Care Quality Commission

Nursing Direct Healthcare Limited

Nursing Direct Ltd - DCA Office

Inspection report

NWS House
1E High Street
Purley
Surrey
CR8 2AF

Tel: 07725693354

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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 7 June 2018 and was announced. We gave the provider 48 hours to make sure a member of the management team was available in the office to meet with us.

This was our first inspection of this service since registration with us on 6 March 2017.

Nursing Direct is a domiciliary care agency that provides personal care and nursing care to people living in their own homes. People had a wide range of complex nursing needs. The agency provided care to people across a large area which included Peterborough, Sussex and London. There were 23 people receiving services from Nursing Direct at the time of our inspection.

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

The provider did not always carry out assessments in line with the Mental Capacity Act 2005 when there was reason to suspect people lacked capacity. This meant there was a risk people may receive care inappropriately. However we were not concerned this was the case with people using the service at the time of our inspection. The provider took immediate action when we raised our concerns in carrying out MCA assessments and arranged 'best interests' meetings where they had assessed people lacked capacity.

Staff training was developed and delivered around people's individual needs. The provider developed a staff training package for each person in relation to their needs. The provider assessed each staff member was competent in all aspects of care before they were able to lone work with them. Training was also tailored to the individual needs of staff and nurses were provided with training in specialist clinical skills to enable them to meet people's needs.

The provider managed people's medicines safely. Staff received training in medicines management, including in specialist techniques people required to administer and monitor their medicines.

The provider had suitable recruitment systems to check staff were safe to work with people. There were enough staff to support people safely. People were involved in the recruitment of staff. People met with staff selected to support them before their care began to check they wanted to receive care from them.

The provider assessed risks relating to people's care and put robust risk management plans in place to guide staff. Care plans informed staff about people's individual needs, and the best ways for staff to care for them.

People felt safe with the staff who supported them. Staff understood how to respond if they suspected

anyone was being abused and received training from the provider to refresh their knowledge.

Staff were supported through a programme of supervision, appraisal and mandatory training to help them understand their role and the best ways to care for people. Care workers were also encouraged to complete diplomas in health and social care to further their knowledge.

People received the necessary support from staff in relation to eating and drinking including support with any specialist equipment. The provider also catered to people's ethnic and cultural needs. People were supported with their day to day healthcare needs.

Staff treated people with kindness, dignity and respect and respected their privacy. Staff developed good relationships with people and understood their needs and preferences. People were involved in their care and were supported to maintain their independence.

The provider had systems in place to investigate and respond to concerns and complaints appropriately.

The provider had systems in place to assess, monitor and improve the service. The provider also gathered feedback from people and staff and used this as part of improving the service.

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.

The provider managed people's medicines safely.

Staff knew how to recognise abuse and how to respond to it to protect people.

There were enough staff to care for people. Staff suitability was checked during recruitment.

Risks relating to people's care were assessed and managed appropriately.

Is the service effective?

Good

The service was effective.

Staff training was developed and delivered around people's individual, assessed needs. Staff training was also tailored to the individual needs of staff.

The provider did not always assess people's mental capacity in line with the Mental Capacity Act 2005 although they improved their procedures immediately.

People received the right support in relation to eating and drinking and their healthcare needs.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and respected people's dignity.

Staff understood people's needs and preferences and developed good relationships with them.

People were involved in their care.

People were supported to retain their independent living skills as far as possible.

Is the service responsive?

Good

The service was responsive.

People's care plans were sufficiently detailed to guide staff in caring for them.

Systems were in place for the provider to investigate any concerns or complaints.

Is the service well-led?

Good

The service was not always well-led. The quality assurance processes in place had not identified the issues we found relating to the MCA.

Leadership was visible and competent.

The provider had systems to gather feedback from people and staff.

