Interserve Healthcare Limited

Interserve Healthcare Liverpool

Inspection report

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Date of inspection visit:
08 August 2017

Date of publication:
18 September 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 8 August 2017 and was announced. The registered provider was given 48 hours' notice because we needed to be sure that someone would be available at the office.

Interserve Healthcare Liverpool is a domiciliary care agency providing nursing and personal care to adults and children in their own homes. At the time of the inspection Interserve Healthcare Liverpool was providing services to six adults and eight children.

The service was previously inspected at a different address in July 2016 and was subsequently re-registered. This was the first inspection at the current address. During the previous inspection the service was found to be in breach of regulations. The breach was in relation to the management of risk and associated care plans. During this comprehensive inspection in August 2017, we checked to see that improvements had been made and sustained.

The records that we saw relating to risk assessment were sufficiently detailed and covered risk in relation to; moving and handling, falls, use of bedrails and pressure area care, in addition to other aspects of care. Each risk assessment showed evidence of regular review and was supported by a plan of care.

The majority of care plans were well detailed especially in relation to clinical practice and contained a good level of person-centred information. However, we saw that a small number of records were lacking in sufficient detail to safely inform staff practice.

During the inspection we were given access to the electronic records relating to the service which included evidence of quality audits. Where appropriate, audits were mapped to the regulations and CQC's key lines of enquiry. However, audit processes had failed to identify the lack of detail in some care plans which placed people at risk of receiving unsafe care.

At the last comprehensive inspection in July 2016 we identified a concern relating to the completion of medicine administration records (MAR). Some records had not been completed when medicines had been administered and some medicines were not administered without an adequate explanation. We made a recommendation regarding this.

As part of this inspection we looked at MAR sheets for four people and medicines' audits to see if the necessary improvements had been made and sustained. Each of the MAR sheets that we saw had been completed fully and correctly.

The people that we spoke with said that their service was delivered safely. Staff were able to explain their responsibilities in relation to safeguarding and what indications of abuse and neglect to look out for. Each of the staff that we spoke with was clear about their role in reporting any concerns.

Accidents and incidents were recorded on an electronic system. Each of the records that we saw contained a good level of detail. Information was recorded under consistent headings to allow for evaluation and comparison.

Staff were safely recruited and deployed in sufficient numbers to meet people's needs. The provider had a small number of vacancies and was actively recruiting at the time of the inspection. The people that we spoke with said that their service was generally provided by the same staff and changes due to annual leave and sickness were communicated to them in good time.

Staff were given regular training and supported through structured supervision sessions. Staff confirmed that they had regular training in relevant subjects including safeguarding, manual handling and specialist care specific to the people supported.

It was clear that staff understood the principles of the MCA and acted in accordance with requirements. The records that we saw indicated that consent was sought from each person or a nominated relative. Staff were able to explain what action they would take if they felt that a person did not have capacity to give meaningful consent.

People were supported by staff and other health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals in a timely manner.

Each of the people that we spoke with was very complimentary about the staff and their caring nature. The staff that we spoke with clearly knew people well and spoke positively about their relationships with them. Staff were able to explain people's needs and preferences in detail and we saw that this detail was reflected in care records.

People and their relatives told us that they were involved in day to day decisions about care and that the service was delivered flexibly to meet people's needs.

Each person had a copy of their care plans in their home. The care plans and the daily records completed by staff were respectfully worded. They were uploaded and stored electronically for managers to use as part of the quality assurance process.

The records we saw clearly indicated the involvement of people or their representatives in conversations about care needs. Each record showed evidence of regular review.

Interserve Healthcare Liverpool maintained regular contact with people using the service and provided a number of methods if people wished to complain. Each of the people that we spoke with understood how to complain and confirmed that they had not done so recently.

The registered manager was supported by a management team with responsibility for assessment, development of care plans, staff coordination and service user contact. Additional support was provided by quality specialists who completed regular audits and provided additional oversight of the service. People spoke positively about the registered manager and the management of their service.

