse.

Staff told us, and care records confirmed, that they supported people to attend medical appointments and made contact with relevant health professionals based on the needs of the people they were supporting. One health professional we spoke with told us the manager kept them fully updated regarding a person's mental health needs and reported any changes or concerns.

Staff supported people to maintain their nutritional wellbeing by assisting with shopping, food preparation and providing support to eat and drink when necessary. Care files we viewed showed that people had plans of care in place to inform staff of their nutritional needs. For instance, one care plan gave specific information regarding how to support a person to eat and the need to wait a set amount of time between mouthfuls in order to prevent choking.

When able, people were supported to make choices regarding their meals. For people who were unable to verbalise their preferences, staff told us they watched people for their facial expressions to establish if they enjoyed the meal. Staff told us they have developed a good knowledge of people's preferences and made meals with these in mind. Food charts were completed when required to monitor people's nutritional intake. Daily records showed that staff always recorded what meal was prepared to prevent repetition. Records showed that relevant health professionals, such as the dietician and speech and language therapist, were contacted when necessary, in order to maintain people's wellbeing.

Good

Is the service caring?

Our findings

In order to gain views of whether the service was caring, we spoke with a number of different people such as relatives, health and social care professionals. This was because the people who used this service communicated in different ways and we were not able to directly ask them their views about their experiences.

All people we spoke with were positive about the staff and their caring attitudes. Comments about the carer's included, "Kind and caring and go above and beyond," "Can't fault them" and people being supported were, "Lucky to have them." Staff spoke about the people they supported in a caring way and they told us they cared about people's wellbeing.

We spoke with an advocate who represented the views of some of the people receiving support from the service, and they told us the carer's were always kind, had good communication skills and act in the best interests of people they support.

Staff had a good understanding of people's needs and how they communicated, such as looking for facial expressions and understanding what certain behaviours might mean for the person. Staff told us that having a consistent staff team helped provide support in accordance with people's individual needs and wishes.

Care files we viewed were very detailed and specific to the person, reflecting their wishes, choices and preferences. Files provided information on people's life events, what people were able to do for themselves, what they required support with and how they would like that support to be provided. Preferences regarding daily routines, where and how they liked to spend their day, meals and night time routines, such as whether they preferred the light on or off, was all reflected. Care files gave an overview of what a good day would look like for each person. This enabled staff to provide support based on people's preferences, wishes and choices.

Care files showed that when able, people were involved in making decisions, such as what to eat or what activities to participate in each day. Care plans also contained outcomes for people to achieve and were written in a way that promoted people's independence. For instance, one care plan explained that staff were required to prepare a person's meal but guided staff to encourage the person to participate where possible, such as chopping vegetables.

All people we spoke with told us staff ensured people's privacy and dignity was maintained at all times. One person told us, "Staff are very conscious of people's dignity." Staff told us they always knocked on a person's front door even when they knew it is open and addressed people by their preferred name. Staff told us they protected people's dignity whilst providing personal care, by making sure curtains and doors were closed and towels were provided to protect people's dignity whilst washing.

For people that had no family to represent them and were unable to make decisions themselves, an independent mental capacity advocate was involved. We spoke with the advocate after the inspection and they told us the staff communicated any relevant information to them and ensured they were kept updated. The care files we viewed showed regular input from the advocate was recorded in relation to decision making.

Good

Is the service responsive?

Our findings

The people who used this service were unable to tell us if they were involved in planning their lives. However, care plans we viewed showed that people were supported to make day to day choices, such as which activities they wished to take part in, what to wear or what food to eat. This was often achieved through staff having a good understanding of people, their preferences and their communication techniques. Plans of care were often developed based upon the advice and guidance of relevant health and social care professionals involved in the person's care. The health and social care professionals we spoke with told us that staff adhered to agreed plans of care and liaised with others if there were any changes in the person's needs. If people were able to be involved in their care planning, consent forms were in place to confirm they had been consulted.

We viewed care files for three people receiving support from the service and these were well maintained and up to date. Files contained relevant information regarding people's health and social history which ensured staff had adequate information to meet people's needs.

Care files we viewed also included a description of the person's day to day needs and preferences. For instance, what social activities they preferred, preferences regarding gender of the carer who supported them, how they liked to dress and how they chose to spend their days. This meant that staff could respect each person's wishes and provide support according to their preferences, even when a person was unable to verbally communicate that information to the staff.

