Allot Healthcare Services Ltd

Allot Healthcare Services York

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place between 15 and 28 August 2018. The provider was given 24 hours' notice. This was the first inspection of the service since it registered with the Care Quality Commission in August 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older adults and younger disabled adults. At the time of our inspection there were 75 people using the service and approximately 1,400 hours of care calls were being delivered each week.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the service was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to governance of the service. This is the first inspection and therefore, the first time the service has been rated Requires Improvement.

Care planning and risk assessment documentation for some people was generic and did not provide staff with sufficient guidance to deliver person centred care. This issue was a risk as people were not always provided with a consistent team of care staff. Records related to the assessment of people's abilities to make an informed decision required improvement. The systems the provider had in place to monitor quality of the service needed to be more rigorous in identifying issues. When issues were identified they needed to be clearer about actions taken to make improvements.

We received mixed feedback from people who used the service about the timelines of care calls and people told us they did not always receive support from a consistent team of staff. We have made a recommendation about this.

Records related to people who were unable to consent to care were not always decision specific which is not in line with the principles of the legislation. We have made a recommendation about this. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible.

The provider had systems in place to protect people from avoidable harm. Staff had received safeguarding training and were able to recognise potential abuse. Accidents and incidents were analysed to ensure lessons were learnt. People were supported to receive their medicines safely.

Staff had been recruited safely and received a robust induction and training programme. The provider had good systems in place for monitoring the effectiveness of care staff.

The service had good links with health and social care professionals and people told us they were supported with their nutritional and hydration needs to help them stay well.

People told us care staff were kind and compassionate. Staff knew people well and respected people's dignity and privacy.

Care planning records required improvement to ensure they were person centred. This issue had already been identified to the provider, by the local authority, and they had a plan in place to address this. New care planning records were much more person centred and individual.

People told us they knew how to make complaints and when they had done so these were responded to. The service had also received a number of compliments about the care they provided.

Staff described a supportive culture by the management team and staff morale was good. The provider had systems in place to assess the care provided, however, these needed to be more robust in identifying and rectifying issues.

People told us they knew how to contact the management team and that their views on the service they received were sought on a regular basis in a variety of ways.

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 consistently safe.

Medicines were safely managed. Staff understood how to safeguard people from avoidable harm.

People were not consistently provided with the same staff team and care calls were not always on time.

Staff were recruited safely.

Is the service effective?

Good

The service was effective.

Staff were provided with the support they required to deliver effective care. Training, supervision and annual appraisals were up to date. Staff could access supplementary training.

People were provided with the support they required to meet their nutritional needs. Staff liaised with relevant health and social care professionals as required.

Staff sought consent before delivering care. Improvement was required to the assessment and recording of people's ability to consent to care.

Is the service caring?

Good

The service was caring.

People had positive relationships with care staff. People told us care staff were kind.

Care staff respected people's privacy and provided care with dignity and compassion.

Is the service responsive?

Good

The service was responsive.

Care plans were improving to ensure they provided staff with the

guidance they required to deliver person centred care.

Reviews of care took place on a regular basis and people had the opportunity to comment on the quality of service they received.

People knew how to raise concerns and these were appropriately responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Whilst care planning records and documentation was improving there was some further work to do to.

Quality assurance systems needed to be more rigorous in implementing improvements.

Feedback from people who used the service was sought in a variety of ways on a regular basis. Staff meetings took place on a regular basis.

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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.

Inspection site visit activity started on 15 August 2018 and ended on 31 August 2018. It included an office visit, home visits to four people, telephone calls to people who used the service and their relatives and telephone calls to staff. We visited the office location on 15, 16 and 24 August 2018 to see the provider and office staff; and to review care records, policies and procedures and other management records associated with running the service.

We gave the service 24 hours' notice of the first site visit on 15 August 2018 because we needed to be sure someone would be available in the office to assist us with the inspection and organise for us to visit some people in their homes.

The inspection was carried out by one inspector. Two experts by experience carried out telephone interviews with people who used the service. We spoke with 19 people and nine relatives.

During the inspection we spoke with the provider who is the registered manager and the nominated individual, the compliance manager, a care co-ordinator, field supervisor and seven care staff. We reviewed six care plans and five staff files.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we held about the service. This included statutory notifications that had been sent to us. We contacted the local authority for their feedback about the provider.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe receiving support from care staff. Comments included, "I am very safe, carers are very kind, very professional", "I am very comfortable and safe with all the care workers who attend" and "The care workers are very kind towards me. I am always safe in their presence." A relative told us, "Safe, absolutely, no concerns at all. My relative is very happy with the carers."

Environmental risk assessments were in place to ensure care staff were safe when providing support to people in their own homes. However, when risks to individuals had been identified, for example, in respect of moving and handling, the risks assessments which were in place were generic. They did not contain the level of detail required to ensure that staff had the written guidance they needed to keep people safe. This issue had recently been raised with the provider by the local authority and the registered manager explained they had a plan in place to improve their risk assessments and care planning documentation to ensure it was individual and person centred.

