Calea UK

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

There were two organisations registered with the Care Quality Commission under one parent organisation at the same address. Calea UK and the parent organisation Fresenius Kabi were registered as Cestrian Court. In practice this meant there was one board of directors and one senior management team shared across both organisations. The provider did not hold separate information for each organisation and therefore the information provided for the inspection covered both Calea UK and Fresenius Kabi. This included training statistics, policies and procedures, human resources information and governance and risk processes. Where the information is pertinent to Calea UK only this has been specified in the report.

We found the following issues that the service provider needs to improve:

- There were systems in place for the reporting and investigation of safety incidents that were not fully understood by staff. The identification and recording of incidents was not clear as these were documented along with complaints.

Summary of findings

- There was a lack of understanding and implementation of the duty of candour.
- The policies and procedures for safeguarding children were not robust.
- The majority of permanent staff and 42% of bank nurses had completed safeguarding training for children, however; this was to level two only and not the required level three.
- Prescription records for all patients were not always fully completed.
- Patient records were completed both on paper and electronically. We observed and the provider's own audits had found that not all records were completed fully.
- Mandatory training rates were poor for bank staff at 54% completed.
- There was a lack of assessment and clarity of actions required for responding to patient risks.
- There was no audit programme in place.
- Policies and procedures were not always referenced and several key policies had been revised or come into effect immediately before the inspection.
- The clinical outcomes for patients were not measured.
- Not all staff had received an annual appraisal and there was no current formal supervision in place at the time of inspection.
- Not all staff competencies were consistently completed; therefore, we were not assured that staff had all the required skills.
- The six weekly field visits to assess staff competence were overdue for most staff.
- Patients' mental capacity was not formally documented and not all staff were aware of their responsibilities towards Mental Capacity Act and Deprivation of Liberty safeguards.
- Patients did not have individualised care plans relating to their clinical, social or emotional needs.
- There was a lack of robust governance processes.
- There were gaps in the controls for identified risks and the system for escalation of risks and forums for discussion were not clearly documented.
- The information obtained in order to appoint directors was not adequate to meet the fit and proper persons' regulation.
- If staff raised concerns they did not receive feedback.
- A staff survey showed some dissatisfaction with the communication within the organisation and nearly a third of staff did not feel valued by the organisation.

However we found the following areas of good practice:

- There was appropriate equipment to provide care and treatment for patients in their home.
- We observed staff following good hygiene practises when delivering care and treatment.
- The majority of permanent staff had completed mandatory training.
- There were vacancies across the service, however bank staff were utilised to make staffing levels sufficient.
- Patients had access to a 24 hour helpline for support and guidance.
- Staff had access to information including protocols and care pathways.
- We observed that verbal consent was obtained prior to any care or treatment.
- Services were delivered by caring, committed and compassionate staff that treated people with dignity and respect.
- Patients were involved in decisions about their care and treatment and told us they were given adequate information before, during and after treatment.
- Staff provided emotional support to patients and recognised the importance of involving families or carers in their care.
- Staff assisted patients with a flexible service to ensure treatment was provided to include life events such as social outings and holidays.
- New patients were provided with a comprehensive welcome pack. This included a step by step guide of what to expect, frequently asked questions and useful contact details including the advice line.
- Patients had access to the helpline if they wished to raise a complaint.
- Staff of all levels were complimentary about their immediate line managers and the senior management team.
- We were told there was an open culture and staff were able to raise concerns freely.
- Procedures were in place to protect staff that were lone working.
- The results of an annual patient survey showed a high level of satisfaction.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements to help the

Summary of findings

service to improve, even though a regulation had not been breached. We also issued the provider with four requirement notices that affected Calea. Details are at the end of the report.

Summary of findings

Contents

Cestrian Court

Services we looked at

Community health services for adults (including reference to community health services for children and young people).

Summary of this inspection

Background to Calea UK

Calea UK is a specialist community nursing service which provides a service to patients in their own homes or other care settings such as care homes. The nurses train patients and carers and offer clinical support with parenteral and intravenous treatments and nutritional therapies. For the purposes of this report we have reviewed the service in England only as our regulatory remit does not extend to Wales.

There are two organisations registered at the same address. Fresenius Kabi and Calea UK have been registered with the Care Quality Commission as Cestrian Court since 2 September 2011. There have been two inspections carried out at this service. The most recent inspection was carried out on 24 July 2013 (inspection report published 21 August 2013).

On the same day as we inspected Calea UK a team of CQC inspectors inspected Fresenius Kabi. A separate report has been produced for that organisation.

Our inspection team

The team that inspected the service comprised one inspection manager, five CQC inspectors and one specialist advisor for governance.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive inspection programme for independent healthcare services.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

During the inspection visit the inspection team carried out visits to seven patient's homes and one in hospital with four community nurses, spoke with six patients face to face and 10 by telephone. At the head office we interviewed a range of managers including ; one clinical account manager; one clinical business manager; one human resource manager; one senior professional development manager who was also the advice line manager, a team leader and an administrator. We interviewed the nurse leadership team and had a telephone interview with the Managing Director.

We observed how staff were caring for patients and carers during field visits and observed one discharge planning assessment at an NHS trust.

We reviewed a range of policies, procedures, patient records, personnel records and other documents related to the running of the service. We also reviewed data and information provided by the organisation.

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Summary of this inspection

What people who use the service say

During the inspection, we spoke with six patients and three relatives/carers who were all positive about the care and treatment they had received from Calea UK services and staff. We phoned a further 10 patients who used Calea UK services and all feedback was positive. Patients told us the nurse visits helped them to feel safe and described how nursing staff maintained good hygiene practises when delivering care. Patients felt support was readily available if they had any concerns; nurses were respectful and protected their dignity during personal care. Patients and their relatives felt informed and involved in choices about care.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- There were systems in place for the reporting and investigation of safety incidents that were not fully understood by staff. The identification and recording of incidents was not clear as these were documented along with complaints.
- There was a lack of understanding and implementation of the duty of candour. Since the inspection the provider has told us that duty of candour training and a clear process were implemented, through e-learning, to all field based nurses. They did not provide the evidence for us to review.
- The policies and procedures for safeguarding children were not robust.
- Safeguarding training for permanent staff was at 96% completed for safeguarding adults training to level two and 94% safeguarding children to the same level. However, of the 117 bank nurses employed, only 52% had completed safeguarding adults training and 42% safeguarding children, both to level two.
- Following the inspection the provider has told us that additional safeguarding leads have been appointed and trained to level 4 for children. Level 3 safeguarding training was implemented for all staff. Bank nurses were suspended within 10 days of the inspection if the training was not completed. They did not provide the evidence for us to review.
- Prescription records for all patients were not always fully completed.
- Patient records were completed both on paper and electronically. We observed and the provider's own audits had found that not all records were completed fully.
- Mandatory training rates were poor for bank staff at 54% completed. Following the inspection the provider told us that 64% of bank nurses had completed the training. The remaining 36% were suspended as they had not completed this training. The reduction of the bank nurse availability had not had not had any impact on the delivery of the service.

Summary of this inspection

- There was a lack of assessment and clarity of actions required for responding to patient risks. Following the inspection the provider told us a risk assessment tool had been introduced and training was being implemented. They did not provide the evidence for us to review.

However;

- There was appropriate equipment to provide care and treatment for patients in their home. The equipment was well maintained and tested to ensure its safety and effectiveness.
- We observed staff following good hygiene practises when delivering care and treatment.
- The majority of permanent staff had completed mandatory training.
- There were vacancies across the service however bank staff were utilised to make staffing levels sufficient.