Care files showed that people were supported to participate in activities which they enjoyed. One person liked animals and had visited the zoo, safari park and local farm. Other recorded activities included trips to the local cinema, bowling and a pantomime. Some people had been on holiday recently with the support of staff and some had visited the set of coronation street as part of their birthday celebrations.

Visits from health care professionals, such as GPs; district nurses; physiotherapist; community mental health team; optician and dentists were recorded so that all staff would know when these visits had taken place and whether any changes were required to people's plan of care.

Staff, advocates, health and social care professionals and the registered manager, all explained to us that some people they support had moved into their current homes from a residential home setting. As some people had complex health and social care needs, staff who knew them well, also transferred to the new setting in order to ensure people received consistent, planned and coordinated care and support.

People's views regarding the service were sought. For instance one care file contained a completed quality assurance survey that had been completed by the person receiving support from the service. This had been developed in an easy read format to better meet the needs of the person providing the feedback.

The service had a complaints policy in place which provided a clear process to record and investigate any complaints received. This helped to ensure any complaints were addressed within the timescales given in the policy. The registered manager informed us that no complaints had been received or were being investigated. Staff told us that a copy of the policies and procedures were available in each person's home that they support, so could be easily accessed by staff, people using the service or their relatives. Relatives we spoke with told us they knew how to raise a complaint, but had not needed to do so.

Good

Is the service well-led?

Our findings

People we spoke with told us that the service was well run. There was a registered manager in post and people we spoke with knew who the manager was and how to contact them. People told us they could raise any concerns with the manager and were confident they would be listened to and staff felt well supported in their role. We received positive comments regarding the manager and people described her as, "Very approachable," "Supportive," "Cooperative" and "Always on the end of a phone." This demonstrated that the manager encouraged an open and transparent culture.

Relatives we spoke with told us that they had been given written information about the service that contained information about the service and contact telephone numbers in case they needed to ring the service office to speak to a manager.

Health and social care professionals we spoke with told us that the manager works in partnership with them to ensure the people they support received coordinated, joined-up care. One professional told us they received daily contact from the service to ensure they were kept up to date with the changing needs of a person being supported.

We looked at the quality assurance systems in place to monitor the quality of the service and drive forward improvements. We found that audits were completed monthly by team leaders, in areas such as finances and medicines. The manager completed a six monthly service review which looked at the service as a whole, including management of medicines; equipment maintenance and staff knowledge regarding equipment use; financial audit; staffing levels; safety of the premises including maintenance and smoke alarms; meals provided; record keeping and the general environment of each person's home. Records showed that these reviews were completed regularly. Records also showed that the manager completed spot checks, which focused on one area at a time, such as completion of MAR charts. Although staff files contained completed checklists, these had not been audited and had not identified the issues we raised with regards to reflecting safe recruitment processes.

The manager told us an internal auditor visited annually to complete checks and we observed them to visit on the day of the inspection. Manager meetings took place every three months to enable managers from other parts of the company to discuss issues and share best practice.

The registered manager took an active role in the running of the service. Our conversations with the manager confirmed that they knew the people the service supported well. The manager told us they visit each person regularly in their homes, complete spot checks and audits to ensure staff are adhering to the services' policies and procedures and providing quality care.

Processes were in place to seek views and gather feedback from people regarding the service. Care files evidenced that people who used the service and were able to do so, completed quality assurance surveys. Staff suggestion forms were utilised as a way for staff to share their views and one staff member told us changes had been made following a suggestion they put forward. An advocate we spoke with confirmed they had been asked for their views and felt able to raise any concerns.

Regular staff team meetings were held which enabled staff to raise any issues and be updated regarding the running of the service. We viewed a selection of the minutes from these meetings which showed issues such as medicines, outcomes of audits, care planning and any changes in people's needs were discussed.

From speaking with staff we found a person centred culture operated within the service. This meant that people's individual needs and choices were promoted and staffing was provided to support this. People's personal routines were followed and staff supported people to take part in the activities they wanted to.

The manager is required to send CQC notifications to report on incidents that affect people's safety and wellbeing. Before the inspection we looked at what notifications had been made by the service and none had been made. The manager told us there had not been any notifiable incidents. A care file we viewed however, recorded an incident for which the police were involved. The manager was unaware that a notification was required in this instance as the incident was not serious, but was aware of other incidents that required a notification to be made. The manager agreed to ensure notifications were made for any future incident which involved the police.

Good

Is the service well-led?

Staff we spoke with were able to describe the arrangements for whistleblowing. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right. CQC had received no whistleblowing complaints in the period since the last inspection. Staff told us they would not hesitate to raise any concern they had.