Nestor Primecare Services Limited

Allied Healthcare Goldsborough - Stevenage

Inspection report

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17 January 2018
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 was the first comprehensive inspection of this service since the provider re-registered with the Care Quality Commission (CQC) in November 2016. This inspection took place on 17 January 2018. We also made telephone calls to people who used the service, their relatives and staff to obtain their views. These calls took place on the 23, 24, 25 and 26 January.

At the time of our inspection the provider had moved to a new location at Unit B Gateway 1000 Whittle Way Stevenage Hertfordshire SG1 2FP. The applications to change the location address had been made to CQC and we are in the process of updating these changes.

Allied Healthcare Goldsborough - Stevenage is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and in specialist housing. It provides a service to adults with learning ,physical disabilities and older people, including people living with dementia who live in their own homes. At the time of our inspection there were 548 people using the service.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At this inspection we found a breach of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care. The provider had failed to operate effective systems to meet people's needs and reflect their preferences.

There was not enough staff available at all times to meet people's needs. People and their relatives told us that the care and support provided by Allied Healthcare Goldsborough - Stevenage was not always appropriate to meet people's preferred preferences.

Staff helped and supported people to take their medicines safely. Staff received training in safe administration of medicines and knew how to make sure people received their medicines safely. However, we found that there had been some medicine errors that had not been identified by the providers monitoring systems in place.

The provider had policies in place to monitor any concerns and complaints raised by people who used the service or their relatives. The manager investigated and responded to complaints. However not everyone felt the communication was good. Some people felt that although they had raised issues about their call times, however they felt that calls times remained inconsistent.

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People felt safe using the service. Staff demonstrated they had a good understanding of abuse and were able to escalate concerns when required. The provider had safe recruitment practices in place.

Staff received training to enable them to carry out their role effectively and safely
Staff sought people's consent to care. People received support to access healthcare appointments if needed.

People and their relatives told us they were satisfied with the staff that provided their care. Staff members often took the time to have a chat and support people with their needs. People were fully involved in making decisions about their own care. People felt staff treated them with dignity and respect.

People and their relatives told us they had been involved in developing people's care plans and felt that staff listened to them. The manager demonstrated a good knowledge of the staff they employed and people who used the service. Staff understood their roles and responsibilities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always consistently safe.

There were not always enough staff to meet people's needs.

People who required a call to be completed by two staff were occasionally attended to by a single member of staff.

The provider had safe recruitment practices in place.

People felt safe using the service. Staff understood about protecting people from abuse and understood how to escalate any concerns.

Is the service effective?

Good

The service was effective.

Staff received appropriate training that met peoples needs.

People and their relatives told us that staff offered choice and Staff sought people's consent to care.

Staff where required supported people with their nutritional needs..

Staff were available to support people to access healthcare appointments if required.

Is the service caring?

Good

The service was caring.

People were fully involved in making decisions about their own care and felt their views were listened to and respected. However call times were inconsistent with people's preferences.

People and their relatives were satisfied with the staff that provided people's care.

Staff were fully committed to providing good quality support and

care to people.

People felt that they were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff did not always receive sufficient travel time and some calls had no travel time allocated between the call

People and their relatives had been involved in developing people's care plans.

The provider had procedures in place to help ensure that any concerns and complaints raised by people who used the service or their relatives were appropriately investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The manager had not registered with the Care Quality Commission at the time of the inspection but has now started the process to register.

Systems in place for monitoring quality or auditing the service to identifying improvements that needed to be made were not always effective.

People were not listened to by the provider and their preferences were not respected or upheld.

Medicine errors were not always identified by the providers monitoring procedures.

The manager demonstrated a good knowledge of the staff they employed and people who used the service.

The manager kept up to date with changes in the care sector and changes in legislation.

Allied Healthcare Goldsborough - Stevenage

Detailed findings

Background to this inspection

This inspection took place on 17 January 2018. and was announced. We provided 48 hours notice of the inspection because the location provides a domiciliary care service and we needed to be sure staff would be available for us to talk to, and that records would be accessible. One inspector undertook the inspection.