Staff explained that the values base on which the service operated focussed on putting people at the centre of the decision making process. The registered manager explained that the vision was to provide high quality services to people with complex needs.

The management team had access to a range of resources to support the effective management of the service. This included extensive electronic recording and storage systems and specialists to advise and audit performance.

The staff that we spoke with told us that they were happy in their jobs and understood their roles.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding the service.

Ratings from the last comprehensive inspection were on display as required.

You can see what action we told the provider to take at the back of the full version of this report.

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.

Medicines were administered safely in accordance with people's needs and records were properly maintained.

Risk was assessed in appropriate detail and subject to regular review.

Staff were safely recruited and deployed in sufficient numbers to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff completed regular training and received support in accordance with the provider's schedule.

The service operated in accordance with the principles of the Mental Capacity Act 2005 (MCA).

People were supported to access a range of healthcare services in a timely manner.

Is the service caring?

Good

The service was caring.

People who used the service spoke positively about the caring nature of the staff.

People told us that they were actively involved in making decisions about their care on a day to day basis.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care records were not sufficiently detailed to instruct staff in the provision of safe and effective care.

People were involved in regular reviews of their care.

There were a small number of complaints about the service that had been processed in accordance with the relevant policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service completed audits of safety and quality which identified areas of improvement and led to action. However, audits had failed to identify a lack of detail in some care plans which placed people at risk of receiving unsafe care.

People spoke positively about the management team and the quality of communication.

Notifications had been submitted to the Commission as required.

Interserve Healthcare Liverpool

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 August 2017 and was announced. The registered provider was given 24 hours' notice because we needed to be sure that someone would be available at the office. The inspection was conducted by one adult social care inspector.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. The provider had submitted a provider information return (PIR) with information about the service and feedback from CQC' questionnaires. We also contacted the commissioners of the service.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, a client manager, a branch nurse, two members of the care team, two people using the service and three relatives.

We looked at the care records of five people receiving support from the service, four staff recruitment records, medicine administration records (MAR) and other records relevant to the quality monitoring of the service.

Good

Is the service safe?

Our findings

The people that we spoke with said that their service was delivered safely. Comments included, "There was an incident that was dealt with. I've no concerns whatsoever", "I trust [staff name] implicitly with my [relative]" and "Yes I feel safe. They let me know the time and who's coming. Staff are regular."

At the last comprehensive inspection in July 2016 we identified a concern relating to the completion of medicine administration records (MAR). We found that some records had not been completed when medicines had been administered and that some medicines were not administered without an adequate explanation being recorded. We made a recommendation regarding this.

As part of this inspection we looked at MAR sheets for four people and medicines' audits to see if the necessary improvements had been made and sustained. Each of the MAR sheets that we saw had been completed fully and correctly. However, because staff did not always provide care over seven days it was not clear if staff had been in attendance and therefore required to administer medicines. We spoke with the registered manager about this and they confirmed that all medicines had been administered and signed for as required. They agreed to develop their MAR sheets to clearly indicate when staff were present and required to administer medicines. MAR sheets were scanned and stored electronically and subject to regular audit by the provider. We spoke with people and their relatives about the administration of their medicines. One person administered their own medicines while the others said that they always received their medicines on time and in a safe manner. We saw evidence that staff received regular training in the administration of medicines and had their competency assessed by a senior colleague.

Staff explained how they acted to keep people safe. One member of staff said, "One of the key roles is keeping an eye out for [equipment] safety alerts and escalation." While another told us, "I ensure that staff are there to provide the care. I check on people's [staff's] whereabouts." Other members of staff explained how people's safety is promoted through regular training. For example, in the use of moving and handling equipment and safeguarding procedures. Staff were able to explain their responsibilities in relation to safeguarding and what indications of abuse and neglect to look out for. Each of the staff that we spoke with was clear about their role in reporting any concerns internally or externally (whistleblowing).