Quality assurance procedures were in place to monitor and improve the service.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This was a comprehensive inspection. The inspection took place on 7 June 2018 and was announced. We gave the provider 48 hours' notice of the inspection to make sure a member of the management team was available in the office to meet with us. The inspection was carried out by an inspector and an expert by experience who made phone calls to people and their relatives after the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed information we held about the service. This included statutory notifications received from the provider and the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make.

During the inspection we spoke with the registered manager, the operations manager, the nurse manager and two care workers. We looked at a range of records including three staff files, three people's care plans, records relating to medicines management and other records relating to the management of the service. On the same day as our inspection our expert by experience spoke with five people and four relatives via telephone.

After the inspection we contacted six professionals to gather their feedback on the service and we received feedback from two.

Good

Is the service safe?

Our findings

People's medicines were managed safely by the provider. People were positive about the support they received from staff with their medicines. Staff received training in safe medicines administration and in specialist administering procedures as required. The provider had robust systems to assess the competency of staff in administering medicines. We viewed medicines administration records and found they were completed appropriately and the provider had audited them comprehensively. The provider collected and audited medicines records each month to check people received their medicines safely.

Risks relating to people's care were reduced as part of keeping them safe. The provider identified risks relating to people's care and put clear management plans in place for staff to follow in reducing the risks. For example, the provider assessed risks relating to people's individual clinical needs and moving and handling and had clear plans in place to guide staff in reducing the risks. These plans included guidance on the best ways to reduce the risk of pressure ulcers or infections relating to equipment used to support people to eat or to breathe. The provider reviewed risk assessments which meant information for staff to follow remained current.

People were supported by staff who the provider checked were suitable. The provider interviewed staff to check they had the right qualities to care for people. In addition, the provider obtained references from former employers and checked for any criminal records. The provider also checked candidates' identification, proof of address, right to work in the UK as well as any health conditions which may affect their performance. The provider continued to check the suitability of staff for the role during their probationary period.

There were enough staff deployed to care for people. Most people told us they did not experience missed visits or lateness. The registered manager told us there were enough staff to care for people although they continually recruited to help expand the service. The registered manager and operations manager told us they, and other trained and experienced office staff, were available to care for people if necessary although that was rarely required.

Systems were in place to protect people from abuse and neglect. People felt safe with the staff who supported them. Comments we received included, "Very safe!", "They do very nicely", "They are perfectly okay. We're great friends in fact", "I feel very safe. The way that they move me from place to place using the hoist makes me feel safe" and "They let me know when they are going to be late." Staff received training in safeguarding and knew signs of abuse and how to respond to keep people safe. Staff were confident to whistle blow if they had any concerns and had confidence in the way the provider would respond. The registered manager had a good understanding of their responsibilities in relation to safeguarding.

The provider had systems to learn and improve in response to any safety incidents. Staff recorded details of accidents and incidents and the provider analysed reports to ensure people and staff received the right support. The provider maintained a spreadsheet of accidents and incidents which they reviewed to identify any patterns and to determined action to take to reduce the risk of reoccurrences. As an example, the

provider reviewed the way staff cleaned equipment to help people breathe after an incident highlighted a safer way was required.

Good

Is the service effective?

Our findings

Staff training was developed and delivered around people's individual assessed needs. One person told us, "Yes, they are trained well enough for my needs." A professional told us the assessment process was thorough. The provider developed a training programme termed 'competency observation frameworks' individual to each person to help all staff working with them to develop a thorough understanding of their needs. The frameworks were developed through a thorough assessment of people's needs. For example, one person had complex and unique needs in relation to moving and handling so the provider developed a framework to ensure all staff understood how to support the person to transition and to ensure all staff were supporting them in the same way. Another person had a framework which covered how to communicate with them. This ensured all staff were trained in the same way to understand the equipment in place to support a person to communicate. Other 'frameworks' included clinical needs such as how to use specialist equipment to support people to breathe, eat and drink and how to support people with their personal care and elimination needs. Each person had several different 'frameworks' to train staff thoroughly in all areas of their care. Each framework included instruction, observation and assessment of staff carrying out each task by a senior nurse. Staff were only permitted to lone work with people when they had been assessed as competent against each framework. Staff were reassessed each year to ensure their skills and knowledge remained up to date.