Are services effective?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- There was no audit programme in place. Two audits had been completed in the past 12 months and there had been delays with the production of action plans following these.
- Policies and procedures were not always referenced and several key policies had been revised or come into effect immediately before the inspection.
- The clinical outcomes for patients were not measured.
- Patients' weights were documented, however; it was unclear as to where and when the weight had been performed. This meant it was difficult to assess accurately when patients had gained or lost weight.
- Not all staff had received an annual appraisal and there was no current formal supervision in place at the time of inspection. On average 71% of staff were up to date with their annual appraisal
- The six weekly field visits to assess staff competence were overdue for most staff.
- Not all competencies were consistently completed, therefore; we were not assured that staff had all the required skills.
- Patients' mental capacity was not formally documented and not all staff were aware of their responsibilities towards Mental Capacity Act and Deprivation of Liberty safeguards. Following the inspection the provider told us mental capacity act training was added to the mandatory e-learning. No evidence was provided for us to review.

Summary of this inspection

However;

- Patients had access to a 24 hour helpline for support and guidance.
- A multi-disciplinary assessment was completed prior to hospital discharge for each patient. We were told this assessment was shared with all nurses in the patient's team.
- Staff had access to information including protocols and care pathways.

We observed that verbal consent was obtained prior to any care or treatment.

Are services caring?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- Services were delivered by caring, committed and compassionate staff that treated people with dignity and respect.
- Patients were involved in decisions about their care and treatment and told us they were given adequate information before, during and after treatment.
- Nurses asked about a patient's general wellbeing and health during their visits. If a patient had any issues or concerns they were directed to an appropriate health practitioner.
- Staff provided emotional support to patients and recognised the importance of involving families or carers in their care.

Are services responsive?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- There was a specific team to plan the visits to patients. These staff were accessible to patients and would make changes to visit times if this was required.
- Staff assisted patients with a flexible service to ensure treatment was provided to include life events such as social outings and holidays.
- New patients were provided with a comprehensive welcome pack. This included a step by step guide of what to expect, frequently asked questions and useful contact details including the advice line.
- Examples were shared of when staff had responded to patient's individual needs.

Summary of this inspection

- Patients had access to the helpline if they wished to raise a complaint.

However;

- Patients did not have individualised care plans relating to their clinical, social or emotional needs.

Are services well-led?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- Staff other than senior managers were not aware of the vision and strategy for the service.
- There was a lack of robust governance processes. This included a lack of reviews of policy standards, no discussion of quality or risk in the management team meetings and a lack of clarity of governance processes within the nursing services.
- There were gaps in the controls for identified risks and the system for escalation of risks and forums for discussion were not clearly documented. Following the inspection the provider told us the nursing risk register was reviewed in the monthly leadership meetings. It was also a mandatory agenda item on all executive management meetings.
- The information obtained in order to appoint directors was not adequate to meet the fit and proper persons' regulation.
- If staff raised concerns they did not receive feedback.
- A staff survey showed some dissatisfaction with the communication within the organisation and nearly a third of staff did not feel valued by the organisation.

However:

- There was a governance structure for the parent organisation of which Calea UK nursing services were a part.
- Staff of all levels were complimentary about their immediate line managers and the senior management team.
- We were told there was an open culture and staff were able to raise concerns freely.
- Procedures were in place to protect staff when they were lone working.
- The results of an annual patient survey showed a high level of satisfaction.

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for adults safe?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Safety performance

- Safety information, such as venous thromboembolisms and pressure ulcers, was not monitored by this provider. Other care providers, such as district nurses and home-care providers, within the multi-disciplinary team had the responsibility to obtain and monitor this information where it was applicable to the individual patient.

Incident reporting, learning and improvement

- Staff told us they reported incidents by contacting the internal helpline or their managers.
- The provider had a policy which was titled: "Handling customer complaints". In this policy it was stated that the complaints officer should identify the appropriate complaint category, one of which was an incident. Reference was made to another policy for the management of incident reports, which were received directly from an NHS trust. There was no procedure for the notification and management of incidents identified internally, unless they were raised as a complaint.
- There was no direction for staff as to what should be reported as an incident. Staff we spoke with told us they would report any change to the routine care and treatment a patient would receive via the internal helpline; however, they did not recognise this as reporting incidents. This included administration of parenteral nutrition which did not meet the prescription and incomplete administration of feeds.
- On requesting information from the provider about incidents, a database of information which contained complaints was provided. All entries on the database had a "complaint" number and a "complaint" description. Examples of these included medication errors, patient feeds not going through correctly and missed visits. As clinical incidents and complaints were recorded together on the same database, it was difficult to determine the difference in how complaints and incidents were managed. Nurses told us they would report such occurrences to the internal helpline, who would generate a report. These reports had been analysed monthly for the past two months by a senior manager.
- The analysis of the helpline data for February 2017 did not provide the total number of calls made to the helpline or how many were categorised as incidents.
- There were no never events reported in the 12 months prior to the inspection. A 'never event' is defined as: 'A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers'.
- There had been no serious incidents reported in the 12 months prior to this inspection.
- On the database provided there were 96 "complaints", which had been recorded against the Calea nursing service in the three months prior to the inspection. Of these, one was classified as critical, 43 as major and 52 as minor. At the time of the inspection, six investigation reports had been approved and 50 were under investigation.
- We requested three investigation reports from the provider and were provided with one. This was a customer complaint and not an incident investigation report.

- A draft process for triage of advice line reports was reviewed. This was a flow chart for the reporting and management of clinical incidents and complaints. This had been developed by the provider during the inspection.
- Staff told us they received emails which told them about changes to practice or reminded them about aspects of best practice. However, they were not always clear if this information had been generated as a result of learning from incidents.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We were provided with a policy relating to duty of candour, which was effective from the first day of our inspection: 27 March 2017. Although this policy was version two, the previous version had never been in circulation as it was the same policy with a slight change to an annexe. This meant prior to the inspection there had been no policy in place for staff to refer to and ensure that the duty of candour was followed. The duty of candour regulation was introduced into legislation for providers of independent healthcare in April 2015 and there had been no measures put into place to attempt to meet this regulation for almost two years.
- In reviewing the duty of candour policy, we noted that it did not reference the complaints policy and vice versa. As a result, staff may be unable to correctly identify instances that would meet the threshold for the duty of candour and review the policy to ensure that the regulatory responsibility is discharged appropriately.
- Nurses we spoke with were not aware of the duty of candour policy or their role within its implementation.
- One complaint we reviewed had been classified as major. There was no evidence that duty of candour had been followed in the management of this complaint/ incident.