Care records were produced and maintained on an electronic system. Paper copies of care plans and risk assessments were printed and held in people's homes for staff to access. The records that we saw relating to risk assessment were sufficiently detailed and covered risk in relation to; moving and handling, falls, use of bedrails and pressure area care in addition to other aspects of care. Each risk assessment showed evidence of regular review. However, there was more than one risk assessment template in use at the time of the inspection and the electronic records were not consistently named on the system. This meant that it was sometimes difficult to find information. We spoke with the registered manager about this and were shown a printed copy of a care record which was easier to navigate. The registered manager assured us that the transfer to a new risk assessment format and a review of the current naming and electronic storage would be completed as a priority.

Accidents and incidents were recorded on an electronic system. Each of the records that we saw contained a good level of detail. Information was recorded under consistent headings to allow for evaluation and comparison. It was clear that records were assessed for trends and promoted a culture of learning from mistakes. The action required in each case was clearly documented. For example, one record referred to an incident where a person had struggled to use community facilities. This led to a referral to an occupational therapist and contact with the moving and handling team. Each record was signed-off by a clinical lead for the service.

Staff were safely recruited and deployed in sufficient numbers to meet people's needs. The provider had a small number of vacancies and was actively recruiting at the time of the inspection. The people that we spoke with said that their service was generally provided by the same staff and changes due to annual leave and sickness were communicated to them in good time. However, one person did comment that they would like to know further in advance who would be providing care when their regular carer was on annual leave. We spoke with senior staff about this and they agreed to issue a full staff rota to this person.

The recruitment records were held electronically and were accessible to the registered manager. We looked at four recruitment records and found that each contained a full employment history, two references and evidence of a Disclosure and Barring Service (DBS) check. DBS checks are used to establish if staff are suitable to work with vulnerable adults and children. Photographic identification was held separately within the service in the form of an identification badge. Some of the staff records for long-standing employees were difficult to find within the electronic record. The most recent records were organised in a consistent and logical manner.

Good

Is the service effective?

Our findings

Staff received regular training and were supported through structured supervision sessions. The majority of people that we spoke with said that staff had the right skills and training to meet their needs or those of their family member. Comments included, "I get all I need. They've [staff] had all the training", "They have the right skills and training", "[Relative] has complex health conditions. New staff shadow [work along-side a more experienced colleague] a regular member of staff" and "Most staff have the right skills. Sometimes I feel they're not quite there yet, but new staff are usually shadowed. I've no real concerns."

Staff confirmed that they had regular training in relevant subjects including safeguarding, manual handling and specialist care. For example, renal (kidney) care. They told us they felt well-supported by the service. One member of staff said, "I get regular supervision and annual appraisal with a competency assessment. I could ask for more if I needed it." While another told us, "I received really in-depth training."

The service did not recruit staff with less than six months experience in health and social care and so was not expected to support staff to complete the Care Certificate. The Care Certificate is a recommended standard for the induction of staff who are new to social care. However, the service adhered to the principles of the Care Certificate by providing a full programme of training and assessing people's competency prior to lone working. Records showed that staff were given an individualised induction which included shadowing and assessment.

Records relating to staff training, supervision and appraisal were held electronically and provided the registered manager with a clear indication of when training or supervision was due. The records that we saw indicated a high level of completion in accordance with the relevant schedule. Training compliance averaged in excess of 90%.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the community this process is managed through the court of protection.

It was clear that staff understood the principles of the MCA and acted in accordance with requirements. They gave examples of asking for consent before care was provided. The records that we saw indicated that consent was sought from each person or a nominated relative. Staff were able to explain what action they would take if they felt that a person did not have capacity to give meaningful consent.

Staff supported people with their nutritional needs in accordance with the relevant care plan. Records were maintained to ensure that special dietary needs were accommodated in the delivery of care. This included

the use of thickening agents to facilitate safe swallowing and percutaneous endoscopic gastrostomy (PEG) feeding. The care plans in relation to nutrition were sufficiently detailed to instruct staff and provide safe care. Staff maintained records of food and fluid intake where this was required.