People and their relatives were involved in planning framework training. The registered manager told us how people and relatives were consulted when developing people's individual competency frameworks to ensure they reflected people's needs and preferences.

Training was tailored to the individual needs of staff. Each staff member had a training programme in place. The provider identified any gaps in staff training and sourced courses to ensure their training was comprehensive. A registered nurse told us the provider had trained them in a number of advanced techniques to enable to them to meet people's healthcare needs. These included courses in taking blood and inserting cannulas into veins to administer medicines. The nurse told us the provider helped them prepare for a nursing evaluation by the regulatory body and described the registered manager as "very supportive." A different registered nurse told us the provider had also trained them in advanced techniques including the use of specialist equipment to help people eat and breathe and to understand people's needs in relation to swallowing better. The provider did not permit staff to work with people if their mandatory training was out of date and electronic systems were in place to monitor staff training needs. Mandatory training included a number of topics such as safeguarding, infection control and the MCA. The provider also encouraged care workers to complete diplomas in health and social care. New staff were encouraged to complete the care certificate. The care certificate is a national qualification developed to provide structured and consistent learning to ensure that care workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe, quality care and support.

People and relatives were involved in the recruitment of staff. One person told us, "I always do a `meet and greet' with new carers." People met with the staff the provider identified as suitable to support them beforehand. This gave people the opportunity to find out if they were well-matched to the staff and if they

wanted to receive care from them and were able to change their staff.

Staff received regular supervision sessions with their line manager and annual appraisal. During supervision staff reviewed the best ways to care for people, their personal development and training needs.

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. The provider did not have robust systems to provide care in line with the MCA at the time of our inspection, although they took action immediately to improve when we fed back our concerns. The management and staff told us there were four people who they had reason to believe lacked capacity in relation to their care. For one person a GP had carried out an MCA assessment which found they lacked capacity in relation to a particular decision. However, the registered manager told us they disagreed with the outcome as they believed the person had capacity. The provider was advocating for the person by challenging the GP in relation to their MCA assessment. For a second person their relative had legal authorisation to make decisions on their behalf, although this was not clearly referenced in their care plan for staff to be aware of. After the inspection the provider told us they had improved the way this information was recorded. For the other two people the provider had not carried out MCA assessments and ensured decisions were made in people's 'best interests', in line with the Act. The provider told us the CCG carried out MCA assessments although records showed these were not always relevant to the care the agency provided to people. This meant the agency should have carried out their own MCA assessments before providing care to these people to determine their capacity. The day after our inspection the registered manager told us they had carried out MCA assessments for these three people and were arranging 'best interests' meetings with others involved in their care as soon as possible. The registered manager also confirmed they had improved their pre-admission assessment processes to ensure they considered whether MCA assessments were required . Staff received training in the MCA to help them understand their responsibilities in relation to this. The provider told us they would review training for staff who would be involved in carrying out MCA assessments for people referred to the service.

People received the support they needed in relation to eating and drinking. One person told us, "I'm on a special diet and they help me to measure food that I find difficult, prepare and cook what I need to eat." A second person told us, "I'm quite happy with everything. They have encouraged and supported me to eat well." A relative told us, "Staff help [my family member] with the diet as it is very precise." Some people had specific requirements in relation to eating and drinking, such as equipment to provide nutrition directly into their digestive system. The provider ensured only staff who received training in relation to these specific needs provided nutritional support to people. The provider recorded clear guidelines in people's care plans for staff to follow in providing this specialist support. The provider monitored people's risk of malnutrition and liaised with professionals such as dietitians to ensure people received the right support. The operations manager gave us examples of how they had met the needs of people who had specific needs and preferences in relation to cultural and ethnic foods. Some people had been matched with staff from particular ethnic or cultural backgrounds who were able to prepare people's preferred meals.

