Prestige Nursing Limited

Prestige Nursing - Chingford

Inspection report

Ground Floor
97 Old Church Road
London
E4 6ST

Tel: 02085319779

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 11 October 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Prestige Nursing - Chingford is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of the inspection it was providing a service to 21 people.

There was a registered manager at this service. 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.

People received care which protected them from avoidable harm and abuse. Staff understood people's needs and knew how to protect them from the risk of abuse. Risks to people's safety were identified and assessments were in place to manage identified risks. Where people required support to take prescribed medicines, staff had received training to assist people safely.

There were enough skilled and experienced staff to meet the needs of people who used the service. People were supported by staff who had the skills and training to meet their needs. Recruitment checks were completed on new staff to ensure they were suitable to support people who used the service. Where required, people were supported to have sufficient to eat and drink and their health needs were regularly monitored.

Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in making every day decisions and choices about how they wanted to live their lives.

People were supported by a team of regular staff that they knew and who they said were kind and caring. Staff respected people's privacy and dignity and promoted their independence. People and their relatives said the support they received helped people who used the service live independently in their own homes.

The service was responsive to people's needs and wishes. People were provided with care and support which was individual to them. Care plans were detailed and personalised. People's care and support needs were reviewed regularly. People's end of life wishes were explored.

Staff told us the registered manager was supportive. People liked the registered manager and found her

helpful. The service had various quality assurance and monitoring mechanisms in place.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Prestige Nursing - Chingford

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 11 October 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection team consisted of two inspectors.

Before we visited the service we checked the information we held about the service and the provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placed people with the service, and the local borough safeguarding adult's team. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with the registered manager, the field care manager, the training officer and three care workers. We also spoke to four people who used the service and 13 relatives. We looked at four care files which included care plans and risk assessments, three staff files which included supervision records and recruitment records, quality assurance records, medicine records, training information, policies and procedures, and complaint information.

Good

Is the service safe?

Our findings

People and their relatives told us they felt the service was safe. One relative said, "[I feel] my [relative] is safe." Another relative told us, "No concern for safety of [relative]."

The service had policies in relation to safeguarding and whistleblowing. Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them. One staff member said, "If I see anything, I'll blow the whistle or let the office know." The registered manager was aware of their responsibility to liaise with the local authority and CQC if safeguarding concerns were raised.

Systems were in place to identify and reduce the risks to people living in their home. People's care records included detailed and informative risk assessments. These documents were individualised and provided staff with a clear description of any risks and guidance on the support people needed to manage these. Staff understood the support people needed to promote their independence and freedom, yet minimise the risks.

People, relatives and staff told us there was enough staff available to meet their needs and to keep them safe. One person said, "[Staff] do [come on time]." A relative told us, "Yes, I feel enough time is given to care for my [relative]." Another relative said, "The carers usually let me know if they are going on holidays or if they are running late. They would ring me." One staff member told us, "The majority of time I have enough time to get from one person to another. If I'm five or 10 minutes late, it's not a problem but any more I'll call the office." The service had an out-of-hours on call system available. The field care manager told us, "We don't have any missed calls. If a care worker can't do it, I will. We are all very hands on. Since I've been here, no one's had a missed visit."

Accident and incident policies and procedures were in place. Accidents and incidents were documented and recorded in people's care files and we saw instances of this. The service had a system in place to record all accidents and incidents on a centralised database so they could be analysed. However, the registered manager was not always recording accidents and incidents on the database but instead in people's care records. This meant the service did not have an overview of accidents and incidents and any themes arising. We spoke to the registered manager about this and she told us she would start recording all accidents and incidents on the database.

A robust recruitment and selection process was in place and staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed.

Staff had received training to administer medicines safely and had been assessed as competent to support people with their medicines. Staff signed a medicine administration record (MAR) sheet and recorded in people's records that medicines had been given to confirm this. One staff member said, "I've had medicines training. If someone refuses, I write it on the MAR sheet and let the manager know." MARs were checked

when they were returned to the office. Records confirmed this. This was to ensure they were completed accurately and any discrepancies identified in a timely way.