Safeguarding

- Safeguarding training was in place and provided for all staff, but it was provided to level two only. This included nurses working with children and managers who provided advice and support to other staff in the organisation. This was discussed with the registered manager during the inspection and immediate action was taken to provide staff with advice and support from an appropriately trained person external to the organisation. Additional training to level three for staff who provided care to adults and children was also identified and booked to be completed by the end of May 2017.
- As of February 2017, 96% of permanent nursing staff had completed safeguarding adults training to level two and 94% safeguarding children to the same level. However, of the bank nurses employed, only 52% had completed safeguarding adults training and 42% safeguarding children both to level two.
- Whilst most nurses we spoke with were aware of how to identify a potential safeguarding concern, some were not clear about all issues they could encounter during their home visits, such as child sexual exploitation.
- Nurses told us they would report any concerns they had to the internal advice line and rely on them to pass the information to the necessary authorities. We saw examples where staff at the advice line had taken appropriate action to protect patients identified as being at risk. This included a concern raised by nursing staff regarding a patient with a mental health disorder, where follow up contact was made with the multi-agency safeguarding team. Appropriate procedures were followed to ensure patient safety.
- When nurses did inform the helpline about any concerns, they did not keep their own records of information provided and did not receive feedback about the actions taken. There was no record on the information we saw about how this information was passed to nurses making subsequent visits to the patient. This included concerns about a partner of a patient who refused entry for the nurses to complete the patient's care.
- The safeguarding policy we reviewed had become effective on the day of the inspection. We reviewed the previous policy .This policy, which came into effect on 27 March 2017, was identified as being the first issue of Standard Operating Procedure (SOP Safeguarding Vulnerable Children). The policy included guidance for Female Genital Mutilation (FGM) and Child Sexual Exploitation (CSE). This previous policy had not

contained the information required in the intercollegiate guidance "safeguarding children and young people: roles and competences for healthcare staff" (third edition March 2014).
- A generic service level agreement document we reviewed stated "paediatric nurses will have had level 1 safeguarding training for children". This did not meet the intercollegiate guidance.
- At the announced inspection we raised a concern with the provider regarding staff working alone to provide visits to a vulnerable child when they did not have the knowledge and skills to carry this out. During the inspection, changes to these visits were made, which included introducing a multi-disciplinary approach.
- The safeguarding lead for the organisation was in the process of being changed at the time of the inspection. The safeguarding lead at the time reported to the head of nursing and not directly to the organisations board. There was a board member appointed as the lead for safeguarding at that level; however, there was no mechanism for providing assurance to the board that safeguarding policies were being followed.

Medicines

- We saw that nurses followed the procedure in the medicines policy for checking the parenteral nutrition, intravenous antibiotics and other medicines against the prescription prior to administration.
- On the prescription records we reviewed, not all areas had been completed fully. For the 11 prescriptions we reviewed, three had the pharmacist's signatures missing.
- On all prescriptions there was no description of who the prescriber was and nurses told us this was the hospital consultant. However, there was no documentation to identity them, or their designation.
- The fridges provided by the organisation for patients to store their nutrition and medicines had external digital temperature displays. We observed nurses checked and recorded the static temperature. The fridges displayed the temperature ranges. If the temperature was outside the safe ranges, the nurse would inform the advice line and follow the guidance provided. Information was given to patients to do the same if they were able.
- Fridges were lockable and patients could request they were locked if required and would keep the key themselves. Nurses told us if there were any risks associated with the safe storage of medicines or nutrition, a risk assessment would be completed. However, we did not see any risk assessments in the records we reviewed.
- In three out of five records reviewed, 'relevant medications' were not documented within patient's records, therefore; staff did not have information about patients' current medications.

Environment and equipment

- The equipment required to administer the feeds and medicines was delivered to the patient via an automatic stock checking system. This meant it was not reliant on nurses completing order forms and reduced the risk of human error.
- Patients spoke highly of the system for delivery of their nutritional feeds. Two weeks of feed was delivered at once and they agreed a convenient time for it to be delivered. Patients received a text message on the day of delivery to remind them and check it was still convenient.
- Should there be any emergency situation when feeds were required at short notice; there was capacity to have them delivered the following day.
- The ancillary products, such as gloves, dressings, tubing, cleaning fluids, wipes and kitchen towel, were ordered by the nurses and part of their documentation for each visit required them to check this stock and order anything necessary. We observed checking, including stock rotation and ordering of ancillaries.
- Sharps boxes for the safe disposal of clinical sharps waste were provided. The records requiring a signature and date of use had not been completed on all those we saw.
- Equipment had stickers present, which identified dates for maintenance. All the equipment we saw was up to date at the time of the inspection, which indicated that it had been maintained as required. There was also a record for the nurses to complete to monitor when the equipment was due for servicing.
- All equipment we saw, including pumps and fridges, were visibly clean. The pumps used had back up batteries in case of a power cut.
- The risk assessment process for the home environment was completed at the pre-discharge assessment meeting, undertaken with the patient in hospital. This involved completing a tick box assessment, which identified any risks, including pets, smokers within the

home and whether the patient lived alone. During a pre discharge assessment we also observed the nurse discussing additional details with the patient about access to the property including parking availability, also what area treatment would be administered and if it was near hand washing facilities were available. Staff told us that this assessment was re-visited during the first visit to the house by a nurse when the patient was discharged from hospital. We saw that this was not a thorough risk assessment process as not all potential risks were identified, such as, the general cleanliness of the environment or personal safety of the staff.

- We spoke with a nurse who had been unaware of potential risks prior to the first visit as the information on the pre-discharge assessment was not available on the electronic records system. This meant nurses did not always have sight of the risk assessment until they were already inside the property.

Quality of records

- The provider was in the process of changing the record keeping processes from a paper based system to an electronic system. At the time of the inspection, this meant nurses were recording their information from visits on both systems. Handwritten records were legible, stored in folders, however; not always complete. We saw in six out of nine patient records we reviewed that patient identifiers were not present on each of the loose sheets contained in the record.
- An audit of Calea patient records documentation on the electronic record system was completed in November 2016. The final report was completed 21 March 2017. The electronic system had been used for two months prior to the audit and was designed to replace the paper based records. Areas which were consistently identified from the audit as requiring improvement included the following: checking of ancillary supplies at every visit; details of specific regimen to be recorded in relevant section of records; venous access details to be fully recorded; the device used for infusion, including serial number and service date to be recorded; flushes and batch numbers need to be recorded and variances must be saved and signed to prevent multiple entries. The outcome of this audit of electronic records was that both the paper and electronic records needed to continue for the next quarter, with a re-audit after this. Nurses we spoke with were unaware when the paper records would be discontinued.
- An audit of Calea care profile paper based records was completed in January 2017, with the final report being completed on 21 March 2017. The aim of this audit was to assess the quality and accuracy of completion of the documentation to ensure that it met Nursing and Midwifery Council standards of good record keeping. Eight care profiles were audited by regional nurse managers with a further 20% audited from copies provided to the clinical governance manager. The results of the audit showed there were consistent areas that required improvement, including: the consent section was not always signed; there were gaps in patient details section, such as the GP details not being completed; there were missed fields or they had not been scored out (where not required) and treatment forms being incomplete.
- The audit had been completed before a date had been set for the service to become paperless and move forward with electronic records only. The outcome was that further training would be required to ensure standards met the NMC code of practice; however no action plan was seen. Nine out of 14 nurses we spoke with were not aware of the audit or any actions taken or planned as a result of this audit.
- There was one staff member in the office that supported nurses that used the electronic record system. They advised nurses and assisted them with any issues or concerns they had.
- We observed that where patients had connected and disconnected their own feed, this was not consistently documented by staff, therefore; it was not known on how many occasions this had occurred.
- We reviewed 15 archived patient notes in head office. In one of these records another patient's records were present.
- We reviewed ten records and the patient's allergies were appropriately recorded in all but one set of notes.
- Nurses relied on emails to contact each other about specific patient's care, including changes to visit times or patient's personal circumstances. These emails were not copied to any manager and no record of them was kept. Nurses used this informal communication to pass on vital information for which there was then no audit trail.

Cleanliness, infection control and hygiene

- The information provided by the organisation for mandatory training compliance did not include

Infection control training. Data provided showed that 83.7% of permanent staff had completed all aspects of infection control training, whereas; only 33.3% of bank nurses had completed the same training.

