Nestor Primecare Services Limited

Allied Healthcare Lechlade

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

We carried out an announced inspection on 13 April 2015. Allied Healthcare provides personal care services to people in their own homes. At the time of our visit the service was supporting 167 people. At our last inspection on 14 February 2013 the service was meeting the regulations inspected.

At this inspection the service did not have a registered manager. The service had been without a registered manager since December 2014. 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 and associated Regulations about how the service is run. The service was not always notifying CQC of incidents they were required to notify.

People using the service and their relatives had mixed views about the service. Some people told us the service was good. Other people said care staff were often late

Summary of findings

and sometimes did not arrive at all. Some people experienced missed visits on a regular basis. Missed visits were not monitored. People were often notified at short notice that they would not be receiving their care visit.

People's medicines were not managed so that they received them safely. Guidance to staff was not always available about people's prescribed medicines and where information was available it was not always accurate. Records of medicine administration were not always available and the records we looked at were not always accurate.

People's needs had not always been assessed. Assessments we did see were not up to date. Some people's care records contained information that was significantly out of date. Staff did not have access to guidance that reflected people's needs. Risks had not always been assessed and therefore plans were not in place to reduce risks.

Systems in place to monitor the quality of service were not effective. Audits of care plans and medicines records did not identify issues found during the inspection. There was no system to monitor missed visits and prevent them. Where missed visits were identified there was no investigation of the cause.

An action plan developed by the management team did not address all of the concerns identified during the inspection.

Care staff, who visited people in their homes, had a caring attitude and people were complimentary about care staff supporting them. Care staff received regular supervision. People did not always speak positively about the support they received when calling the office.

We have made a recommendation regarding the providers responsibilities relating to the Mental Capacity Act 2005.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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

Medicines were not managed safely.

Care staff understood their responsibilities to report concerns relating to abuse.

Inadequate

Is the service effective?
The service was not always effective. Care staff did not always understand their responsibilities in relation to the Mental Capacity Act 2005.

Care staff did not always have the necessary skills and knowledge to meet people's needs.

Care staff had regular supervision and spot checks.

Requires Improvement

Is the service caring?
The service was not always caring. People were not always treated kindly by staff answering the telephones.

Care staff were kind and caring.

People were treated with dignity and respect.

Requires Improvement

Is the service responsive?
The service was not responsive. Care records did not reflect people's needs.

Care records did not contain accurate information relating to the number of staff required to meet people's needs.

There was a system in place to monitor and respond to complaints.

Inadequate

Is the service well-led?
The service was not well led. Systems for monitoring the quality of the service were not effective.

There was no system to monitor missed visits.

There was poor communication between care staff and office staff.

Inadequate

Allied Healthcare Lechlade

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 checked whether the provider was 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 the 13 April 2015. The inspection team consisted of three inspectors. Notice of the inspection was given to make sure a senior person was available for the inspection. At the time of our inspection the provider was supporting 167 people living in the community.

Before the inspection we asked the provider to complete a 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. The provider did not return a PIR and we took this into account when we made the judgements in this report.

Prior to the inspection we looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law.

We sent out questionnaires to people who used the service and received 13 completed questionnaires.

During our inspection we looked at 12 people's care records, five staff files and a range of records showing how the service was managed. We spoke with the operations support manager, the care delivery director and 11 care staff. We observed two care workers supporting people in their own homes.

Following our inspection we spoke with 12 people who use the service, five relatives and two health and social care professionals.

Inadequate

Is the service safe?

Our findings

Some people told us they felt safe. However, other people did not always feel safe. People experienced visits being cancelled at short notice. One person told us they were sometimes notified, at short notice, they would not be receiving their care visit and said "I just have to wait for the next person [care worker] to come". This person told us they experienced this once a week. One relative told us, "They phoned me 20 minutes after they were due and said 'we can't send anyone out today because we're training. They did this again the following day'."