Staff told us they were provided with personal protective equipment (PPE) in order to ensure people were protected by the prevention and control of infection. Staff told us they could collect PPE from the office. One staff member said, "All the gloves and aprons [are] always in the [provider's office]. I'll come and take anything I need."

Good

Is the service effective?

Our findings

People and their relatives expressed their confidence in the staff and felt they knew the needs of their family members well. One person said, "[Prestige Nursing] has been with me for four years . If they weren't any good I would find someone else." One relative told us, "If [the care] wasn't good [we] would leave."

Before a person started to use the service, one of the office staff would carry out an assessment of their needs, before an agreement for placement was made. This was carried out to ensure that the service could meet the person's needs. Records showed that an assessment of their needs had been carried out for people who used the service. The field care manager said, "We'll get the referral, the care plan or assessment, we'll look at it and see if we can manage the care. Then we go out and do our own assessment, we'll do our own risk assessment, assessment of needs, medication assessment, complex care assessment if necessary."

Staff told us they had completed training to enable them to carry out their roles. They said they completed an induction to their role when they started to work for the service, which included working alongside (shadowing) more experienced care staff. Records showed staff completed the Care Certificate. The Care Certificate sets the standard for the key skills, knowledge, values and behaviours expected from staff within a care environment.

Staff were trained and supported to have the right skills, knowledge and qualifications necessary to give people the right support. A staff member told us, "There was classroom training and e-learning. Still doing e-learning. The training is good." Staff we spoke with confirmed that they had received all of the training they needed to do their job effectively. Records confirmed staff had received training for their role which would ensure they could meet people's individual needs. This included training in topics such as emergency procedures, health and safety, administration of medicines, safeguarding, infection control, food and hygiene, moving and handling, dignity in care, care of the dying and the Mental Capacity Act 2005 (MCA).

Staff told us they received regular supervision to support them in their role. Records confirmed this. One staff member said, "[Supervision] every other month but if I have any concerns I will always come in [to the office]." Staff also confirmed they had observations of their practice with regular spot checks.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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. We checked whether the service was working within the principles of the MCA and found that it was. Staff demonstrated their awareness about when they should obtain people's consent and confirmed they asked people for permission before carrying out care tasks. Records showed

that people had agreed to their care plan by signing a consent to care agreement form. Relatives were involved in making decisions where people lacked capacity. Records confirmed the service has sighted Lasting Power of Attorney (LPA) documents when people were unable to make their own decisions. One person told us, "The carers explain what they are going to do before they start."

Care records included people's nutritional and hydration requirements and preferences. Staff confirmed that they helped people with meal preparation and demonstrated awareness of different nutritional requirements. One person said, "[Staff] get my dinner for me." A relative told us, "The carer cooks [relative's] meal."

Care records included contact details of GP's and relatives. The registered manager told us they worked with other healthcare agencies to promote people's health such as district nurses, pharmacists and GP's.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were caring and supportive. One person said, "I find the [staff] to be very helpful." A relative told us, "[Staff] are really lovely to [relative]." Another relative commented, "[Staff] are really kind to [relative]."

Staff spoke in a caring way about people they supported and told us that they enjoyed working at the service. One staff member said about their person they cared for, "I have a regular [person], been with him 10 months. I can always tell what their mood is going to be, because I know him so well. We can have different conversations to take his mind off things." Another staff member told us, "Yes I am very caring person. I know that I put myself in their shoes. I know that one day I'm going to get old."

People and their relatives told us they were actively involved in making decisions about the care and support provided. Care plans were reviewed every six months with input from people and their relatives. Records confirmed this. One relative said, "The care plan was reviewed due to changes in [relative's] care."

Care plans were personalised. They contained information about people's medical and life history, current living situation, and what is important to them such as family, hobbies and spiritual needs. For example, one care plan stated, "Lunch time at arrival I will be in my armchair. Prompt my [relative] to excuse himself, before assisting me with incontinence care. Once my incontinence care is done, assist me back to the armchair and make me and my [relative] a cup of tea or coffee no sugar with whole milk." This helped give staff the information they needed to provide personalised care and support.

People's privacy and dignity was respected. Care plans provided information to maintain people's dignity. For example, one care plan stated, "Wrap me in a big towel so I do not catch cold, also for my dignity and respect. I am a private person and no one should be around during personal care, not even my [relative]." One staff member said, "I always think of how I'd like things to be done. I treat people with respect."