- Nurses were observed to follow the appropriate hand-washing technique in patients' homes. The protocol for hand-washing states "staff are to use single use towels to dry hands". Nurses were seen to follow the correct protocol and used paper towels supplied by the organisation and stored in a patient's home.
- Nurses were seen to use hand gel appropriately and clean the equipment they were going to use in line with the organisations protocol.
- We observed that Personal Protective Equipment (PPE) such as sterile gloves and disposable aprons were used as per protocol. Staff adhered to the 'arms bare below the elbow' protocol.
- Two inspectors observed sharps bins in three patient's homes that were not signed or dated. This was not in-line with the providers Standard Operating Procedures for the prevention of infection**.**
- Not all nurses we spoke with aware of the waste management policy and this included for infectious waste.
- Nurses used an assessment tool to monitor the risk of infection at the cannulations site; however this was due to be reviewed. Nurses knew changes were to be made, but had received no training on the system to be introduced in its place and were not aware of the timescale for this.

Mandatory training

- All mandatory training was delivered via e-learning and permanent staff had protected time to complete it.
- Mandatory training included key areas, such as adult basic life support, consent and the mental capacity act, anaphylaxis management and personal safety. However, there were some areas not covered. For example, paediatric life support was not included, despite a service being provided to children. Also, there was no training for safe moving and handling. Managers told us that nurses did not move and handle patients, but we found that they may need to assist patients to be in the correct position for their treatment and had equipment to move around.
- Standard Operating Procedures were provided for adult and paediatric resuscitation, however; the paediatric document was in draft form only.
- Information provided showed that 95% of permanent staff, across Cestrian Court, had completed their mandatory training at the time of the inspection. However, only 53% of bank staff were up to date. Managers discussed the issues they had with bank staff completing this training and had introduced incentives to try and encourage them to complete it. Further strategies were being introduced such as payment for their time spent completing this training.
- The lowest rates of completion of mandatory training for bank staff were for the subject of consent and mental capacity at 47%, adult basic life support at 60% and anaphylaxis management at 51%. This meant staff may not have up to date skills and knowledge in several key areas.
- Details of mandatory training for 16 registered agency nurses were provided. Records showed that three nurses had not completed medicines management training, four had not completed pharmacovigilance training and two had not completed either module. We were told that if all nurses were not fully compliant by 10 April 2017, they would not be offered further work.

Assessing and responding to patient risk

- There were a limited range of risk assessments completed by nurses from the service for patients in their care. Those present focussed on environmental risks in patients' homes, rather than clinical issues. Nurses relied on other professionals from a multi-disciplinary approach to provide these and keep them informed. This included for risks, such as venous thrombo-embolism (VTE), pressure ulcers and risk of falls. Staff told us that these may be kept within the district nurse notes in a patient's home, however we saw that nurses did not always review these notes on arriving at the patients' home.
- Calea nurses who administered intravenous antibiotics carried anaphylaxis management kits. However, nurses who did not carry out this procedure did not have anaphylaxis kits provided. This was discussed during the inspection and this equipment was to be provided to all nurses by 24 April 2017. In addition, e-learning training for the management of anaphylaxis and the safe use of this equipment was to be completed by 4 April 2017. This would be followed up by classroom based training and competence assessments during field visits.
- A nurse told us about an example of a patient who experienced an anaphylactic reaction The nurse

followed best practice guidance in requesting emergency services attending the patient. The treatment this patient received was an example of when nurses did not routinely carry an anaphylaxis kit.

- Nurses gave conflicting information about the actions they would take should a patient's condition deteriorate during their visit. Some would ring for emergency assistance immediately, whilst others would ring the internal advice line before doing so. Nurses were guided to inform the advice line if a patient was unwell during their visit. Managers told us they should follow their clinical judgement to assess the seriousness of the situation and take the most appropriate immediate action.
- There was no procedure for staff to follow should a patient's condition deteriorate. Nurses told us that a new system for assessing and responding to patient risk was currently being introduced. This was a traffic light system which would guide the nurse on the actions they should take.
- A sepsis flowchart for 'Training / Infection prevention and Sepsis Flow' was provided post inspection to indicate how to escalate suspected infection, however; no parameters or threshold for escalation were included. A clinical competency form for sepsis prevention was provided to show how staff were initially assessed, however; it was not clear how often this was re-assessed.
- Nurses did not carry any equipment to monitor the condition of a patient; for example, to check their blood pressure. However; disposable thermometers could be ordered as part of the ancillary items and should be present in all patients' homes. This meant nurses based their decision using their clinical judgement on whether or not to escalate a patient for review by the emergency services.
- There was a lack of consistency with nurses' understanding of how the temperature record should be used. This was part of the variance record. Some nurses said this was for patients or their carers to document any check of the temperature they had done themselves, whilst others said it was for the nurse's use.
- The "Protocol for administration of intravenous intermittent infusion via an eclipse" stated that the nurse must monitor progress regularly throughout the infusion. We were told by senior managers that this meant the nurse was expected to stay with the patient throughout the administration. The only deviation from this would be at the patient's request and with the agreement of the NHS body who commissioned the service. Therefore not all nurses were following this protocol. This was brought to manager's attention following the inspection.
- There was a lack of clarity for one patient we spoke with about the need for nurses to remain present during intravenous antibiotic administration. They stated some nurses remained in the house with them, whilst others left and returned at the end of the 80 minute administration time.

Staffing levels and caseload

- All nurses who provided visits for Calea UK patients were employed by the parent company Fresenius Kabi as stated in their contract of employment. Therefore we cannot state how many nurses worked for each registered provider. On 12 April 2017 there were 208 nurses employed, which included 21 vacancies. There were six nurses due to start employment in May 2017. In February 2017 there were 117 bank nurses employed.
- A weekly capacity report was generated, which provided information on the total number of patient visits made and the allocation of permanent, bank or agency nurses to those visits. Managers used this report to identify trends in any increased use of agency or bank staff and to inform the recruitment processes in each geographic directorate.
- Information provided for capacity planning for week commencing 27 February 2017 showed of 2,627 visits, 75% were covered by permanent staff, 7% by overtime, 9% by bank nurses and 9% by agency nurses.
- Throughout January and February 2017, the use of agency staff varied regionally from 0% in the South West and Midlands to 29% in the South East.
- Nurses undertaking visits for Calea had an average of 3.75 visits per day. Those we spoke with said their caseloads were manageable; however sometimes they had to travel long distances to cover short notice sickness, or new patients, which increased their workload.
- For patients receiving parenteral nutrition, the resource planners scheduled the visits and allocated to the relevant nurses. These visits were planned in advance and there was the ability for nurses to discuss with the planners any issues they had in managing the work they were allocated.

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- The resource planners were kept up to date with any changes to a patient's care by the visiting nurse or the helpline. This included changes to the visit times, and they managed this when planning the schedule of visits for each individual nurse.
- All patients had a named nurse who was responsible for monitoring their care and treatment; however, patients told us they saw a team of nurses and not necessarily their named nurse. This included arrangement of the pre discharge assessment, organising a home visit prior to the installation date, checking the equipment and if possible carry out the first connection visit. The care profile should be kept up-to-date and the package reviewed regularly, including the monitoring of stock and equipment. Weekly reports were submitted about the patients, with 'buddy' arrangements for planned leave.

Managing anticipated risks

- There was a nursing contingency plan, which defined specific actions to be implemented in the event of an incident which may cause major disruption to patients' treatment. This included road closures, major epidemics and severe weather. This planning included discussions with the patient and carers to change infusion times and duration; to alter a nurse's work pattern; or to refer to the discharging hospital to ensure patients received their prescribed nutrition.
- The risk of not being able to meet a growth in demand for patient's visits was recognised by managers we spoke with. Actions to reduce this risk included the continued recruitment of permanent staff and the employment of bank staff to provide a large flexible workforce.

Are community health services for adults effective?
(for example, treatment is effective)

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Evidence based care and treatment

- There were a range of standard operating procedures, which supported the nursing team. We reviewed some of these procedures and saw that the first issue was recent. One example was the infection prevention procedure which had been issued in August 2016. There was no record that before that date any other infection prevention procedure had been in place.
- Standard operating procedures were not in place for all required practices, such as escalation of a deteriorating patient or management of sepsis.
- The service was registered with the British Association for Parental and Enteral Nutrition. The managers told us they used guidance from this association for their procedures; however we saw no evidence of this on those we reviewed.
- Nurses were unable to access the policies and procedures for the organisation via their tablet computers. A project was ongoing to provide an IT solution for them to access this information via an application. This was expected to be achieved by the end of April 2017. Following the inspection the provider told us this had been implemented.
- Managers and staff told us that policies and procedures followed the home parenteral nutrition framework, which was national guidance. However, we did not see reference to this guidance on any of the records we reviewed and nurses we spoke with were unaware of how this guidance was implemented.
- Nurses followed the protocol of the discharging hospital for patients who received parenteral nutrition. This provided guidance in the management of the patient, including the Total Parenteral Nutrition line. However, a named copy of one of these protocols was not documented in one of the records we reviewed (which meant nurses unfamiliar with that protocol could not be sure they were following it).
- There was no audit programme in place for Calea UK. " Following the inspection evidence was provided that an audit cycle had been put in place. This included audits with varying time cycles and several clinical and non-clinical subjects".
- Two audits of patient records had been undertaken. Another for central venous catheters had been completed; however at the time of the inspection the data from this was being analysed.
- The audit of patient records resulted in increased monitoring and communication with nurses about completion of records both paper and electronic. A date for the repeat of this audit was set.

Pain relief

- Nurses did not provide pain relief to patients, but told us they would discuss with the patient how to get advice about appropriate management of pain.
- Records we reviewed showed inconsistency in the recording of advice given when a patient complained of pain. For one patient there was a record of signposting to their GP and for another there was no record of advice or signposting.
- We observed nurses asked patients about their general wellbeing during visits and this included if they were experiencing pain.

Nutrition and hydration

- Although nurses told us they did not weigh patients, this was discussed with patients, but not documented.
- Two of six paper records we reviewed had no weight for the patient recorded, although this was a mandatory field on the documentation.
- When weight was recorded, there was no record of when this taken, for example before the service was provided or whilst the patient was still in hospital.
- When patients attended outpatient clinics or dietician appointments and their weight was checked, this was not recorded in the patient's notes. Therefore, there was no record of whether the nutrition provided was effective for weight gain or maintenance.
- The records we reviewed had the amount of feed which had been provided to the patient recorded; however, there was no record of action taken if the complete feed had not been infused.

Technology and telemedicine

- The organisation provided a 24 hour advice line, which was for both patients and nurses. Both patients and nurses could ring with any queries about their feeds, prescriptions, visits or changes in a patient's condition.
- Information was provided about advice line activity for January and February 2017.This showed that most calls were made in the early evening between 5pm and 6pm, with the greatest number of calls about rota queries.
- Out of the clinical calls, the highest numbers recorded were for suspected line sepsis, followed by dehydration, fluid overload and general pyrexia.
- The organisation was considering the possibility of phone consultations and use of smart phone technologies for patients in remote areas, to promote flexibility and independence for patients. However; this was in the planning stages at the time of the inspection.

Patient outcomes

- Key performance indicators were not focused on patient outcomes. The indicators recorded were around staffing capacity.
- There was no process to assess and monitor the clinical outcomes of the service provided for the patient. The effect of the nutrition provided on the patient's nutritional status was not measured.
- There had been no delays in starting a patient's treatment in the community, which had been caused by the provider in the last 12 months. This did not include delayed discharges from hospital that could change a patient's start date for treatment as this was outside of their control.

Competent staff

- Annual appraisal rates for permanent staff were on average 71% compliant across the business. The North region reported the highest compliance with appraisals at 78.6%; the South East was 82.5% compliant; South West was 64.5% and the Midlands was the lowest with a compliance rate of 43.6%.
- The field visits, which included competence assessments, were not completed within the provider's timescale of six weeks for most staff. Information we reviewed showed in one geographical area there was no completion date of the next visit, when the previous one was dated over 12 months ago. In another area 20 visits of 28 were overdue. These visits should be completed by either their line manager or a practice development manager.
- Staff told us that formal clinical supervision groups were due to start in April 2017.
- We were told that there were 12 nurses who provided parenteral nutrition completing an external clinical supervision course and following this they would set up clinical supervision groups consisting of four nurses.
- We reviewed the competency assessment documentation for 10 nurses which consisted of a total of 64 competency sheets. Of these, 11 were not signed by the trainee; however, all were signed by the trainer. Nine competency sheets were dated 2015. A total of 11

records were signed to indicate that the nurse was competent overall; however for these nurses, not all individual competencies were signed or documented as not applicable and some had been left blank. Some of these records had comments next to the specific task as 'not observed', but the nurse was still signed off as competent.

- One of the implications for nurses deemed to be competent in specific practices was that the electronic rota system allowed visits to then be allocated to those nurses. The rota planners told us that these nurses could be allocated to carry out practices for which they had not been assessed as competent to complete if they were deemed to be competent overall.
- We received the 10 most recent field visit check records. These included assessment of whether nurses were deemed competent, had development needs or if there were any alerts noted regarding their skills. Any improvements or changes from previous visits were also documented.
- For paediatrics, a project / focus group, made up of a clinical excellence manager, a paediatric team leader, professional development managers and paediatric nurse advisors met monthly. A paediatric study day was organised, by the group, in October 2016. This featured specialist guest speakers, including a paediatric gastroenterology consultant, dietician and pharmacist. The day also included workshops for dressing and pump competencies.

Multi-disciplinary working and coordinated care pathways

- There was good multi-disciplinary working during the discharge of a patient from hospital. The manager with responsibility for that NHS trust attended a meeting with the patient's consultant, dietician and ward staff and community nurses. This was carried out prior to discharge to ensure the information was as up to date as possible. The information obtained included a past medical history, allergies, medicines and personal information.
- In the ten patient records we reviewed there was no documentation of communication with other health professionals such as district nurses or hospital specialists.

Referral, transfer, discharge and transition

- Patients were referred directly to the service by hospital specialists and dieticians.
- A pre-discharge assessment was completed by the clinical accounts manager before the patient left the referring hospital. This consisted of a visit to the patient in hospital to commence an assessment of the patient's needs and their understanding. Staff told us that this was followed – up and completed in the patients home
- Prior to discharge of a paediatric patient a multi-disciplinary team meeting took place at the referring NHS trust. The clinical account manager and paediatric nurse attended as part of the planning stage prior to discharge.
- Referrals for parenteral nutrition were made via NHS email. There were discussions with the patient prior to the start of the service to make sure they were aware of the size of the fridge to be supplied. This was delivered within five days of receipt of information.
- We reviewed data provided by the organisation showing details of referral to treatment times. Forty four records confirmed there were no delays for patients commencing their treatment after they had been accepted by the service. Thirty three of these records indicated delay in referral to treatment as a result of hospital discharge delays.
- We reviewed four service level agreements with NHS trusts. These contained details of the agreed referral and assessment procedures, but not information about discharge from the service or transition to another service.

Access to information

- The organisation's advice line was available to provide support, help and guidance to patients 24 hours per day. Patients were given the telephone number in their patient advice pack.
- Protocols for parenteral feeds were provided for nurses which included contact numbers from each referring NHS trust.
- Staff told us the main source of information for nurses was via emails: this included information about changes in a patient's conditions and changes to visits. This was an informal system and did not have manager oversight; also there was no central storage system for this information, some of which was about risk management.

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- The provider's electronic system had the facility to flag certain important information about a patient. This could be clinical, social or environmental information which all visiting nurses and resource planners needed to be aware of.
- Staff told us the latest three months' paper patient records were kept in the patient's own home. Older records were archived off site and sent to head office.
- There was no access to hospital medical records on the electronic patient records system. This included the patient's weight and blood results. This information was entered onto paper documentation and kept in the patient's home; however it could not be viewed on the nurses tablet computers and therefore they had no access to this information prior to their first visit.
- Nurses were unable to access the policies and procedures for the organisation via their tablet computers. A project was ongoing to provide an IT solution for them to access this information via an application. This was expected to be achieved by the end of April 2017.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training on the Mental Capacity Act as part of their mandatory training. Records provided showed that at the time of the inspection 82% of permanent staff had completed this training. However for bank nurses it was 39%.
- Signed consent forms were present in the patient records we reviewed. These had been signed by the clinical account manager or named nurse and the patient.
- The consent form stated that nurses would obtain verbal consent prior to each procedure, implied consent was defined and the right of the patient to refuse treatment was included.
- During the inspection, we observed that verbal consent was obtained.
- Nurses we spoke to had inconsistent knowledge of the mental capacity act and their role within it. Some knew the basic concept of the act; however none were aware of their role in assessing a patient's capacity if this was required.
- Where patients had refused treatment there was no assessment of their mental capacity to understand the implications of their actions. Nurses and managers confirmed they did not assess or record a patient's capacity in such circumstances.

Are community health services for adults caring?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Compassionate care

- We observed that nurses were respectful patients, carers and their families and understood the need to respect any wishes they may have about how care was delivered. Staff always knocked on the patient's internal doors to obtain consent for access.
- Nurses were compassionate and paid attention to the patient's comfort throughout procedures.
- Patients told us all the nurses who visited them were very friendly and approachable.
- We received comments from patients and relatives as part of the inspection. Some examples included that staff went above and beyond, were very supportive, respectful, friendly and went out of their way to help.
- Patients were complimentary about the service provided and found them very responsive to any concerns they had.
- Although some patients had several nurses visiting them they told us they were a "lovely team of nurses" and all were caring and patient.
- We saw that staff spoke to patients in a kind and caring manner, encouraging them positively to do what they could for themselves.
- A patient survey in 2016 was sent out to 895 patients and 366 (39%) were completed and returned. The survey showed that 96% of patients would recommend Calea to friends and family. Where training had been delivered by the nurse, 97% were satisfied.

Understanding and involvement of patients and those close to them

- Patients were involved in their care during the procedure. For example, patients were asked where

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they wanted the equipment to be positioned. One patient told us they had requested as little equipment as possible to make it less clinical in their home and this had been accommodated for them.
- Nurses asked about a patient's general wellbeing and health during their visits. If a patient had any issues or concerns they were directed to an appropriate health practitioner.
- We saw relatives and carers were supported to participate in care if they wished. The responsibility for providing care to a patient was shared with carers and relatives when they wanted to be part of the care giving team.
- Should patients or carers decide they could not manage their own care, they were supported in this decision and care was provided as necessary.
- Patients who had received training to manage their own enteral feeds had a follow up appointment every three months to assess their continued ability to manage their own care.
- Patients and carers spoke highly of the support they received from the internal 24 hour advice line.

Emotional support

- Nurses we spoke with recognised the emotional impact of parenteral nutrition and considered this when providing advice and support
- Patients said staff on the advice line had assisted them by speaking slowly and clearly, keeping the patient calm and provided reassurance whilst their issue was resolved.
- Staff and patients told us they had time to spend longer on a visit if additional emotional support was required and would signpost to the G.P. if required. Staff told us they were never rushed to finish their visit. This was observed during our inspection.

Are community health services for adults responsive to people's needs?
(for example, to feedback?)

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Planning and delivering services which meet people's needs

- Managers were aware of the activity within the local hospitals which could have an impact on the service requirements. The clinical account managers in each area had good working relationships with the nutrition teams, palliative care teams or specialist teams in the hospitals in their area.
- These managers attended multi-disciplinary team meetings two to three weeks prior to potential discharge from hospital. This gave them the opportunity to plan ahead for a patients home care needs including any additional staffing requirements in their area.
- Managers explained how they were involved in discussions about changes to care provision locally which could affect their service. This included specialised units being developed in some hospitals resulting in reduced referrals from others.
- Changes in the requests for service provision were monitored and where necessary additional training was provided to ensure increased demands could be met. We were given an example of a trend of increased immunoglobulin service requests in the north and therefore more nurses were being trained in that area.
- The clinical account manager met with the major accounts (the larger NHS hospital trusts) on a six weekly and discuss each patient with the specialist nurse, consultant and home parenteral nutrition co ordinator This was not consistent in every geographical location.
- The resource planners also recognised trends and changes to the service within the geographical area they supported. They would highlight this to their manager in order for planning resources for the future to be implemented

Equality and diversity

- The patient assessment process took account of the needs of different people, for example on the grounds of age, disability, gender, religion or belief.
- Part of the assessment would be to ensure the equipment required met the patient's specific needs. Any adaptations would be done in line with the discharging hospital, the patient and their carers.
- If there were any special access arrangements these would be documented on the patients records and the visit planners also had this information so all staff could be made aware.

- Nurses we spoke with understood the need to consider any reasonable adjustments which may be required to accommodate a patient's needs.
- Nurses we spoke with could not provide any examples of where they had to change their practices to meet the cultural needs of patients.

Meeting the needs of people in vulnerable circumstances

- Examples were given of where the service had been adapted to meet the needs of vulnerable patients. This included a patient who did not respond well to nurses they were not familiar with. For this patient the carer would always be informed of any nurse new to the patient and they would accompany a nurse the patient was familiar with on the first visit.
- Patients told us the nurses had changed their planned work to give them additional support if their needs changed. This included patients who were unwell, where nurses had stayed with them until the ambulance had arrived.
- Nurses we spoke with were unclear how they would access a translation service should they need it for any patient. They thought this could be done via the advice line. Nurses had used a search engine to find "the odd word" when necessary.
- Nurses we spoke with did not know if the patient information handbook could be accessed in languages other than English, however; we observed it was available in an 'easy read' version.
- There were no recorded plans of care which contained information about a patient's clinical, social or emotional situation. This meant that patients in vulnerable circumstances may not be identified or managed appropriately
- If a patient rang the advice line and needed some assistance, any vulnerable circumstances would be taken into account when the response was considered. We observed a vulnerable patient being added to the visit list for one nurse on the same day they requested advice.
- Staff told us that if there was no reply at a patient's home the nurse would contact the patient by phone. If there was no response they would contact the next of kin or other professionals involved in their care, such as the dietician or district nurses.

