Allcare Community Care Services Limited

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Inspection report

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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

Overall summary

We undertook an announced inspection of Allcare Community Care Services on 3 December 2014. We informed the provider two days before our visit that we would be inspecting.

Allcare Community Care Services office is based in Birkdale, Southport, Merseyside. It provides personal care services to people in their own homes in the local and surrounding area. At the time of our inspection the organisation was providing support to over 120 people.

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

Summary of findings

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 who used the service told us they felt safe and secure in the way they were supported by the care staff. There were appropriate numbers of staff employed to ensure a flexible service and to ensure people received the support at a time when they needed it.

Although not all staff had received their refresher adult safeguarding training, they were knowledgeable about adult abuse and clear about the arrangements for reporting any concerns they may have.

Effective recruitment processes were in place to ensure staff were suitable to work with vulnerable people. Staff received regular training for their role, supervision and an annual appraisal.

Each person had a care plan and people told us they were involved with developing and reviewing their care plans.

People who needed support with meals said the care staff prepared food in a way they liked and ensured sufficient food and drink was available to them until the next visit from care staff.

Processes for routinely monitoring the quality of the service were established, including an annual survey and visits to people to check they were satisfied with the service.

Summary of findings

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 was safe.

Risk assessments had been undertaken depending on each person's individual needs and plans were put in place to manage any identified risks.

Care staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

People told us care staff supported them with their medication at a time when they needed to take it.

Measures were in place to check the safety of equipment.

There were sufficient numbers of care staff available to ensure people received care when they needed it. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Good

Is the service effective?
The service was effective.

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

People who needed support with meals said the care staff prepared food in a way they liked and ensured sufficient food and drink was available until the next visit.

Care staff said they were well supported through induction, supervision, appraisal and on-going training.

Good

Is the service caring?
The service was caring.

People told us they were happy with the care they received. They spoke highly of the care staff and said they were treated with dignity and respect.

People told us they were involved in developing and reviewing their care plan.

Good

Is the service responsive?
The service was responsive.

People's care plans were regularly reviewed and reflected their current needs. People said their care was individualised and provided at a time and in a way that they liked.

A process for managing complaints was in place. People we spoke with knew how to raise a concern or make a complaint.

Good

Is the service well-led?
The service was well led.

Care staff spoke positively about the communication and support they received from the registered manager and the office-based staff.

Good

Summary of findings

Care staff were aware of the whistle blowing policy and said they would not hesitate to use it.

Processes for routinely monitoring the quality of the service were established.

Allcare Community Care Services

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.

The inspection took place on 3 December 2014 and was announced. The provider was given 48 hours' notice because the organisation provides a domiciliary care service and we needed to be sure that someone would be available. The inspection was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the organisation. This included a review of the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we looked at the notifications and other information the Care Quality Commission had received about the organisation.

As part of the inspection we spoke with 13 people who used the service. The majority of people were contacted by telephone but we did visit two people who had agreed to us calling to their home. We also had a discussion with two relatives of people who used the service. We spoke with the registered manager. We spend time with office-based staff, including a care assessor, two care coordinators and the personnel/training coordinator. We spoke with nine care staff who provided direct support to people.

We looked at the care records for two people, three staff recruitment files, training records and other records relevant to the quality monitoring of the service.

Good

Is the service safe?

Our findings

The people who received a service from Allcare told us they felt safe with care staff coming into their homes and safe in the way care was provided. One person said, "They [care staff] are never short with me and always look after me very well." Another person told us, "I feel safe when the carers help to shower me, and they treat me with dignity and respect."

The care staff we spoke with said they had received training in adult safeguarding. They had a good understanding of what constituted adult abuse and were clear about the arrangements for reporting any concerns. Care staff said they would not hesitate to report any concerns. An adult safeguarding procedure was in place and it was last reviewed in September 2013. We could see that safeguarding awareness training formed part of the care staff induction programme.

We looked at the electronic record for monitoring staff training and noted it clearly indicated adult safeguarding training was refreshed every two years. However, the monitoring system suggested that a large number of staff, including care and office-based staff had not received the refresher training for some time. The registered manager was unable to explain why refresher training had not taken place in accordance with the training arrangements. The registered manager confirmed after the inspection that training had been arranged for the staff who needed it in January 2015.