People were supported by staff and other health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals in a timely manner. We saw evidence of involvement with a range of healthcare professionals including; GP's, opticians and district nurses. People said that staff supported them with medical appointments. Staff told us how they were vigilant in monitoring people's health and looking out for indications of any deterioration. One member of staff told us, "I would take people to the hospital if necessary." Where appropriate, care records detailed indicators that the person was becoming unwell. For example, in relation to breathing difficulties.

Good

Is the service caring?

Our findings

Each of the people that we spoke with was very complimentary about the staff and their caring nature. Comments included; "[Staff name] is marvellous. More like a daughter. Always offering to help", They ask me every morning how I'm doing", "They treat my [family member] with dignity and respect. I've turned-up unannounced and they always follow the care plan", "It's all good. Staff understand my [family member's] needs" and "My [family member] communicates through laughing. They communicate very, very well. They love the bones of [family member]."

The staff that we spoke with clearly knew people well and spoke positively about their relationships with them. One member of staff who provided clinical care said, "We know our patients. We've got good relationships." While another told us, "Everyone has different needs and preferences." Another member of staff explained how one person liked to 'have the TV on or have an iPad' to distract them when clinical care was being delivered.

Staff were able to explain people's needs and preferences in detail and we saw that this detail was reflected in care records. For example, one care record reflected a preference for a shortened version of the person's first name and their wish to pick-out their own clothes. Staff used the shortened version of the person's name in conversation about their care. Other care plans were worded to promote people's continued independence. For example, 'Encourage [name] to maintain their own personal hygiene e.g. washing hands before meals.'

People and their relatives told us that they were involved in day to day decisions about care and that the service was delivered flexibly to meet people's needs. One person said, "I've got [staff name] and them coming and explaining things to me." Staff told us how they talked to people throughout the care processes and asked about their wellbeing. Where people did not use speech staff understood and used other methods of communication. For example, monitoring facial expressions and body language.

People's right to privacy and dignity were clearly understood and staff told us how they applied in practice. One staff member told us how they would still close doors when providing personal care even if there was nobody else in the house. Another member of staff outlined a plan of care for somebody with a life-threatening health condition. The plan involved the purchase of specialist equipment to promote their dignity and reduce the person's distress when they were unwell.

Each person had a copy of their care plans in their home. The care plans and the daily records completed by staff were respectfully worded. They were uploaded and stored electronically for managers to use as part of the quality assurance process.

None of the people that used the service at the time of the inspection was making use of independent advocacy services, but we were told that information would be made available to people if they required it. Advocacy is a process of supporting and enabling people to express their views and concerns, access information and services as well as defending people's rights and responsibilities.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people and looked at care records to establish if people were involved in the assessment and care planning processes. The records clearly indicated the involvement of people or their representatives in conversations about care needs. Each record showed evidence of regular review. One person using the service said, "I get involved in regular reviews with Interserve and community health. We have three, six and twelve month reviews." A relative told us, "[Staff name] comes and reviews once a year or if something changes, which is often enough." We saw evidence in care records that additional, internal reviews were completed regularly and following any significant change to people's care needs.

At the last comprehensive inspection in July 2016, the provider was found to be in breach of regulations because risks were not always assessed accurately and care plans did not always provide sufficient information to enable people's needs to be met. As part of this inspection we looked at records relating to risk assessment and checked that appropriate plans of care were in place where required.

We checked a total of five care records. We found that risk was clearly identified in records and that there was a plan of care to assist staff in managing the risk. The majority of care plans were well detailed especially in relation to clinical practice and contained a good level of person-centred information. However, we saw that a small number of records were lacking in sufficient detail to safely inform staff practice. For example, a care plan relating to a person who experienced seizures said, 'Place in a safe position'. There was no further instruction on what a safe position would be. In another example, a care plan relating to moving and handling stated, '1:1 assistance required'. It did not provide any further detail including; where the member of staff should position themselves or what form the assistance should take. This placed people at risk of receiving unsafe or inappropriate care. In each case further guidance was added to the care plan during the inspection.

This is a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to follow their interests in accordance with individual preferences. The service continued to operate flexibly and supported people to access their local communities as requested. Examples included; supporting people to go on holiday and visit family members.

