Care Quality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Prestige Nursing – Milton Keynes

192 Queensway, Bletchley, Milton Keynes, MK2 2ST

Tel: 01908711960

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Prestige Nursing Limited
Registered Manager	Mr. Steve Hayward
Overview of the service	Prestige Nursing – Milton Keynes provides personal care packages to young people and adults in their own homes. Further information about this service can be obtained from the provider.
Type of services	Community health care services - Nurses Agency only Domiciliary care service
Regulated activities	Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 3 January 2013, talked with people who use the service and talked with staff.

What people told us and what we found

We spoke with one person who used the service and two relatives of people who also used the service. This was to find out their views about the quality of care provided. Most people and their relatives told us that the care received by the service was of a good standard. One person said that they had a regular carer who respected their views and listened to them about how their daily care needs were to be provided.

The two relatives we spoke with told us that their family member's were usually well cared for by their regular carer who had a good understanding of how to meet their care needs. However, they told us that when their regular carer was on holiday, the level of care received was not at the usual standard. One relative of a young person told us that the agency provided staff cover when their regular carer was on holiday. However the care staff sometimes attended later than the agreed time and this meant that the care delivered was rushed. They also told us that on one occasion the care staff had forgotten to give their family member their breakfast. They told us that the late arrival of care staff impacted upon their family member's ability to get ready and attend school. Another relative told us that the staff who covered the shifts when their regular carer was on leave, did not have a good understanding of their family member's routines and the reasons why this was important for them to have this correct routine followed each day.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 19 February 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our

decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People expressed their views and were involved in making decisions about their care and treatment. We looked at the care plans of four people who used the service and saw that an individualised assessment had been completed before people started to receive care. We also saw that the assessment was completed with the involvement of people who used the service and where this was appropriate, their representatives were also involved. This ensured that the care plan reflected people's individual needs. For example we saw that one person's assessment contained detailed information about their life history and family background.

People who use services were given appropriate information and support regarding their care or treatment. People were provided with a service user guide, which told them the aims and objectives of the service, standards relating to staff training, out of hours contact telephone numbers and a copy of the complaints procedure. This was to make sure that people using the service understood the level of care to be provided by the service and they could contact the service or make a complaint should they wish to do so.

The provider might find it useful to note that two relatives of people using the service told us that they were not routinely informed about changes to their family member's rota of care staff attending to them. This meant that relatives did not always know, which care staff would be caring for their family member and when their carer was running late to provide care.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. We looked at the care records of four people and saw that people had received an assessment of their needs and any risks relating to their care before they started to use the service. We saw that people's assessments had been completed in a range of areas such as, medical health, behaviour, dietary requirements, moving and handling and the risk of falling. We also saw that care plans had been put in place to make sure that any care provided was in accordance with people's needs. We found young people's care records included an assessment of their abilities and aimed to provide care that supported their developmental needs.

We found that most people using the service were new clients and they had received a satisfactory assessment of their needs. However we saw that one person's care plan had not been reviewed for a period of three years. We were concerned about this because the person had a variety of different needs which may have changed during this time. After the inspection visit the manager confirmed that they had re-visited the person and had reviewed all necessary risk assessments and updated the care plan accordingly. This was to make sure that people using the service continued to receive care that was in line with their current requirements.

We also spoke with two relatives of people who used the service. They told us that their family member's were usually well cared for by their regular carer who had a good understanding of their needs and knew how to provide their care. However, they told us that when their regular carer was unable to attend because of periods of sickness or annual leave, the level of care received fell below the usual standard provided. One relative of a younger person told us that staff that provided cover when their regular carer was off, they sometimes attended later than agreed time and that this meant the care delivered was rushed. We were told that on one occasion staff had forgotten to give their family member their breakfast. They told us when staff arrived late, this impacted upon their family member's ability to get ready for and attend school. Another relative told us that the staff who covered for their family member's care when their regular carer was on holiday, did not have a good understanding of their family member's routine. They also

said the care staff did not understand the reasons why it was important for their family member to have the correct routines followed each day.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We saw that people who used the service were given information in their service user guide about how they could contact the safeguarding agencies if they suspected either a child or vulnerable adult was being abused. We also saw that the service had protection of vulnerable adult's and protection of children's policies in place, which outlined to staff the different types of abuse that people using the service might be at risk of. The policies also outlined the correct procedure for staff to follow if they suspected someone using the service was being abused.