Half of the people we spoke with told us they had experienced missed visits. People had not always reported these. For example one relative told us a lunchtime visit had been missed. They did not report this to the office as another relative had provided the support needed.

There was no system to monitor missed visits and do all that was practicable to prevent them. The provider was only aware of missed visits if people, relatives or care workers notified them. The management team told us all identified missed visits were treated as complaints and would be logged on the complaints system. However, we found that not all missed visits were recorded or investigated. For example, one person had contacted the on-call service to report a missed visit. This had been recorded, however there was no investigation or outcome as a result.

The management team told us a system for scheduling care visits was in place. There was a new system for notifying care workers of their rota that had been introduced to reduce the risk of missed visits. Care workers we spoke with told us the new system had been used for a few weeks, however on the week of our visit care workers had received their rotas using the previous system, which meant that that they did not receive information about where and when they needed to provide care in a timely way. One care worker told us they had not received a rota at all for one week. Another care worker told us they received rotas late.

People and relatives told us there were not always enough staff available. Comments included; "They come late to appointments, sometimes they don't come in two's [when care needed to be provided by two carers]", "Weekends are the worst. Sometimes you don't know what time they are coming" and "Not reliable, don't give a proper time and sometimes I don't get a cup of tea, mainly at the weekends".

Care staff told us they felt pressured and visits were scheduled too close together. Comments included, "You can't catch up without compromising the client", Weekend's a nightmare, they don't give you any time".

A social and healthcare professional told us there had been times when a person who required the support of two care workers had only been supported by one. The professional also said there was poor continuity of care at weekends.

Risks to people were not always assessed. Where risk assessments were in place they were not always fully completed or accurate. For example, one person required the support of two carers. The moving and handling risk assessment had not been completed. Another person's risk assessment stated 'no risks at this time' and contained no further detail. When people's needs had changed, risk assessments had not been reviewed.

Medicines were not managed so that people received them safely. Medicine administration records (MAR) were not always present, or completed accurately. Some care records in the office contained no MAR. The management team told us these would be in people's homes. However, where there were MAR in care records there were large gaps between dates of the records. Staff told us MAR were often not available in people's homes to know what medicines to administer and to record it appropriately. A social and healthcare professional told us one person had been without a MAR for more than two weeks.

Details of people's prescribed medicines were not always accurate. One person's medicine assessment listed a medicine that had been discontinued by the GP prior to the assessment being completed. Another person's care record contained details of a medicine being administered. There was no record of this on the person's MAR within the office files.

These issues are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a safeguarding policy and procedure. The management team were aware of their responsibilities to

Inadequate

Is the service safe?

notify the local authority safeguarding team and CQC of any incidents of potential or actual abuse. However the provider had not notified CQC of recent safeguarding concerns.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff we spoke with had completed safeguarding training. Staff were aware of their responsibilities to report all concerns relating to suspected or actual abuse. Staff understood the different types of abuse and were aware of external agencies they could report concerns to.

Requires Improvement

Is the service effective?

Our findings

Some people were not always supported by staff who had appropriate skills and knowledge to meet their needs. One person told us "I have to talk them through what needs doing". One relative told us, "Some staff have been totally unskilled. They did not know how to heat food". However people and their relatives told us staff knowledge and skills were improving. For example one person told us there had been, "small improvement, they're [care workers] quite good."

Staff told us they had recently attended training updates. This included moving and handling, safeguarding and infection control. The management team told us training was being updated for all staff. Training records showed that staff had attended recent training and further training had been arranged.

Most staff felt supported. Staff told us they had regular supervisions. Staff files had records of supervisions and appraisals. New staff attended a four day induction programme and then spent time shadowing more experienced staff. Some care staff had achieved their level two diploma in health and social care. One care worker was hoping to complete their level three diploma.

Care records identified where people needed support to eat and drink. People were given a choice regarding the food they wanted to eat. People told us they were supported to eat at their own pace.

Most people we spoke with were able to contact health professionals themselves. One person told us a care worker had contacted the GP for them when they had felt unwell. One person required support with continence products. They told us a senior member of staff had been supportive and helped them access a suitable product. However the person told us they had been unable to get a supply of a product as Allied Healthcare staff told them health professionals were responsible and health professionals told the person Allied Healthcare were responsible. The person was still waiting for the situation to be resolved.

Some staff were aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and understood how to protect people's rights. However some staff had no knowledge of the MCA or the principles underpinning the act. The management team told us MCA training was included in care workers induction but there was no update training. We could not be sure people's rights were being upheld.

People's care records contained appropriate consent forms signed by people. There was no records relating to people's capacity to make decisions. However the care records we looked at did not identify any concerns regarding people's capacity to make decisions.

We recommend the provider refers to the Mental Capacity Act codes of practice

Requires Improvement

Is the service caring?

Our findings

People told us care staff were kind and caring. Comments included "[The care worker] goes out of her way to help", "Really good staff, they are nice and kind" and "Lovely, they're really nice and kind to me".

People told us most staff answering calls in the office were kind and helpful. One person said, "They're very good, very nice". However some people did not feel office staff listened to them. Comments included; "I try not to ring, sometimes they're [office staff] OK" and "The office are not very nice to me".

People told us they were treated with dignity and respect. One relative told us their relative's dignity was respected by staff keeping the person covered when providing personal care and keeping the door closed. The relative said, "They [care staff] are all very respectful, I couldn't wish for better".

We observed two care workers supporting people in their own homes. They treated people with dignity and respect. Care staff spoke with people in a friendly manner and had a clear understanding of people's needs.

Care staff we spoke with had a caring attitude. One care worker told us, "I love my job". Some staff supported people regularly and knew them well. Care staff understood the importance of building trusting relationships and respecting people's homes.

People told us they were involved in their care. One person told us, "They always ask what I want". Some people told us care staff did not always ask what they wanted. Several people said, "They just get on with it". However people told us they accepted this as staff knew their routine and were happy for staff to support them in this way.

One care worker told us how they supported a person to be involved in their care and explained the importance of encouraging them to remain as independent as possible.

Inadequate

Is the service responsive?

Our findings

People's needs were not regularly assessed and reviewed. Some people told us they did not have reviews. One person told us "Haven't had one for ages, it has not been looked at since 2013". One relative told us "No, and [relative] has gone downhill".

Care records were not up to date. People's care records did not reflect their current needs. One person had been reviewed by the local authority social services. The review identified the person's needs had changed. The care plan had not been updated to reflect these changes. Staff we spoke with knew the person well and were aware of their needs. Staff advised us that many care plans were out of date and they referred to the daily records for information relating to a person's' needs. This put people at risk of unsafe care.

Some people did not have a care plan. One person had been receiving care for more than two weeks. The provider had not carried out an assessment and there was no information available about the person's needs. We raised this with the management team who stated they would rectify the situation.

Care plans did not always accurately reflect the number of visits people required or the time allocated for each visit. Care plans did not always identify the correct number of staff required for each visit. For example, one person's care plan identified 'double handed visits three times a day'. This is where two staff are needed to support the person. However correspondence from the local authority identified the person required 'single handed visits four times a day'. Care staff we spoke to were aware of the required visits.

These are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records contained inaccurate and conflicting information. One person's care record identified their sight was impaired. However one risk assessment for the person contained a scoring for sight which identified 'no problem'.

One person's care plan contained an assessment relating to eating and drinking. The assessment identified the person used a feeding tube. This was not reflected in the care plan. We spoke to a member of the office staff who told us this person did not use a feeding tube.

These are breaches of Regulation 17 of the health and social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they knew how to make a complaint and would feel confident to do so.

The provider had a complaints policy and procedure in place. There was a system for recording all complaints and the outcomes. For example one person had made a complaint relating to the time a carer left the person's home and the timings of visits. Records show the complaint had been investigated and resolved to the person's satisfaction. Learning from the complaint was shared and a memo had been sent out to staff advising them of changes as a result of the complaint investigation.