We asked the provider to complete a Provider Information Return (PIR) as part of this inspection process. This 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. We also checked the information we held about the service and the provider and saw that no concerns had been raised.

We spoke with 29 people who used the service and received feedback from 14 relatives to obtain their views on the service provided. We received feedback from the care delivery manager, care quality supervisor, scheduler and the manager. We also spoke with eight staff members.

We looked at the care records for four people who used the service. We reviewed three staff recruitment files and training records. We also looked at further records relating to the management of the service, including quality audits, in order to ensure that robust quality monitoring systems were in place.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us staff did not always arrive on time and if they were running late, they were not always informed by the office of a delay. There were not always enough staff available to meet people's individual needs. Staff received their rotas by email and post on Thursdays for the following Monday. Although the schedulers told us this worked well and allowed time to reschedule cover if required, people told us that their calls were regularly late or early. Due to staff shortages, the manager used agency staff to cover shortages. However, we found that the provider had not ensured people's preferences with regard to their call times were respected and an inconsistency of staff to support and care for people.

We spoke with people who required two staff members to provide their support. However, people confirmed that they had sometimes received their support by only one staff member. Two staff we spoke with also confirmed they had attended double up calls on their own. One relative told us one staff had not turned up, they said, "One girl [staff] came on her own to wash and dress [name]." A staff member commented," I have had to complete a double up call on my own." We spoke with the manager about this; they confirmed they were only aware of one incident where this had happened. This meant that people did not always receive the correct support to ensure they were safe; this did not promote best practice.

There were processes in place to monitor incidents and accidents. People who used the service told us that staff helped and supported them to take their medicines safely. Staff received training in safe administration of medicines and knew how to make sure people received their medicines safely. Staff had their competency regularly checked by the care quality supervisors, there were also spot checks completed to ensure best practice. However, we found there had been some medicine errors that had not been identified when the medicine audits had been completed. We spoke with the manager who agreed that, there was an auditing shortfall. The manager confirmed their compliance teams would review and rectify these errors immediately.

People told us they felt the service they received was safe. One person said, "I feel very safe and comfortable with the staff."

Staff identified potential risks to people's health, welfare or safety and appropriately managed and mitigated risks to help keep people safe. For example, staff told us they made sure people's key safes were secure and they checked people's front doors closed properly when they left. Staff told us they informed the office of any changes to people's needs. Staff had completed risk assessments and environmental checks to keep people safe. We noted there was clear guidance in care plans for staff on how to support people's needs.

Staff had received training with regard to safeguarding people from harm. Staff we spoke with demonstrated their knowledge about how to identify any signs of abuse. They knew how to raise concerns, both internally and externally. One member of staff told us, "I would always contact the office and report any concerns. Staff we spoke with understood the reporting procedures to keep people safe.

Safe and effective recruitment practices were followed to make sure that all staff were of good character and suitable for the roles they performed. We noted the provider had the necessary pre-employment and identity checks in place before staff could commence work. This included verifying references. One staff member said, "I had to provide references and had my DBS [disclosure and barring service] checks completed before I was allowed to start work."

Good

Is the service effective?

Our findings

Newly employed staff were required to complete an induction programme during which they received training relevant to their role. They worked alongside other experienced colleagues until they were competent. Staff received training in areas such as safeguarding, medicines, health and safety, moving and handling and first aid. Staff were also encouraged and supported to obtain national vocational qualifications (NVQ). One staff member told us, "The training is second to none. The trainer is so helpful and answers all our questions."

Staff had 'one to one' supervisions where they had the opportunity to review and discuss their performance. One staff member told us, "I have had supervisions; to see how I was getting on. We talked about any concerns I might have and we discussed training." Staff confirmed they had the opportunity to attend meetings and staff we spoke with felt they had a voice. However, staff and people told us that communication could be better. For example, one staff member confirmed that they had been asked to attend calls but had not received any details about the person's needs or how to support them. Another staff member told us they attended a call that had previously been cancelled by the person. However, office staff had not passed on this information. People also told us that office staff did not always inform them if staff were running late or if there were changes to the staff attending calls.