People received support in relation to their healthcare needs. Many people had complex healthcare needs and the provider ensured their care plans contained detailed information and guidance for staff in relation to these needs. Contact details for other professionals involved in people's care were also accessible to staff in people's care plans.

Good

Is the service caring?

Our findings

People were positive about the staff who supported them and staff were kind and caring. One person told us, "Staff know to massage my shoulders and neck area when I am in pain, as just taking pain killers alone doesn't always work." A second person said, "Everything is done in the way that I like. I do enjoy the company and having a chat when they come, it breaks up my day." A relative told us, "They have been excellent caring for [my family member], much better than the previous company. The carers are genuinely kind and gentle." A second relative said, "They are kind and caring. We've not got a problem really. They always let him know what they are doing." Staff we talked with spoke about the people they supported in a caring manner and told us they were passionate about helping people live their lives as they chose.

Staff treated people with dignity and respect. Feedback from people and relatives supported this. One relative told us, "There is a curtain which divides the room where my [family member] lives from the rest of the lounge area, and staff always close this when attending to my [family member's] needs, affording him some privacy and to keep him in a dignified way." The provider promoted dignified care and several staff were 'dignity champions' having pledged to be good role models. Staff completed training in dignity in care and their competency in providing dignified care to people was assessed by the provider.

People received care from staff who understood them and their needs. People were listened to by staff. People and relatives told us people received care from the same staff which provided consistency of care and staff came to know them well over time. However, when their usual staff went on leave or were sick people and relatives told us they were often not provided with replacement staff who knew them well. The provider told us they were aware of this issue and were looking to address it.

People's communication needs were understood by staff. People's care plans guided staff on people's communication needs and any specialist equipment which was required. Staff received training in people's specialist communication needs and a senior nurse assessed staff were competent for each person before they were able to lone work.

People told us staff had sufficient time allocated to interact with them in a meaningful way and always did so. This meant care was not just task based and people were treated as if they mattered. In addition, people told us the service provided them with staff of their preferred gender.

Some people received care from staff with specific backgrounds or skills. For example, some staff with specific language skills and cultural backgrounds had been recruited when people required this. The provider had also matched some people with staff who shared similar hobbies and interests to help them build a relationship.

People were encouraged to be involved in their care. One person told us, "They respect my choices." People told us staff listened to them regarding the care they needed and respected their preferences, in this way people directed their own care.

People were supported to maintain their independence as far as possible. One person told us, "They encourage and push me to do as much for myself as possible." Care plans contained details of how staff should involve people in their care, including offering choices and what aspects of their care people should be prompted to do for themselves.

Good

Is the service responsive?

Our findings

People's care was planned and delivered according to their needs and preferences. A relative told us, "[My family member] has a Care Plan which I've been involved with. We have just done the six-monthly review." Care plans were comprehensive and guided staff on people's identified needs as well as their backgrounds, hobbies and interests and people who were important to them. Care plans also set out how people preferred to receive their care.

Staff were well supported to understand and meet people's needs. Staff told us the provider discussed people's needs with them before they began providing care and they always read people's care plans. When the provider recently began providing care to a person with an established team of care staff the provider arranged a training day for the team in a local hotel. Staff used this opportunity to improve their communication as a team and ways of working together. The provider recruited and trained staff so they had the specialist clinical skills each person required. For example, the provider ensured only staff who received tracheostomy training worked with people who had this specific requirement.

People's needs were reviewed regularly by the provider. The provider reviewed care plans every six months or more often if people's needs changed or if their needs were particularly complex. The provider often met with other professionals involved in people's care as part of the review process to share learning and best practice. This meant information in people's care plans was up to date and reliable for staff to follow. The provider involved people in the review process by meeting with them and their families to discuss how well their care package was meeting their needs.

People were supported to plan their end of life care where appropriate. The provider trained staff to understand best practice in end of life care. When people required specific nursing care, such as pain relief, at the end of their lives staff were able to provide this.