Inadequate

Is the service well-led?

Our findings

People were not always positive about the management of the service. Some people found it difficult to speak with office staff. One person told us, "Sometimes I keep ringing and there's no answer, or they promise to ring you back and they don't". People were not always told when visits would be late and did not always know the name of the care workers making visits.

People told us there had been several management changes and this had impacted on the service they received. Staff told us it had been a difficult time due to all the changes. One staff member told us, "There have been a lot of changes with management. Managers leaving unsettles things". Care staff told us they enjoyed their work. However one member of care staff told us "I don't feel proud to work for Allied".

Some care staff told us there was a lack of communication. Some staff took action themselves rather than call the office. For example one care worker told us they called people to say they were late. Another care worker told us they would contact the GP for a person as they knew "It would get done".

There was a system in place to record calls made to the office and actions taken as a result. However the system was not always effective. One person's care record showed a care worker had contacted the office on three separate occasions regarding a person's medicines. There was no record of the calls on the system and no record of any action taken.

There was no system to monitor and investigate missed visits. The provider was only aware of missed visits if people, relatives or care workers notified them. The management team told us all identified missed visits were treated as complaints and would be logged on the complaints system. Not all missed visits were recorded. One person had contacted the on-call service to report a missed visit. This had been recorded, however there was no investigation or outcome as a result.

The management team told us a new system for scheduling and notifying care workers of their rota had been introduced to reduce the risk of missed visits. Care workers we spoke with told us the new system had been used for a few weeks, however on the week of our visit care workers had received their rotas using the previous system. One care worker told us they had not received a rota at all for one week. Another care worker told us they received rotas late.

Audits carried out were not always effective. Audits were completed for care records, however audits carried out had not identified issues found during this inspection. For example one audit stated 'All care plan requirements met'. This care plan was not up to date. One person's daily records showed that on two occasions visits were not recorded. An audit of the daily record had not identified the possibility that visits had been missed. Audits of medicine administration records (MAR) were not accurate. For example, one audit of a person's MAR stated there were no gaps. However there were several gaps.

Records were not always legible. For example, on one incident report in a person's file it was not possible to read the person's name or any detail relating to the incident.

The provider carried out an annual customer survey. The outcome of the 2015 survey showed areas for improvement. There were no actions identified as a result of the survey or dates by which improvements would be made.

The management team had developed an action plan to improve the quality of the service. The action plan identified the need to review all care plans that had not been reviewed for a year. However this did not address the issues found during our inspection. The action plan also identified that regular audits were being carried out. The audits had not been effective.

These are breaches of Regulation 17 of the health and social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team told us improvements to systems were being made. A system to enable visits to be closely monitored was in place and staff were currently being trained to use it.

Communication with care staff was being improved. Weekly memos were being sent out with rotas. We saw copies of three memos that had been sent out.

Care staff received regular spot checks. These were carried out unannounced and enabled the provider to monitor the quality of care delivery.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider did not notify CQC of all safeguarding concerns.**

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not ensure that the care and treatment of service users was appropriate, meet their needs or reflects their personal preferences. Regulation 9 (1), 9 (3)(a)(b).**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that care and treatment was provided for service users in a safe way. Missed visits were not monitored. Risks were not assessed or regularly reviewed. Medicines were not managed safely. Regulation 12 (1), (2)(a)(b)(g).

The enforcement action we took:
We issued the provider with a Warning Notice telling them they are required to become compliant with regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 22 May 2015

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider have effective systems in place to assess, monitor and improve the quality and safety of the services. Effective system were not in place to mitigate the risks relating to the health, safety and welfare of service users. Records were not complete or up to date. Systems to evaluate and improve the service were not effective. Regulation 17 (1), (2)(a)(b)(c)(f)

The enforcement action we took:
We issued the provider with a Warning Notice telling them they are required to become compliant with regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by31 July 2015