Access to the right care at the right time

- During the assessment of a patient prior to using the service the timings of visits was agreed with the patient. This was within a two hour timescale (visit window).
- In February 2017 there were 30 calls to the advice line about visits outside the two hour window. This represented 14% of the total calls. There had been no investigation into themes and trends of these issues
- Nurses made every effort to visit within the agreed window, however they would ring ahead to inform patients if they were unable to visit at the planned times. If there were changes to a visit plan due to unforeseen circumstances, the resource planners would inform the patients.
- There was a team of office based staff who planned the resources to ensure all visits were provided by appropriately trained staff and were delivered within the agreed visit window.
- Patients, carers and staff could contact this team directly and discuss necessary changes to visit times to meet the needs of patients. This included planned or short notice changes to meet the social needs of patients.
- Patients and carers were informed of any changes to scheduled visits with as much notice as possible. They told us they knew the change of time, but not always aware of which nurse would be visiting.
- The length of time a feed took to be administered could be changed to make sure the disconnection visit was within the agreed window for the patient. Nurses tried where possible to adjust the delivery of the feed to meet the patient's needs.
- All 21 patients we spoke with were very complimentary about the delivery drivers. They delivered within a two hour window of time and sent a text message before the delivery as a reminder.
- There was a named nurse system which provided each patient with an identified lead nurse. This nurse was not responsible for providing every visit to the patient however they were their main point of contact to aid a smooth transition from hospital and promote continuity.

Learning from complaints and concerns

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- There was a policy for the handling of customer complaints**.** This was for all complaints made against the organisation, including products and services such as the community nursing service.
- There was no definition in the document of the level of competence of the staff member with responsibility for investigating the complaint. It was stated in the policy there would be a complaint investigation leader and a complaint officer. There was no clarity as to who would fulfil these roles.
- The service had received 18 complaints in the 12 months to January 2017. Of these complaints, 12 were upheld and no complaints were referred to the Ombudsman or the Independent Healthcare Arbitration Services**.**
- Seven of the upheld complaints made were regarding missed or delayed visits and rota changes.
- The complaint documentation we reviewed was not fully completed. We reviewed the files for five complaints. There was no copy of the final response in one file, for another there was an undated response and there was no written response to the complainant in another. There were no root cause analysis reports in any of the files.
- Complaints were discussed as part of the managers meetings and the monthly team meetings.
- Nurses told us when they were informed via email or the internal newsletter that changes had been made, they were not made aware whether this was due to the outcome of a complaint.
- Information about how to complain was provided in the patient information booklet. The handbook included details about how to contact the Freephone advice line, together with details about how to give feedback to the company or independent bodies. The handbook was also available in an 'easy read' version with more pictures and a larger font. The complaint process, however; was not included in the handbook.
- Patients told us they would ring the advice line should they want to complain about the service. Patients we spoke to were generally very positive about their care. If nurses were expecting to be delayed, they contacted the patient to inform them. One patient had experienced a bank nurse who was consistently late and the patient had complained to the named nurse. This was escalated and the nurse did not return to the patient. One patient was concerned that some scheduled nurses did not have the appropriate skills. This was managed and resolved by the named nurse escalating the issue.

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Are community health services for adults well-led?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Leadership of this service

- The leadership was the same for both organisations within Cestrian Court. There was an operations manager for patient services with a business unit director and head of nursing as the senior management team. The nurses were led by directorate business managers who had responsibility for clinical account managers and regional nurse managers. There were team leaders who also had nurses directly reporting to them. This structure meant there was local management support in the community for the nurses who were working remotely, as well as senior managers. There were also opportunities for staff to progress within the leadership team.
- Both first line and senior managers had access to a leadership training programme which was provided by an external organisation. This 12 month training programme was open to aspiring managers, through the annual succession planning process, as well as those already in that position.
- Staff of all grades told us their managers were very supportive, approachable and helpful. Senior managers attended directorate meetings when possible and most nurses we spoke with knew who the senior management team were.
- Nurses told us they felt valued and had good peer support within their teams. Team meetings took place on a monthly basis and nurses attended these if they were able. They told us they received the minutes via email if they were unable to attend.
- The managers we spoke with showed a good understanding of their own teams and how they worked together.

- Although nurses were home based they said their managers were always easily contactable.
- One nurse told us that if they needed to speak to a senior member of staff, other than their manager, they could speak to one of the other manager including the clinical business manager.
- The rota planning team had developed some strategies to improve their team working. These included a weekly presentation by the team manager to look at any issues which had occurred and discuss ways to improve or celebrate a successful week.
- Nurses discussed there were opportunities to progress within the organisation and felt enabled to apply for management posts if they became available.
- Team working was encouraged in staff development through their working across the directorates. This was discussed at the November nurse leadership meeting.

Service vision and strategy

- Managers told us the vision for the service was to improve the life of patient's in their care. The way this was to be achieved was documented in the overarching "game plan." The 2017 "game plan" had four strategic objectives which were underpinned by projects and initiatives. This was separated into divisional game plans for example the nurses' game plan. This identified the business objectives for the nursing services and detailed the nursing projects to deliver this plan within an agreed timescale.
- The objectives and game plan were discussed at the directorate management meetings in February 2017. We saw this included how the various categories and personal objectives for individuals would be managed.
- Nurses we spoke with had a varied understanding of the vision and strategy for the service. The majority were not aware of what the strategy was, whilst others told us it was the same as the organisations' values.

Governance, risk management and quality measurement

- There was a governance structure which provided a platform for sharing of information between the various divisions of the company and across the geographic directorates. The executive management team met quarterly and the heads of services had met bi-monthly since 2016. The senior management team met twice yearly at a discussion forum and there were monthly management team meetings and geographical directorate meetings for the nursing services.
- Despite this structure there was a lack of a robust quality assurance framework. One example was there was no retrospective review of compliance against policy standards such as the duty of candour, or the fit and proper person requirements.
- There was no record of a discussion of the quality of the service or the risk register in the senior management team minutes we saw. We reviewed the minutes of three meetings of the board of directors and minutes of four meetings for the executive management team. There was reference to the risks to the service in the executive team agenda; however there were no minutes for this part of the meeting.
- Governance meetings did not always take place in a timely way or in line with the agreed strategy. Clinical governance meetings had taken place in February, May and December 2016. The minutes from the February meeting stated the last recorded meeting was in 2014. It was documented in the minutes of the February 2016 meeting that quarterly meetings had been set up; however three meetings took place and not four in 2016.
- Due to the variety of services offered there was a lack of clarity of some governance processes within the nursing services. This included the rating of risks which was done using a matrix. However the only way to have a rating of major was using the rating for "Good manufacturing practices (GMP)". This meant human errors in the administration of intravenous drugs were classified as manufacturing practices.
- The organisation's approach to the identification, management and mitigation of risk was documented in the Quality risk management policy. This policy had become effective in August 2016. The method for allocating a risk priority number was included; however there was no reference to the forums in which risks were discussed and how assurance was provided to the board.
- Cestrian Court submitted their strategic risk register dated December 2016. This was applicable to all services provided by Fresenius Kabi Limited and Calea UK Ltd. The risk register contained four risks; of which two were rated 'low' and two were rated 'trivial'.