We spoke with three members of staff about how they would safeguard vulnerable adults and children using the service. They all gave good accounts of how they might recognise the signs of abuse and the procedures they would follow if they suspected someone was being abused. They also told us that they had received a recent training update on safeguarding vulnerable adults and safeguarding of children.

We looked at staff training compliance spreadsheet that detailed the mandatory training each member of staff had completed and whether they had received an up to date CRB (criminal records bureau) check. We saw that all staff had completed a safeguarding adults and children's training update and that each member of staff received a CRB check that was renewed every 12 months. We looked at three staff personnel files and these confirmed that CRB checks had been completed and that staff held recent certificates to say they had completed a safeguarding of vulnerable adults and children's training update. This was to make sure that staff were aware of safeguarding principles, of good character and able to work with vulnerable adults and children.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. We spoke with two members of staff about the training and support they had received at Prestige Nursing-Milton Keynes. Two members of staff told us that they received regular supervisions from their manger and that they were able to discuss any concerns they had about their roles, their training requirements and how they worked as a team.

We looked at staff training and compliance spreadsheet, which detailed each member of staff and the training that they had completed. We saw that staff had completed a range of mandatory training and that this included, manual handling, health and safety, safeguarding children and adults, food hygiene, infection prevention and control and medication awareness. We also looked at four staff training records and training certificates and these confirmed that staff had completed mandatory training updates. We also found that some of the staff had completed dignity in care and dementia training and that the manager had planned for all staff to complete the training in the near future. The staff training records also confirmed that staff had received a recent supervision with their manager so they could discuss requirements about their role.

However, we found that staff did not routinely complete training regarding the specific needs of children or young people using the service. We spoke with the manager about this and they told us that some staff who worked with young people had not completed formal training about the specific needs relating to children. We were concerned about his because children have a range of specific needs which are different from that of an adult. The manager told us that a training course about children with complex needs was available for the staff to attend. However they told us that staff had not attended this training because none of the young people receiving care had complex needs. We looked at the care plans of two young people using the service and saw that they had a variety of different needs including physical, communication and learning disabilities. This meant that staff providing care to young people had not been supported by management to take up adequate training to make sure that care received was in line with young people's requirements.

We also saw that the majority of staff who had worked for the service for over 12 months had not received an appraisal of their performance. We were concerned about this because there was no formal system to make sure staff were able to develop their role and set objectives to improve their work performance. We spoke with the manager about this and they confirmed that staff appraisals had not been completed recently. They told us that they had planned for every staff member to receive an appraisal of their work in the near future and told us that they had sent out invitations asking staff to book an appointment for an appraisal.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive

Reasons for our judgement

People who use the service were asked for their views about their care and treatment and they were acted on. The manager maintained a quality monitoring spreadsheet, that detailed each person receiving care and the quality monitoring checks that were required. We saw that the system checked that people had received risk assessments before they started to use the service. We saw that the people received a review of their care plan after 12 months and they also received regular telephone monitoring calls and planned quality monitoring visits to find out that the care received was of a good standard. We saw that the manager had recorded that most people had received quality monitoring checks. We also saw that a few people were overdue to receive quality monitoring checks about their care. We spoke with the manager about this and they told us that they had recently appointed a new member of staff who was responsible for co-ordinating people's care and ensured that quality monitoring was completed. They told us that the introduction of the new member of staff would make sure that people could continue to provide feedback about the service and ensured people received high quality care.

We looked at the care plans of four people and saw that a series of quality monitoring reviews and visits had been completed. We saw that people were regularly asked for their feedback regarding their care and they were able to make suggestions about how care could be improved. We also saw that people were able to express their dissatisfaction and saw two examples of people's feedback relating to staff. We spoke with the manager about this and they told us that they had addressed the issues with the staff to make sure people continued to receive a good service. We saw that records had been maintained by the manager which detailed the actions they had taken to resolve any issues relating to the quality of staff.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People who used services did not receive the delivery of care which met their individual needs. Regulation 9 (1)(b)(i)
Regulated activities	Regulation
Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Staff were not enable to deliver care to people safely and to an appropriate standard becasue they have not received appropriate training. Regulation 23(1)(a)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 19 February 2013.

This section is primarily information for the provider

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk