Nestor Primecare Services Limited

Allied Healthcare London North

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

Summary of findings

Overall summary

Allied Healthcare London North provides a range of services to people in their own home including personal care. People receiving care were mostly older people living in their own homes in the community in the London boroughs of Barnet and Islington. The service mainly provided personal care for people on short visits at key times of the day to help people get up in the morning, go to bed at night and support with meals.

Not everyone using Allied Healthcare London North receives a regulated activity. CQC only inspect the service received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection 400 people were receiving a personal care.

There was a registered manager in post at the time of our inspection. 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.

When we last visited the service on 10, 11 and 12 January 2017 the service was rated as 'Requires Improvement', and we identified a breach related to staffing. Therefore, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions 'Safe' and 'Well-Led' to at least good. At this inspection we found action had been taken to make improvements.

At this inspection, we found that significant improvements had been made in relevant areas as detailed throughout this report. Staff punctuality had improved owing to a new IT system that had been implemented to improve staff deployment. Care workers were now mostly allocated according to geographical areas, which reduced travel time and therefore improved timeliness.

There were effective systems and processes in place to minimise risks to people. There were safeguarding, whistleblowing and anti-bullying and harassment policies in place and care workers were aware of how to raise concerns. Care workers had been recruited safely. They underwent appropriate recruitment checks before they commenced working at the service to ensure they were suitable to provide people's care. There were also effective systems and processes in place to minimise risks to people. Care plans contained risk assessments which identified the risks to the person and how these should be managed. Equally, there were robust arrangements around the management of accidents and incidents, medicines and risks associated with poor infection control.

People gave us consistently positive feedback about how the service was meeting their needs, including how they were supported to have sufficient amounts to eat and drink. Their needs had been assessed by the service before they started to use the service. Care plans included guidance about meeting these needs. This was accomplished by working alongside a range of health and social care professionals. People's capacity

to make choices had been considered in line with the Mental Capacity Act 2005 (MCA). They told us that care workers asked for permission before carrying out any care. The service had supported care workers to have the skills and knowledge to carry out their role. They had received regular training and support.

People told us care workers were caring and compassionate. They told us care workers treated them with respect and maintained their privacy. People's individual preferences were respected. Their care plans contained detailed information so that care workers were able to understand their preferences. Care workers had a good understanding of protecting and respecting people's human rights. As a result they treated people's values, beliefs and cultures with respect. The service ensured there were practical provisions for people's differences to be respected. Although people's communication needs were considered, this needed to be developed in terms of the requirements of Accessible Information Standard.

People received person centred care. They told us that they had been consulted when their care plans were written. Consequently, by involving people, the service was able to deliver the care that met their preferences. People's diversity and human rights were highlighted in their care plans. This ensured care workers were aware if they needed to make reasonable adjustments to meet people's needs. We spoke with some people who told us provisions had been made to support their diversity, and this included gender preferences. People and their relatives confirmed that they could complain if needed. There was a complaints procedure which they were aware of.

The management team had continued to improve the quality of service provided. The registered manager had a clear sense of responsibility and had led a management team to embed robust processes to monitor the quality of the service. A range of quality assurance processes, including surveys, audits, management of accidents and incidents, management of complaints had been used continuously to drive improvement. People had derived benefits from constant quality monitoring as we gathered from their feedback. Care workers were equally satisfied with the leadership of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service had made improvements to ensure people were safe. Staff punctuality had improved because of effective systems that had been implemented to improve staff deployment.

Care plans contained risk assessments which identified the risks to the person and how these should be managed.

Care workers had been recruited with care. They underwent appropriate recruitment checks before they commenced working at the service to ensure they were suitable to provide people's care.

People were supported with their medicines in a safe way by staff who had been appropriately trained.

Is the service effective?

Good

The service was effective.

People needs were met. This is because their needs had been assessed by the service before they started to use the service. Care plans included guidance about meeting these needs.

Care workers received regular training to help ensure they had up to date information to undertake their roles.

The service worked alongside a range of health and social care professionals.

People's capacity to make choices had been considered in line with the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

People told us care workers were caring and compassionate.

People told us that care workers treated them with respect and

maintained their privacy.

People's individual preferences were respected. Their care plans contained detailed information so that care workers were able to understand their preferences.

Although people's communication needs were considered, this needed to be developed in terms of the requirements of Accessible Information Standard.

The service treated people's values, beliefs and cultures with respect.

Is the service responsive?

Good

People received person centred care.

People's care plans gave a comprehensive account of people's needs and actions required to support them.

People's diversity and human rights were highlighted in their care plans and had been considered in relation to gender preference.

Is the service well-led?

Good

Improvements we identified in our last inspection had been maintained and fully embedded into practice.

A range of quality assurance processes had been used continuously to drive improvement.

There was a clear management structure in place. Care workers understood their roles and responsibilities.

The service sought people's views on the service to monitor quality.
People and care workers were complimentary about the leadership of the service.

Allied Healthcare London North

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 20 March 2018 and was announced. The provider was given notice because the service provides care at home and we wanted to make sure the manager and staff would be available to speak with us.

The inspection was carried out by two adult social care inspectors and an Expert by Experience (ExE) who had experience of care services for older people and people living with dementia. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The Expert by Experience made telephone calls to people and relatives.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also reviewed the Provider Information Return (PIR). 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.

During the inspection we spoke with 16 people using the service and 9 relatives to obtain feedback about their experiences of the service. We spoke with the operational manager, registered manager, and seven care workers. We examined six people's care records. We also looked at personnel records of seven care workers, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including staffing rotas and quality assurance processes, to see how the

service was run. We also spoke with the commissioning manager of the borough of Islington.

Good

Is the service safe?

Our findings

At our inspection in January 2017 we found the service was not safe and we rated the provider as 'Requires Improvement' in this key question. We found that the service did not always have sufficient care workers to meet people's needs. At this inspection we found that improvements had been made.

There were now enough care workers to support people in their homes safely. People told us they received a reliable service and were kept informed of any changes. Their feedback included, "My care worker has never missed a call", "Care workers are on time or early. They have never missed a call", "Care workers are pretty regular. They get here on time. Only once or twice they have not come. The office phoned up to say there was an emergency" and "I feel safe. The four care workers who attend to me are very good. If they are running late or if there is an emergency, they will ring me."

The service had addressed concerns around late and missed calls by employing an IT system, which ensured effective allocation of most suitable care workers to people receiving care. The registered manager told us, "Based on the feedback from 'client survey' that care workers were running late, care workers are now allocated according to geographical areas. This had reduced the amount of time care workers had to travel as they would have been already in the geographical area." A care worker told us, "Punctuality has improved. We are no longer as stretched because we do not have to run from one area of the town to another." Based on people's feedback, if care workers were delayed for one reason or another the management would let people know or find a replacement care worker.

Care workers knew and understood their responsibilities to keep people safe and protect them from harm. They had an understanding of different types of abuse. This is important as it meant they could spot the signs of abuse and report accurately to relevant authorities. Care workers were clear about reporting procedures inside and outside of the organisation. There were safeguarding, whistleblowing and anti-bullying and harassment policies in place. Care workers were aware of how to raise concerns through the relevant policies and were confident any concerns raised would be dealt with effectively to make sure people were protected. Where there had been concerns raised, these had been promptly investigated. People told us that they felt safe in the presence of care workers. One person told us, "I have used the agency for many years. I definitely feel safe." Another person told us, "I am happy with the agency. Care workers are competent." A third person told us, "I feel safe. We have the same person Monday to Friday. We have become friends."

Care staff had been recruited safely. They underwent appropriate recruitment checks before they commenced working at the service to ensure they were suitable to provide people's care. The recruitment files showed all pre-employment checks had been carried out to make sure new care workers were of good character to work with people. Checks included, at least two references, proof of identity and Disclosure and Barring Service checks (DBS). The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people. These checks helped to ensure only suitable applicants were offered work with the service.

There were effective systems and processes in place to minimise risks to people. Care plans contained risk assessments which identified the risks to the person and how these should be managed. Risk assessments covered a range of areas, including moving and handling, medicines, nutrition and environmental safety. The assessments provided information about how to support the person to ensure risks were reduced. This was kept under review with the involvement of the person, or in some instances, their representative. This ensured that risks to people's safety and wellbeing were monitored and managed properly.

The CQC has no regulatory powers or duties to inspect people's own homes. However registered providers have responsibilities in relation to the environments people who use their service live in. We looked at how the service ensured people were supported in a safe environment. The service carried out an environmental risk assessment of the home at the first contact with the person. The assessment covered a range of areas, including trip hazards, fire safety, and moving and handling. Where risks were identified, there were specific actions to take to reduce the risk. For instance, one assessment identified fire risk from smoking. There was a risk assessment in place with instructions to ensure that the person smoked without putting themselves or others at risk from fire. Care workers were instructed to carry out regular checks on the environment to reduce the risk to people in their own homes.

There was a process in place to monitor any accidents and incidents. The registered manager explained all accidents and incidents were logged centrally to ensure management oversight over any emerging trends. There was evidence that accidents were discussed in staff and management meetings to identify any trends and to ensure appropriate action had been taken.

People were protected from the risks associated with poor infection control because the service had processes in place to reduce the risk of infection and cross contamination. Care workers told us they were supplied with appropriate personal protective equipment (PPE), including gloves and aprons, when they supported people.

People received their medicines as prescribed. Care plans described what medicines were prescribed and the level of support people required. Medicine administration records (MAR) were completed appropriately and regularly audited. All care workers had received training in the administration of medicines which was regularly refreshed. The service had a medicines policy which was accessible to staff.

We asked people if they received their medicines at the right times. Their comments included, "Care workers help me to take my medication. It is on time. I already know what it is for", "Care workers remind me to take my medicines", "Care workers bring the medicines to me on time" and "My medicines are always on time." This was also confirmed by relatives. One relative told us, "We complained previously as my relative's medicine was not given to her on time. This has now been resolved and she gets it on time." Another relative told us, "Care workers give my relative his medicine on time."

There was a difference in protocols for medicines administration between the service and the local authority. The local authority had a policy that certain medicines could only be administered by the district nurses. The provider told us this was not always possible because district nurse were not always available. Therefore, there was a potential risk that some people would receive their medicines late. We contacted the local authority with our concerns and were assured action was being taken to resolve this. The local authority has since sent their revised policy the Commission's medicines team to review. This is still in progress.

Good

Is the service effective?

Our findings

People's needs had been assessed by the service before they started to use the service. Assessments covered areas such as nutrition, moving and handling, communication, health and safety, and relevant medical conditions. Care plans included guidance about meeting these needs. People gave us consistently positive feedback about how the service was meeting their needs. One person told us, "The care workers are aware of what they are doing and they know my needs." Another person said, "My needs are met. I have had the same care worker for many years." A third person said, "The care worker who comes during the week is brilliant. She goes the extra mile. She will sing with my relative and jolly him along." Equally, care workers were described in complimentary terms by people's relatives. One relative told us, "I am quite happy with the care. No qualms about it."

People's needs were assessed to inform care plans. The care plans provided guidance to care workers about how to meet identified needs. Depending on people's needs, care file contents included a personalised communication plan, environmental risk assessment, mobility, nutrition, medicines, and skin integrity plans. Also included were local authority contracts and agreements, consent forms, information about the care package and support provided. As part of meeting people's needs, the service worked with a range of health and social care professionals. We asked people about what happens when they felt unwell. One person told us, "Care workers arrange for the GP to do home a visit. " Another person said, "The care workers will call the doctor for me as I am not able to read or write." A relative of one person told us, "There is a process in place. The care worker would ring me and the management. And if necessary the care worker will ring the GP or 999."

People were involved in their care. Their choices were recorded in care plans. People told us that care workers asked for permission before carrying out any care. They told us that they were involved in making decisions about their care. One person told us, "I am always involved in my care. The care workers do not take anything for granted." Another person said, "Care workers always ask for permission. They use terms such as 'May I' to be given a go ahead." People's capacity to make choices had been considered in line with the Mental Capacity Act 2005 (MCA).

The 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 interest and legally authorised under the MCA. The application procedures for people living in their own homes are through Court of Protection orders.

Care records recorded whether people had capacity to make decisions about their care. Care workers told us they always assumed people had mental capacity to make their own decisions. They told us they always asked people for their consent before providing care. Care records showed that people, or their legal representative, signed to give their consent to the care and support provided.

There were systems and processes in place to support staff care workers. Care workers received regular supervision, which included one-to-one meetings, work based observations (spot checks) and annual appraisals. Care workers told us supervisions provided an opportunity to discuss working practices and identify any training needs. One care worker told us, "I meet with my manager on a regular basis. She has been very supportive. I have learnt so much from her." This was a generally held view from all care workers we spoke with.

Care workers were supported to have the skills and knowledge to carry out their role. They had completed an induction programme according to the Care Certificate framework. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should be covered if you are 'new to care'. New care workers shadowed experienced members of staff until they felt confident to provide care on their own.

There was also evidence of on-going essential training, including infection control, equality and diversity, end of life awareness, moving and handling, safeguarding and medicines handling. Records confirmed care workers were up to date with their training. Where refresher training was due this had been scheduled. Care workers consistently told us they were supported with training

People told us care workers were available to make sure they had enough to eat and drink. One person told us, "Care workers cook meals for me. They do a good job. I am on a special diet that I follow." Another person said, "My care worker cooks breakfast for me." A third person said, "My care worker puts my food in the microwave. I am happy with that." A relative of one person told us, "I cook and puree the food and freeze it. The care worker defrosts and heats it up for my relative and supports her with eating."

Good

Is the service caring?

Our findings

People told us care workers were caring and compassionate. One person told us, "Care workers are caring, compassionate, faithful and honest. I feel safe in their company. My care worker will sit and have a chat with me. If I feel down my care worker always ask if I am ok." Another person told us, "My care worker is very gentle and polite." A third person said, "My care workers are kind and polite. They do my laundry and pay attention to little details." Relatives were also complimentary. One relative told us, "Care workers have different personalities. They are all caring."

People's individual preferences were respected. Their care plans contained detailed information so that care workers were able to understand their preferences. As a result, the service was able to match care workers according to people's interests. We saw examples where care workers were matched according to age, language, hobbies and religion. As such, rotas were organised so that people received care, as much as possible, from regular care workers.

People told us that they were introduced to new care workers before they could start working with them. One person told us, "My care workers was shadowing at least three times before they were allowed in my house on their own." Another person said, "If my care worker is off sick or on holiday the service rings to inform me someone else will be coming."

Care workers had a good understanding of protecting and respecting people's human rights. They had received training around equality and diversity. The registered manager was familiar with relevant policies, including The Equality Act 2010 and The Human Rights Act 1998. The service treated people's values, beliefs and cultures with respect. There were practical provisions for people's differences to be observed. For instance, the service had some people who attended church services and we saw that the service considered this when deciding on which care workers will be working with them.

People told us care workers respected their privacy. We asked people if care workers treated them with respect and maintained their privacy. Comments from people included, "Always", "Care workers are excellent. There are no complaints at all" and "Yes care workers respect my privacy." This was also backed by relatives. One relative told us, "Care workers are respectful. They get on well with my relative. They have a laugh. The door is shut for personal care." Care workers confirmed they ensured people were covered up during personal care. They told us they kept doors closed and curtains drawn when they were delivering personal care.

From 1 August 2016, providers of publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full. Services must record, flag, share and meet people's information and communication needs. Even though the service had not yet formalised the standard's assessment process, each person's file contained a 'personalised communication plan', which showed people's communication needs had been considered. In one example, a person receiving care had been matched with a care worker on grounds of a mutual language and religion. In another example, the service had sought input from an interpreter to complete an assessment. We also noted that help had been sought from family members, who translated to

facilitate communication with people. Even so, communication is an area the service had to develop in terms of the requirements of AIS.

Good

Is the service responsive?

Our findings

People received person centred care. There were examples of good equality practice and good care. People told us they had seen their care plans and that they had been consulted when their care plans were written. Their comments consisted of the following, "I have been consulted. I have a copy of my care plan. Staff came in a couple of weeks ago to discuss it", "I feel involved. Staff gave me a new care plan last year" and "Yes, we were consulted. We were here when the care plan was done."

By involving people, the service was able to deliver the care that met their preferences. We received consistent feedback from people about the quality of care. One person told us, "I am happy with the care I receive. The care workers know what they are doing." Another person said, "I am quite happy with the care. I have previously complained, but the issues have been resolved now."

People's care plans gave a concise but comprehensive account of people's needs and actions required to support them. People's likes, dislikes and their preferences for how care and support were provided were highlighted. Specifically, there was a corresponding care plan to every need identified. For instance, one assessment identified one person to be at risk of developing pressure ulcers, and another highlighted symptoms of a person who was living with a chronic condition. In either example, there was a care plan outlining actions essential to meeting each individual's needs. Ultimately, people's care plans reflected their needs and had been reviewed on a regular basis to ensure they remained up to date.

People's diversity and human rights were highlighted in their care plans. This ensured care workers were aware if they needed to make reasonable adjustments to meet people's needs. People told us care workers respected their cultural and religious needs. One person told us, "My care worker wished me happy St. Patrick's Day. I am pleased he remembered that. "Another person said, "We are active Christians and it is important for us to go to Church on Sundays and Easter. We are supported to do this." However, one family's comments were less than complimentary and they agreed that we shared this with the service. The service had assured us that care workers have been reminded to observe the religious requirements of this family. We have since confirmed with the family that improvements had been made.

People's equality, diversity and human rights had also been considered in relation to gender preference. People had been asked if they had any preferences for male or female care workers. Where a preference had been identified this was respected. This requirement was embedded in the care worker IT allocation system. The system had been pre-set to specific requirements relating to gender if needed. The system would not allow a care worker to be allocated a shift if gender requirements had not been met. We asked people if they were happy to have a male/female carer to look after them. One person told us, "When I ask this is provided." Another person said, "I prefer to have a male care worker and this is supported." A third person told us, "I am hoisted and it is hard to push the hoist on the carpet, so the manager suggested that I have a male care worker. I am happy with this."

The service had a complaints policy which provided details of the complaints process, including action to follow if complaints were not dealt with effectively. People were given a copy of the complaints procedure

from the onset. People and their relatives confirmed that they could complain if needed to. One person told us, "I have complained before. I had a care worker who was not good at their job. The care worker has not come back since." Another person said, "I have complained. This has been resolved." One person told us, "The care workers come too early at 7am. I want them to come at 9 or 10am. I phoned up this morning and staff at the office said they will sort something out for me for tomorrow." Complaints were logged to a central system. We looked at the dashboard which displayed all the complaints logged. We saw that five complaints had been recorded. Each had been investigated and action taken.

Good

Is the service well-led?

Our findings

When we last inspected the service in January 2017, we found that improvements had been made since our previous inspection in May 2016. However, further time was needed to ensure that the improvements were fully embedded and sustained. At this inspection we found that improvements had been maintained and fully embedded into practice.

The management team had continued to improve the quality of service provided. The registered manager had a clear sense of responsibility and had led a management team to embed robust processes to monitor the quality of the service. A range of quality assurance processes, including surveys, audits, management of accidents and incidents, management of complaints had been used continuously to drive improvement. We had noted this to be the case at our last inspection and had since been sustained.

We asked people if they knew the managers at the service and what they thought about how the Allied Healthcare London North was managed. Their feedback was consistently positive, including "I think the service is well managed", "The lady in the office is good. I ask for her if I have any concerns "and "I think the service is well managed. One of the care workers has looked after me for 17 years." This was backed up by relatives, with one stating, "I believe the service is well managed. I have no reason to complain. One or two of the care workers go the extra mile."

There was a clear management structure in place. This was comprised of the registered manager, care delivery manager and five care coordinators, in that order. The management team provided clear lines of responsibility and accountability. Care workers understood their roles and responsibilities. One care worker told us, "I am happy because over the last year, the organisation has picked up." Speaking about the registered manager, another care worker told us, "I couldn't ask for a better woman. She is doing a great job." We found the registered manager to be well-informed about people's needs and operational matters of the service.

There was provider oversight, which meant the service was able to make improvements on the basis of best practice transferred from other branches owned by the provider. For instance, a central portal for accidents and incidents, complaints, and surveys ensured the service drew from other similar locations relevant learning. For example, a rota system called 'round optimisation', which was intended to improve efficiency in care worker deployment had been piloted in other branches before it was adopted by the service. This meant that chances of a successful implementation were high, as was indeed the case.

Since our last inspection, the service had continued to seek people's views on the service to monitor quality. We asked people if they were asked of their opinion about the service and they all confirmed this was happening regularly. Their comments comprised, "I am asked on a regular basis. They phone me to ask if anything needs improving. I got a questionnaire about a couple of months ago", "They phone me now and again" and "They do a survey and they ring me from time to time to see how things are." Relative were also in agreement. One told us "We are contacted for our opinion plenty of times."

There was evidence to confirm people's feedback. As part of the quality assurance process, people were visited or contacted on a regular basis. This process was supported by a range of systems, including spot checks, paper surveys, telephone surveys, and service reviews. Feedback from recent surveys was largely positive. People told us the management visited to check on them and acted on any matters raised.

People had derived some benefits from constant quality monitoring as evidenced from their feedback on staff punctuality. For instance, since our last inspection, the service had continued to undertake 'customer telephone quality reviews' alongside other methods of prompting people's feedback. A range of questions had been continually asked, including, 'did your care worker arrive on time today' and 'does your care worker usually arrive on time'. Historically, the most common complaint was around staff punctuality. At our last inspection, we reported a decrease in such complains. At this inspection we noted even greater improvements. This was a result of a decisive action taken by the service to embrace an IT system, which ensured they allocated care workers according to geographical clusters. This reduced the distances care workers had to travel between calls, and therefore improved their timekeeping. One care workers told us, "We are now in walking distance between calls."

Care workers told us they enjoyed working for the service because of good level of support from their managers. They told us they were encouraged to make suggestions about how improvements to the quality of care could be made. The service promoted an open culture by encouraging staff and people to raise any issues of concern. We saw the service drew heavily from their contributions. In particular, they were a source of knowledge in the completion of care reviews as they knew people receiving care well. They also contributed in regular staff meetings and supervisions.