People's independence was encouraged. This was reflected in people's care plans. One care plan stated, "Assist me to undress, starting with the top. I am able to wash my face, neck and hands. I can dry those parts too. Allow me to do as much as possible for myself." One staff member told us, "Encourage independence, let them do what they can do."

Good

Is the service responsive?

Our findings

People and their relatives told us they enjoyed the service and the support they received was responsive to their needs. A relative told us, "The carers know what to do as it's all in the care plan."

People and their relatives told us they had a care plan in their home for staff to follow. A copy of the person's care plan was kept at the office. Care plans contained an assessment of people's needs and a care plan that included how any identified risks were to be managed. People had a personal profile sheet which gave a summary about the person's history and their character. Care plans included a timetable of visits, what needed to be done to assist the person how to achieve this. Care plans provided guidance for staff about everything they needed to do on each visit and how people liked their care provided. Staff told us that care plans were up to date and easy to follow. One staff member said, "We always read the care plan so I know who I'm dealing with."

Care records contained blank charts for staff to record important information such as fluid, food and bowel records. Records showed these were completed and were up to date. Staff completed a care report at the end of each visit so that the next member of staff visiting would be aware of the current situation of the person. We saw that care plans were updated as required when changes to need occurred and were reviewed at least every six months.

People's cultural and religious needs were respected when planning and delivering care. Records showed people had discussions of their spiritual faith during the support planning process. Staff showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "It's about having a non-judgemental approach. You need to train the [staff] to be non-judgemental. We do have dignity in care training." A staff member said, "Would treat [LGBT people] the same as everybody else."

People knew how to make a complaint if they needed to. One person said, "I would complain if something was wrong." Another person told us, "All the [office numbers] are in the [care] file."

The provider had a system in place to log and respond to complaints. There was a complaints procedure in place. This included timescales for responding to complaints and details of who people could escalate their complaint to, if they were not satisfied with the response from the service. The complaints procedure was included in the service user guide which was given to all new people when they first joined the service.

At the time of our inspection the service did not have any people receiving end of life care. The service did have an end of life policy for people who used the service. The policy was appropriate for people who used the service. The service did provide end of life care training for staff. The service had an end of life care plan and assessment which explored people's wishes. One staff member said, "There was a person who was end of life, I was looking after them. Got to give people their care that they need. With dignity and respect."

Good

Is the service well-led?

Our findings

People and their relatives told us they liked the management of the service. One person said, "The staff and management team are very good."

Staff told us that they felt supported by the registered manager. One staff member said, "I love working here. The manager is very supportive. I can come any time [to the office]. You can have a word with them and they are available to listen to you."

Staff meetings were held monthly. Records confirmed this. Minutes of these meetings showed there was regular discussion about people who used the service, daily recording, medicines recording, professional boundaries, electronic call monitoring, food hygiene and health and safety.

The provider had a system of obtaining verbal feedback from people using the service through telephone monitoring calls. Topics discussed with people included staff punctuality, staff appearance, and another concerns and comments. Overall the feedback was positive. The provider also carried out spot checks on staff by visiting people at home and observing how the staff member worked. One staff member said, "[Office staff] will come and observe you, how you look after people and make sure you're doing everything right. It's a spot check and we are never aware of it." Another staff member told us, "[Office staff] do spot checks every three months."

The provider carried out annual audits. We reviewed the most recent audit which had taken place on 23 January 2018. The audit showed the regional manager had checked staff files, care records, staff meeting minutes and the electronic call monitoring system. We saw any gaps were highlighted and passed onto the registered manager to address. Records showed that identified actions had been taken. This meant there were systems in place to monitor and improve the quality of the service provided.

The quality of the service was also monitored through the use of an annual survey for people who used the service. The last survey completed was for May 2018. Overall the results were mostly positive. Comments included, "My two carers were very personable and caring, listening to my needs" and "[Staff member] and [staff member] are very good carers and always understanding of [relative's] dementia."

The service worked in partnership with key organisations to support care provision, service development and joined-up care. The service worked with the social services, GPs, pharmacists, palliative care teams and the local clinical commissioning group.