- There was no documentation of a periodic review of the risk registers. Managers we spoke with told us this was work in progress to identify how and where this should be discussed and recorded.
- Where there was a gap in the control for the risk there was no action to mitigate this recorded on the register. This included the risk of missed treatments through the hard copy prescription not being available in a patients' home. The control was to have electronic prescriptions on the hand held tablet devices; however there was a delay in this system being implemented and no control for this delay was in place. Managers agreed there were gaps in the control measures.
- We saw that in practice the recorded control measures were not always adequate. The risk of gaps in training and competency records for enteral nurses was to be managed by the six weekly field visits. However records we saw showed these visits were not taking place six weekly and for some nurses they were several months between visits.
- Managers we spoke with agreed the assessments of risk within the nursing service may not be adequate as there was a lack of a specific risk assessment tool. We were told this would be reviewed following the inspection.
- The recruitment of directors did not meet the fit and proper person's requirements. Three executive files were reviewed. There were no DBS checks, no annual declarations of fitness and no disqualified director and insolvency checks in all three files. Managers confirmed these had not been done. Although confirmation of identity was present in all three files managers confirmed this had not been obtained at the time of their appointment.
- There was no policy or procedure in place for the appointment of fit and proper persons and managers told us they were unaware of the requirements of this regulation.
- The key performance indicator dashboard for the service was a capacity report. This gave information for the activity within the service, but did not measure the quality of the service provided.
- The monthly reports which had been developed from the advice line activity did have some quality indicators. These included visits being made on time, equipment failures and clinical reasons for calls. This report was under development and the advice line team had started working with quality assurance to ensure the information collected could be used to improve the service.

Culture within this service

- Staff we spoke with said they felt respected by their immediate line managers and the senior management team.
- Staff of all grades described an open culture where they felt able to raise concerns and felt assured that appropriate action would be taken. However they told us they did not always get feedback if they raised issues.
- The discharging hospital retained the overall responsibility for patients. This resulted in a culture of reliance on those hospitals to manage the overall care for that patient. One example of this was nurses not being involved in assessing risks for patients, as they saw themselves as having a smaller role in their care than other community teams. Some nurses stated they felt deskilled by this approach.
- There was a policy statement in the employee handbook about lone working. This set out the nurses and managers responsibilities and the methods to summon help in an emergency and escalate any health and safety concerns.
- Lone worker devices were issued and staff told us and we saw that the system was efficient. Staff said it helped them to feel more protected in their working environment.
- There were processes in place to protect the wellbeing of staff and they told us it was a good organisation to work for with regard to the terms and conditions of employment.
- All staff we observed and spoke with had patient care at the focus of what they did. They spoke passionately about how they could discuss improvements within individual's care, or in the systems of working and they felt listened to by managers.
- There was a culture of promoting patient independence with the support of staff and appropriate training, but recognition that this may not be suitable for all patients.

Public engagement

Community health services for adults

- A patient survey in 2016 was sent out to 895 patients and 366 (39%) were completed and returned. The survey showed that 96% of patients would recommend Calea to friends and family. Where training had been delivered by the nurse, 97% were satisfied.
- Patients and carers told us they were actively involved in their own care and the decisions about how it was to be delivered.
- Examples were given by patients of how they had been consulted about their individual care delivery; however they were unable to say how they had been involved in wider decisions within the service.

Staff engagement

- Staff participated in team meetings on a quarterly basis. They told us between these meetings they could discuss any ideas they may have with their manager; however their views were not actively sought unless they were part of a project group.
- The minutes of the directorate managers meeting included discussions about how to involve nurses in setting objectives for the coming year and their participation in specialist groups.
- Much communication with staff was via email and staff told us this worked well.
- Every three to four months nurses and other staff in the enteral service held a meeting where an external speaker was invited.
- A staff survey for the nurses had been completed in 2016 with data relevant to 2015. This included questions about the effectiveness of communication and how valued staff were. 63% of nurses thought communication was effective in the wider community; however this was lower within the directorates with the lowest being in the Midlands at 35%.
- There were 69% of staff who felt valued by the organisation.
- Managers told us this survey had shown nurses were most dissatisfied with their role in participating in the advice line. As a result a specific team of nurses had been employed for this role, instead of community nurses being expected to rotate into this role.
- An employee forum was in place and through feedback cards and meetings via employee champions staff were enabled to make suggestions, present ideas and feedback to reach the right person.
- There was a company reward and recognition scheme. There were monthly nominations for staff for each of the six core company values, in each directorate, with the winners receiving certificates and vouchers presented at directorate meetings.

Innovation, improvement and sustainability

- The minutes we reviewed from the directorate managers meeting and the regional nurse managers meeting did not have any items regarding innovation and sustainability. They did have areas for improvement of the service which included specific work streams to improve clinical outcomes and communication.
- The organisation was exploring the possibilities of expanding services for oncology patients, however; this project was currently at an early research and pilot phase.
- A project to utilise telehealth in the organisations was being explored. This project had not been approved at the time of the inspection.
- Managers discussed how they worked for continuous improvement of the service; however we found a lack of understanding of the current clinical outcomes for patients and therefore saw no clear direction for innovation or improvement of services. The focus was on expansion of the business and some staff we spoke with thought this was the future plan.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that appointment procedures for directors include checks that they are fit and proper persons for that role.
- Ensure that safeguarding policies and procedures are in place to protect children and adults who use the service from abuse and improper treatment.
- Ensure that all staff that provide care and treatment to children are adequately trained to protect them from abuse and improper treatment.
- Ensure that a lead for safeguarding within the organisation has appropriate skills and knowledge.
- Ensure that prescriptions are accurately and fully completed.
- Ensure that systems and processes are in place to assess, monitor and improve the quality of the service provided.
- Ensure that systems and processes are in place to assess and mitigate risks to users of the service.
- Ensure systems and processes are in place to act in an open and transparent way with users of the service.

Action the provider SHOULD take to improve

- The provider should develop a system to identify and record incidents as separate to complaints.
- Staff should complete patients' records accurately.
- The prescription charts should be fully completed for all patients.
- Mandatory training should be up to date for all staff including those employed on an ad hoc basis.
- Patients should have clinical and environmental risks assessed. This should be documented and actions taken to mitigate those risks.
- The provider should consider having an appropriate audit programme in place.
- Policies and procedures should be reviewed and kept up to date.
- Patients' clinical outcomes should be measured.
- Staff should have their competence assessed to carry out their work in line with the organisations' policy.
- The provider should develop a procedure to assess a patient's mental capacity when this was required.
- Patients should have individualised plans of care.
- The provider should share the vision and strategy for the service with staff of all grades.
- Staff should receive feedback if they raised any concerns.
- The provider should consider how to improve communication with staff across the organisation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors Appointment procedures for directors were not effective. The provider had not ensured all directors were of good character, had the qualifications, skills, competence or experience or were able to properly perform their tasks by reasons of their health. The provider had not ensured the directors had been responsible for mismanagement in any regulated activity and had not ensured they had any grounds for unfitness specified in Part 1 and 2 of schedule 4. This was a breach of regulation 5 (1)(2)(3)(4)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The prescriptions must be fully and accurately completed. This was a breach of regulation 12(1)(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding procedures were not effective. The provider had not ensured staff who delivered care to

Requirement notices

children were adequately trained in safeguarding. The policy and procedures for safeguarding did not include the latest guidance for child protection. There was no lead person for safeguarding who was adequately trained to complete this role.

This was a breach of regulation 13 (1)(2)(3)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems and processes did not enable the registered person to assess, monitor and improve the quality of the service provided. The systems and processes did not enable the provider to assess, monitor and mitigate the risks relating to the health, welfare and safety of service users. This was a breach of regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The systems and processes had not ensured the provider acted in an open and transparent way with relevant persons in relation to care and treatment. This was a breach of regulation 20 (1)(2)(3)(4)(7)