There were arrangements in place to protect people from the risk of financial abuse. The care records informed us that any involvement with a person's money, such as shopping for the person or collecting their pension was clearly recorded and relevant receipts retained. The care assessor (member of staff who monitors and reviews people's care) carried out unannounced spot checks as a minimum on an annual basis. We looked at the paperwork related to some spot checks and noted that shopping and pension collection was monitored as part of the checks.

Some people needed support with their medication and said care staff helped them with this. They told us they received their medication at a time when they needed it. One person said, "They [care staff] prompt me to take my medication."

Care staff said they were familiar with the medication policy and told us they received medication training as part of their induction. The induction programme confirmed this. An assessment was undertaken to ensure care staff were competent before they commenced supporting people with their medication. During the inspection, we observed care staff prompting people in their home to take their medication and completing the paperwork afterwards. The care records informed us that a medication risk assessment was undertaken if a person needed support with their medication. The paperwork associated with the spot checks showed that a large section was dedicated to observing whether medication was managed in accordance with the person's care plan and was in line with expected performance criteria. This demonstrated that a process of on-going assessment was in place to ensure people received their medication safely.

We noted that the Provider Information Return (PIR) identified there had been five medication errors in the last 12 months yet the Care Quality Commission had not been notified of these given that they would likely have been raised as safeguarding alerts. The registered manager explained that she was unaware at the time that medication errors should be reported through safeguarding channels and said all future errors would be reported appropriately.

We could see from the care records that a range of assessments were undertaken to identify and manage risks for each person. These included assessments in relation to environmental risks, moving and handling and assessments regarding the use of equipment, such as hoists, stand-aids and wheelchairs. Guidance was in place for care staff to check that equipment had been serviced and was safe to use.

Individualised risk assessments were developed depending on each person's needs. For example, we could see that a risk assessment had been undertaken for a person who was supported by care staff to access the community. People told us they were involved in assessments of their needs. A person told us, "I was involved with my risk assessment because of the manual handling and transfer from bed to wheelchair/chair."

Good

Is the service safe?

Incidents were recorded on incident forms and stored in people's care records. The care assessor told us they reviewed the incident forms and if there appeared to be a pattern developing, such as an increase in falls then they would visit the person at home and review their needs.

Care staff told us that the staff in the office were responsive to concerns they had about people's safety. One of the care staff described a crisis situation the week previous. They said they contacted the office and one of the care assessors arrived to the person's house within 10 minutes.

Care staff informed us they received awareness training on induction about infection control. We observed care staff using disposable gloves and aprons when supporting people with personal care and food preparation.

We looked at the personnel files for three members of staff recruited in the last 12 months. We could see that a rigorous recruitment process was in place and a formal check had been carried out to confirm each member of staff was suitable to work with vulnerable adults. Two references had been obtained for each of the staff. We spoke with a member of staff who recently started working for the organisation. They confirmed they were interviewed for the job and did not start until two references and a formal check to ensure they were suitable to work with vulnerable adults had been undertaken.

Staffing levels were determined by the number of people using the service and their individual needs. People told us they received care from a regular staff team. They said staff arrived on time but if they were going be a bit late then the office telephoned to let them know.

Good

Is the service effective?

Our findings

We were provided with a copy of the induction programme for new staff. The induction took place over four full days and covered topics, such as communication, equality, safeguarding and person centred support. We spoke with a member of staff who had recently started to work for the organisation. They told us the induction also included four days shadowing an experienced member of staff. They were pleased with the quality of the induction as they had no previous experience of care work.

All the care staff we spoke with spoke highly of the standard of training provided by the organisation and said they received regular supervision and an annual appraisal. We spent time with the coordinator who monitored staff training, supervision and appraisal. The coordinator had a system in place to monitor the status of supervision and appraisals.

We could see from the recruitment files that a training needs analysis was undertaken when care staff first started. The coordinator said this was completed to provide an indication of what priority training staff needed and it also assisted with identifying and matching skills to the needs of people using the service. An electronic monitoring spread sheet was in place to monitor the status of staff training. It identified the required training for staff to complete as: moving and handling; medication; infection control; health and safety; adult safeguarding and fire safety. The coordinator informed us that the spread sheet was not up-to-date as recent training undertaken by staff had not been entered. Besides the moving and handling training which was refreshed each year, it was not clear if other training was refreshed on a periodic basis. We discussed this with the coordinator and the registered manager who said they would clarify what training needed to be refreshed and within what timeframe.

Training was also provided depending on the specific needs of people who used the service. This included end-of-life care and dementia care training. We heard the organisation supported people with unusual or complex conditions and how training was sourced to ensure care staff could support each person effectively. For example, the coordinator informed us about the support provided to a person with a rare progressive condition. The coordinator informed us that only dedicated care staff provided care for the person. Prior to the person being discharged from hospital, the care staff spent two weeks on the ward shadowing ward staff and getting to know the person's specific needs.

We asked people who used the service if they felt confident in the way care staff supported them. A person said to us, "They [care staff] receive the correct training for my needs." Another person told us, "I have never had a problem with the carers and their training is very good."

We spent time with the care coordinators to establish how they matched care staff up with people who used the service. We were informed that the care assessor liaised with the care coordinator to look at the needs and preferences of the person so the most appropriate staff were identified to provide the care. The skills of care staff was also considered when identifying the staff to provide care. The care coordinator used an electronic system to record any staff that were excluded from providing care to a person. For example, we saw that male staff were excluded from providing care to a person who preferred to receive care from female staff only.

We asked what training staff received regarding people's mental capacity to consent to care. Although not explicit in the training programme, the assessor advised us that awareness about the Mental Capacity Act (2005) was touched on during induction. The Mental Capacity Act is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. We were provided with an example of how a person who lacked mental capacity was supported and how staff worked closely with the person's representative in the absence of family. We looked at their care records and could see that detailed records were maintained.

The care plans we looked at were person-centred and were worded in such a way that promoted people to make their own decisions and choices. Terms such as 'encourage' and 'prompt' were used throughout the care plans.

Where appropriate staff sought the input of health and social care professionals if people's needs changed. For example, we heard from the care assessor that if they noted any increase in falls then the local falls team were contacted. We also heard about a complex care package and that a meeting had been arranged with the person's social worker and district nurse.

Good

Is the service effective?

Some people received support with their meals and were satisfied with how this was organised. A person said, “They leave me with enough food and drink until the next visit.” We visited two people in their home whilst they receiving support from their care staff. Both had either a snack or their lunch prepared for them by care staff. The meal or snack was prepared and presented in a way the people liked.

Good

Is the service caring?

Our findings

People who used the service spoke highly of the care staff and the way in which they were supported. They said care staff treated them with dignity and respect. A person said, “The staff are excellent and they take the time with me. They listen to me and are now like friends.” Another person told us, “My carer put my Christmas tree up for me this morning. She can anticipate my needs and never rushes me.”

With their permission, we visited two people in their home whilst they receiving support from their care staff. Both were complimentary about the caring attitude of their care staff. We observed that the dignity and privacy of a person was maintained whilst they were receiving personal care.

Staff we spoke with demonstrated a genuine positive regard for the people they supported. They told us they provided care to the same people on a regular basis which meant they had the opportunity to develop good relationships with the people they supported. One of the care staff told us, “I love my job and enjoy working with the clients. I treat them as if they were my own mum and dad. I enjoy sitting and listening to their stories and hearing what they have done in their lives.” Another of the care staff said, “I like the job because I enjoy caring for people.” Furthermore one of the care staff said to us, “It is a rewarding job. The people are always so thankful. It’s nice to see them smiling when you leave.”

People told us they were involved in developing and reviewing their care plan. They said the care plans were reviewed by staff from the office who came to see them regularly and also came to see them if their needs changed due to illness. A person said, “I have a care plan and it is regularly reviewed.”

Good

Is the service responsive?

Our findings

The people we spoke with said they received care based on what they needed and in a way that they liked. A person said to us, "They are a very good team. I get various carers but I cannot fault them as they help to support my freedom." Another person said, "The carers know what they are doing to meet my daily needs."