People's concerns and complaints were responded to appropriately by the provider. A relative told us, "They're getting better at listening and acting on things. Mainly having the amount of carers that we need, especially covering staff holidays. They've not always got people to cover when the regular staff needs time off." People knew how to complain as people received information about complaints from the provider when they began using the service. The provider kept records of concerns and complaints with details of how they had been investigated and responded to. Records showed the provider responded to concerns and complaints appropriately to improve people's experience of using the service. The provider also kept records of compliments and shared these with staff to increase morale.

Good

Is the service well-led?

Our findings

The provider had quality assurance systems in place. The quality assurance systems included spot checks and observations of staff carrying out care to check they were kind and respectful and care was in line with best practice. The provider closely monitored staff supervision and training, accidents and incidents, medicines records, care plans, complaints and any allegations of abuse by reviewing all relevant reports and tracking progress. The provider also audited staff files and care plans to ensure they contained the necessary information. Although we found concerns regarding MCA assessments the registered manager took immediate action to review processes and carry out the assessments where these were lacking. The findings of the quality assurance processes were discussed during three monthly clinical governance meetings and improvements were made where necessary. The provider had commissioned a company to create an electronic system for them to monitor key aspects of quality at the service and we will review this at our next comprehensive inspection.

Most people and relatives felt the service was well-led although two relatives were less positive and shared suggestions for improving the service. One relative told us, "They have gone above and beyond. Anytime that I email or call they respond immediately. They have been assisting with assessments to support my father's wish to receive his care at home. They get five stars from me, top marks!" A second relative said, "I have every faith that they are well led." Comments from people included, "I've got a good relationship now with the person that manages my care package", "They ring regularly to see if everything is okay" and "They are not too bad." Of the two relatives who were less positive the first held concerns that the service was unable to provide suitable staff when the regular staff were on annual leave or off sick. The provider told us they were reviewing processes to help improve this. The second relative told us, "They have been good but they're not brilliant" and shared concerns about lateness and sometimes staff cancelling shifts at short notice. The relative told us the provider had been working with them in putting in place their suggestions and they had experienced some improvements.

Leadership was visible and competent. The registered manager registered with us in October 2017 and had worked for the provider previously in a different capacity. The registered manager was a nurse with many years' experience as a nurse manager. Our inspection findings and discussions with the registered manager showed they had a good understanding of their role and responsibilities. The registered manager implemented positive changes to the service such as reviewing the bonus scheme for office staff to improve team work. The previous bonus scheme discouraged team work so the registered manager reviewed this so bonuses were gained by the whole team only if all targets for the team were met, such as reviewing care documentation on time and contacting people to gather their feedback on a set basis. The registered manager also spent time with office staff individually and in small groups to help build team spirit. The structure of the organisation was clear with office staff working in distinct teams such as recruitment and quality assurance. Staff were positive about the registered manager and told us they felt well supported. Staff told us the 'on-call' system was robust as a senior member of staff was always available to support them outside the usual office hours. Staff were clear of their roles and responsibilities.

The provider sought and acted on the views of people and staff. Office staff called people each month to

find out their views on the service and the provider reviewed all feedback received, creating a monthly report. We viewed monthly reports and these showed most people were satisfied with the care they received. For example, the May 2018 report showed 60% of people rated their care as 'excellent' and 30% 'good' while 82% felt the way their care was managed was 'excellent' and 12% felt this was 'good'. People also received regular visits from senior staff to review their care in person and check they were satisfied with the quality of care. Systems to gather feedback from staff included regular supervision meetings with line managers and team meetings.

The provider maintained most records well to ensure they contained an accurate record of people's care. However, we identified the way records relating to supporting people to reposition could be improved. For some people the provider had 'repositioning charts' in place to record how staff supported them to reposition. For other people staff recorded repositioning within daily care notes. This meant it was more difficult for the provider to audit to check people were repositioned appropriately. When we discussed this with the provider they told us they would put repositioning charts in place for all people who required this type of care.