People who used the service and their relatives were positive about the staff that provided care and support. One person told us, "I'm happy with the care, staff are very nice altogether." A relative commented, "[name] had two carers, they were lovely. [Name] was really happy with the care."

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. At the time of our inspection, we found that the provider was working within the principles of the MCA where necessary and appropriate to the needs of the people they supported. Staff told us they obtained people`s consent before they offered any support. One staff member said, "I always offer choice, It's important. I wouldn't want people making choices for me."

Staff helped, supported and encouraged people to eat a healthy balanced diet that met their needs. We found that some people needed a minimum amount of support. For example to warm their food or prepare a snack; others required more support. One Relative said, "They help [relative] to get washed and dressed and help with their breakfast. "One person said they always make sure I have had a cup of tea."

Good

Is the service caring?

Our findings

People who used the service and their relatives told us that staff provided support in a kind, compassionate and caring way. One person told us, "I am really happy the staff are lovely. They respond when I request additional support, they listen to me."

People who received a service, and where appropriate their relatives, were involved in the planning and reviews of the care and support they received. One person told us, "I had someone come about a month ago, they sat down and went through the care plan and I was happy with that. "A relative commented, "They [staff] sat down and talked to us both about the care."

We found that people were positive about the care and the staff that provided the care. However, people were not happy about late call times and inconsistency of carers. One person also told us they had cancelled their calls due to the call being late. This meant although people were supported to have a review of their care and support. Their preferences were not always maintained.

Staff we spoke with confirmed that care plans had detailed guidance about the support people required. People told us that staff never rushed them. One person said, "Staff always check if I need anything else and they stay for the allotted time." People commented that staff were caring and respectful. One person said, "Staff spend time to chat, I don't feel rushed."

People we spoke with confirmed that staff promoted their independence and supported them to live at home. One staff member said, "I always encourage people to do what they can. It helps them keep active and makes them feel better." One person said, "They [staff] help with my shopping." A staff member told us that on one call they found that the person had no milk so they popped out to the shop and bought them some from with their own money. They commented," I just bought it with my own money, so they could have a cup of tea. Happy to do that." One relative said, "They [staff] are really good, they are kind and caring. They do little extra things and go out of their way to help."

Records were stored securely and staff understood the importance of respecting confidential information. They only disclosed it to people such as health and social care professionals on a need to know basis.

Requires Improvement

Is the service responsive?

Our findings

We received a mixed response from people and their relatives about continuity of staff and late or early calls. Some people told us staff did not always arrive on time. People told us when staff ran late the office staff did not always contact them to inform them of the delay. One person said, "The weekdays are normally ok, they [staff] do run late but they can't help that. But the weekends are hit and miss with calls usually later in the day." A relative commented, "We used to receive rotas until two or three weeks ago but now we don't. Sometimes they will ring to say staff are running late but not often. "Some people did tell us they had regular staff and received their calls on time.

People we spoke with told us they did not always receive regular staff to promote continuity of care. One person said, "I do like to have regular carers but I don't know who is coming. People told us that they had not received their rotas for at least three weeks. One person confirmed they had contacted the office to ask about their rota and told that there was no point in sending the rota as it will change. This meant that people did not always have the opportunity to develop relationships and for staff the opportunity to learn people's likes and dislikes.

Most people we spoke with felt the staff were lovely but they never knew who or what time people were coming to support them. One person said, "Oh yes happy with the care, only thing that annoys me a little is I have no idea what time they [staff] come." This meant that the provider was not meeting people's preferences and people did not receive their care at a time that suited them. One relative told us that the reason they had the support for their relative was that they could get there rest as they worked but this was not always possible when staff did not always know the routine. A staff member commented about new clients, "We don't always get information about the clients we are going to." One person said, "I get inconsistent carers go to the wrong door, not read the care plan." They went on to explain that one staff member had asked them what they needed to do as they were not familiar with the call and had not read the care plan.