Interserve Healthcare Liverpool maintained regular contact with people using the service and provided a number of methods if people wished to complain. For example, direct contact with managers, reviews and surveys. We checked complaints records and spoke with people using the service and staff to ensure that they understood the processes. Each of the people that we spoke with understood how to complain and confirmed that they had not done so recently. One person said, "[Staff name] has given me a number if I want to complain." There were a small number of complaints recorded since the last inspection. Each had been dealt with in accordance with policy and resulted in a satisfactory outcome as outlined in a letter to the complainant.

Other methods for people to log informal complaints included regular telephone calls to people to ask about their satisfaction with the service and quarterly surveys. The results of the most recent surveys were positive. A member of staff told us, "I ring people regularly. They feel more comfortable and share more with me [over the phone]. I assessed the surveys from May and found one complaint about staff leaving a mess. I contacted the client and sent out an email to all staff."

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by a management team with responsibility for assessment, development of care plans, staff coordination and service user contact. Additional support was provided by specialists with responsibility for monitoring quality who completed regular audits and provided additional oversight of the service.

During the inspection we were given access to the electronic records relating to the service which included evidence of quality audits. Where appropriate, audits were mapped to the regulations and CQC's key lines of enquiry. We saw that the service completed audits on a weekly, monthly, quarterly and six monthly basis. Each audit had a different focus such as care plans, risk assessments or a review of new staff. The records that we saw showed that the schedule of audits had been completed as required by the provider. There was evidence that issues had been identified during audits and that this had resulted in remedial action. For example, one audit reported, 'Care plan needs to be updated to reflect special bed.' The action was completed within 72 hours. However, audit processes had failed to identify the lack of detail in some care plans which placed people at risk of receiving unsafe care.

People spoke positively about the registered manager and the management of their service. One person using the service said, "I haven't got a bad word to say about any of them [managers]." A relative told us, "Leadership and management are good. I always get to speak to the same person. They deal with requests quickly. The service has been impeccable." Another relative commented, "For me it's a welcome change to have a professional organisation to deal with. Credit where credit's due."

Staff were equally positive about the effectiveness of management systems and support. Comments included, "Communication is amazing. People in the office and other staff offer support", "Management support is good. It was difficult at first, but [registered manager] fully supported me."

Staff explained that the values base on which the service operated focussed on putting people at the centre of the decision making process. For example, with regards to recruitment, one member of staff said, "We try to match people to services through their skills, experience and values." The registered provider had developed a clear vision and strong values which were understood by staff and confirmed in promotional materials. The registered manager explained that the vision was to provide high quality services to people with complex needs. They told us that they achieved this through, "High-quality training and staff" and "A drive to review and improve." We saw evidence to support this approach in audits and other processes. The registered manager and other staff were open and honest about issues identified during the inspection and quick to resolve them.

Interserve Healthcare Liverpool is part of a national organisation. The management team had access to a range of resources to support the effective management of the service. This included extensive electronic

recording and storage systems and clinical specialists to advise and audit performance.

The service had policies and procedures that covered all essential areas including; safeguarding, medicines, complaints and whistleblowing. We saw that policies had been subject to regular review. Staff could access policies and other important information through a secure electronic portal. Staff were aware of the service's whistle blowing policy and told us they would not hesitate to raise any issue they had. One member of staff said, "We were trained about informing CQC and outside bodies."

We looked at processes in place to gather feedback from people and listen to their views. As well as completion of quality assurance surveys, there were also staff meetings held to ensure views were gathered from staff. Records we viewed showed evidence of discussions regarding; updates on new services, shadow shifts and staff assessments and training. Actions were recorded and completed appropriately. The provider also facilitated clinical governance webinars and produced a weekly newsletter which provided clinical updates and information on social care developments.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that had occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding the service.

Ratings from the last comprehensive inspection were on display as required. From April 2015 it is a legal requirement for providers to display their CQC rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk of receiving unsafe care because some care plans were lacking in detail.