The care assessor talked through with us how a plan of care was developed for a new person referred to the service. The care assessor visited the person in the first instance to undertake a needs assessment, including the care needed and the person's preferences in terms of the visit times. A care plan was developed with the person and the care assessor then liaised with the care coordinator about the most appropriate care staff to support the person.

The care records, in particular the care plans were detailed and very much tailored to the specific needs of each person. The assessor advised us that they carried out a further home visit 4-6 weeks after the initial care package started to check the person's satisfaction with the arrangements. We were informed that each person then received a minimum of one home visit a year to review the care and check that the care package was still meeting the person's needs.

The care staff we spoke with were knowledgeable about the needs of the people they supported. They told us they provided care to the same people on a regular basis so were familiar with people's preferences and the ways they liked to be cared for. Care staff said the care assessors reviewed care plans as people's needs changed and that they were informed promptly of any changes to care plans. One of the care staff said, "Things are dealt with quickly. They [office-based staff] are on top of it straight away."

A complaints procedure was in place. The people and relatives we spoke with were aware of how to raise a complaint about the service. We noted from the care records that people or their representative signed to say the complaints procedure had been explained to them. The registered manager explained that the organisation received very few complaints in contrast to the large number of compliments they received. Four complaints had been received in the last 12 months.

The registered manager advised us that a 2014 feedback survey was currently in progress. We looked at the results of the 2013 survey. The response to the survey was good as 93 questionnaires were returned out of a total of 145 sent out. The survey covered areas, such as arrival and departure time of care staff, whether care was provided in line with the care plan and whether missed calls had been dealt with effectively. People rated the various areas as either 'good' or 'excellent'. We observed that when a negative or concerning comment had been included in the questionnaire, the registered manager looked into it and responded to the person by letter, including an apology if appropriate.

Is the service well-led?

Our findings

Staff consistently told us they felt well supported by the registered manager and the office-based staff. One of the care staff said to us, "I can't fault Allcare. They are supportive if you have a problem and need time off." Another of the care staff told us, "Allcare has been smashing to me."

Care staff said there was an open-door policy and the registered manager and office-based staff communicated well with them so they were kept up-to-date about any changes. Staff rotas were available at the office for staff to collect each week. If the office needed to communicate with staff then a letter was attached to the rota. We looked at a selection of letters staff had received throughout 2014 and noted they provided staff with reminders about matters, such as timekeeping, recording medication, infection control and annual appraisals.

All staff had the opportunity to attend staff meetings which were held 2-3 times per year. We looked at the minutes of three staff meetings held in 2014. They informed us that issues such as medication, call times, staff attitude and communication were discussed.

Care staff were aware of what whistle blowing meant and said they would not hesitate to raise any concerns with the registered manager or the staff based in the office. One of the care staff said, "I would not hesitate to blow the whistle and I know others would too. I believe Allcare would act on any concerns they heard."

A lone worker policy was in place and staff were aware of the policy and what to do if they felt unsafe. They said the assessors would respond promptly if they needed help. One of the care staff told us, "I feel safe out there because I know when I ring the office they [office-based staff] will respond quickly."

The absence of identified travel time between visits was a consistent concern expressed by the care staff we spoke with. Staff said this was generally not too much of a problem if visits were an hour long and close together. They said a series of half hour visits meant they were rushing from one person to another and most staff said they did not like this work arrangement. Feedback from people we spoke with suggested this did not impact negatively on people's care. They told us staff were nearly always on time and if they were going to be a few minutes late then the office telephoned them to let them know. The registered manager confirmed that people had not raised concerns about the timekeeping of care staff or the length of time they spent on the visit.

The organisation had a number of established systems in place to monitor the quality of the service provided. Each person using the service received a minimum of one home visit from a care assessor each year. This home visit explored whether the care package was meeting the person's needs and whether they were satisfied with the way care was provided. These visits could be increased in frequency if needed. Unannounced spot check visits were also carried out and aimed to check whether care staff were working in accordance with the expectations of the organisations. We saw examples of both home visits and spot checks in people's care records.