The provider had a system to monitor calls throughout the day to ensure people received their support. Office staff told us that staff had travel time added to their rotas to support time keeping. However, we found although there was travel time added to calls this was not always the case. Staff told us that they did not always have enough travel time and that some calls were back to back (This meant one call would finish at the same time the next call was to begin) it would not therefore be possible to arrive at the agreed time. One staff member sent examples of their rota that showed on numerous occasions where they had back-to-back calls.

One person told us there night calls were often over an hour earlier than they preferred. The night call supported the person to go to bed. However, they had sent staff away on occasions because this was not their preference and too early. They told us that their GP's advice is not to lie in bed too long and to have plenty of exercise. They also said, "I have spoken to people in the office time after time and I have been told "We are short staffed and do our best. I don't mind if they are late but I don't want to go to bed early. It's as simple as that." Another person commented, "We get regular care in the morning but at night we just don't

know who is coming. So you end up wondering about who is coming." A family member commented, "My [relative] sometimes knows who is coming but not always and they can get very anxious." We found that although people were happy with the care provided by staff they were not always happy with the times of the calls and we found some people were left feeling anxious about who was coming and what time.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2014.

People were happy with the staff and care they received but wanted more stability around call times and consistency of staff. Staff had good guidance detailed in people's care plans about their support needs. Care delivery managers reviewed peoples care plans every six months and as required. People confirmed that staff sat down with them to discuss any changes to the care or support they required.

There was a complaints procedure in place and people told us they knew how to raise concerns. People were aware of how to make a complaint should they need to. People we spoke with told us that they were very happy with the service. One person said, "I have no complaints." Other people told us that they have contacted the office about the timings of their support but this does not change. We noted that the provider had dealt with complaints in line with the complaints policy.

Requires Improvement

Is the service well-led?

Our findings

We had a mixed response from people about the service. Some people felt listened to. While others did not. One person said, "If there is a problem I can ring them." Another said, "Goldsborough are really good we can cancel visits when we need, they are very helpful." Another person said, "We no longer get rotas, no contact and the communication is appalling."

The provider had an electronic monitoring system that allowed the service to monitor calls, to ensure people received their calls on time. The call times were audited to confirm people had their calls at the correct time. The manager told us they had recently introduced a new system that assisted staff with the rostering of calls. People we spoke with confirmed they did not always receive their calls on time. Staff we spoke with also confirmed that this was an issue. The care delivery manager confirmed they monitored call and contacted staff regarding any late calls. However, we found that people had not always received their calls on time. People told us they were not receiving their rotas even though they had requested them and people were not always informed about late calls or changes to staff.

We saw that the manager had completed audits and there were action plans in place to make improvements where required. The quality team also completed annual audits to ensure best practice. The manager documented all incidents and complaints these were reviewed by head office. This meant there were regular quality checks in place. However as we stated earlier in the report we found that checks on medicines had not identified errors we had found. There had been no improvements made to establishing regular routines in attending calls on time and issues around double up calls had not been identified.

The manager ensured that staff had the resources and training necessary to meet people`s needs at all times. The manager was clear about the values and the purpose of the services provided.

The manager told us they felt supported. They confirmed they had regular contact with the operational manager and held a weekly conference call to discuss any issues. They attended manager meetings to discuss and share ideas. The provider insured that all relevant updates to policies and practice were made available. The manager has used the local authority for training.

Staff were positive about the manager of the service. One staff member said, "We have a great team here and the manager is very approachable." The manager confirmed they were actively recruiting. The office staff were knowledgeable about the people who used the service and about their needs; the care quality supervisors covered shifts when required and were up to date with their training. There was a clear staff structure in place and staff were aware of their roles and responsibilities. There was an out of hour's service operated for people to ensure that people had support when required.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of the service users did not always meet their needs or reflect their preferences.