We received mixed feedback about the consistency of care the service provided. The provider's business model was based on the recruitment of staff living outside of the York area. This meant a large proportion of care staff worked intensively for a short period of time and then took some time off. Whilst this meant the service had been able to expand quickly and had mitigated some of the recruitment challenges faced by providers in the York location, it also meant people saw a variety of support staff. This was not a concern for everyone we spoke with. However, some people told us, "I always have different care staff, you just get used to someone then they change. I had a really excellent carer for a few weeks then I have never seen her again", "I have the same carers for maybe three weeks then they change and I have to start all over again" and, "Carers come for two or three weeks then change." Other people we spoke with told us whilst they saw different care staff this was not a concern to them.

We also received mixed responses from people about the timeliness of care staff. Whilst the majority of people we spoke with were confident that the care staff provided support at the planned time some people raised concerns about late care calls. Comments included, "Timekeeping is pretty good, not often late", "We give the care workers a window of 20 to 30 minutes, they always come within this window and they always stay the full time. I am certainly not rushed." However, relatives told us, "We have had major issues with carers arriving anytime from 8am to 11am. So, I told the office to allocate us the first call of the day at 7am. The company should ring me and tell me when carers are going to be late, not me having to ring them all the time." Another said, "Carers turning up is a bit 'hit and miss'. The plan was originally set for 9.30am, they usually turn up between 10am and 10.30am. Sometimes as late at 11am. I assume it is because they know I [relative] am here."

The provider had an electronic home care monitoring (ECM) system which alerted office staff when care calls were over 30 minutes late. This meant they could take action to address late care calls and the provider told us the management team were trained to deliver care. Despite this we saw evidence from the ECM reporting that a significant number of care calls were outside of the 30 minute time slots allowed via the local authority contract.

We recommend the provider review the planning of care to ensure consistency of staff and timeliness of support.

There were systems in place to manage safeguarding concerns and protect people from avoidable harm and abuse. The provider had safeguarding policies and procedures in place and staff received training in this area. Staff were aware of the different types of abuse that could occur and knew what to do if they had any concerns.

Accidents and incidents were analysed by the provider. This meant the service learnt from incidents and made changes required to improve the safety of people using the service.

People's medicines were safely managed. Staff had received medicines training and were assessed as being competent before they supported people with their medicines. We saw evidence of regular medicines competency checks. We reviewed two people's medication administration records (MAR). These had been completed correctly, they correlated with the prescribing instructions and did not contain any gaps. A relative said, "They [care staff] do my relative's medication. It seems to be fine, all kept in a locked medicine cupboard. Everything is methodically documented in the daily care plan."

Staff were recruited safely. The staff recruitment process included completion of an application form, a formal interview, the provision of previous employer references, proof of identity and a check under the Disclosure and Barring Service (DBS). This service enables the provider to check that candidates are suitable for employment with vulnerable people.

Staff had access to gloves and aprons which were used when providing support with personal care to reduce the risk of the spread of infection. Staff received infection control and prevention training.

Good

Is the service effective?

Our findings

Most people we spoke with were confident staff had the skills they required to deliver effective care. Some people described the staff as being, "well-trained." One person said, "The care workers are trained. They do extremely well and know what they are doing." However, some people felt not all of the care staff had the skills they required. One person said, "Not all as well trained as each other" another told us, "Sometimes I have to tell them what to do. 90 per cent are good and trained."

The provider conducted a detailed assessment of people's needs and preferences prior to them receiving a service. We saw this assessment covered their physical, mental and social needs. The provider worked with other agencies, such as the local authority where required, in planning people's care. We saw evidence that local authority assessments and support plans were included within people's care plans.

The provider ensured care staff had the skills and knowledge required to deliver effective care. New care staff attended a three-day induction training programme at the office. This covered the essential skills staff required, for example; safeguarding adults' awareness, infection control, understanding dementia and moving and handling training. The registered manager was trained to deliver moving and handling and medicines training.

Care staff were also able to access more specific training to meet the needs of people they supported. For example, some staff had received training about how to safely administer medicines through a percutaneous endoscopic gastrostomy (PEG) tube which is passed into a person's stomach to provide a means of feeding when oral intake is not adequate or they are unable to safely swallow. For staff to have the skills and knowledge required to manage PEG feeding specialist training is required. This training was provided by a qualified nurse.

Staff we spoke with told us they felt well supported by the management team. We saw evidence of regular supervision taking place. Supervision is an opportunity for care staff to review their practice and to discuss any development needs they have. Alongside this the management team carried out regular competency assessments and unannounced 'spot checks' in people's homes. This meant they could assure themselves staff were providing people with effective support. Staff received annual appraisals which meant that any areas for ongoing development could be identified.

A care co-ordinator we spoke with explained that they were being supported by the provider to undertake a level 5 NVQ in Health and Social Care. This demonstrated a commitment, by the provider, to support their staff team to undertake ongoing learning and development.

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

is in their best interests and legally authorised under the MCA.

Overall, the service was working within the principles of the Act. Care staff understood the basic principles of the legislation, people told us care staff always sought their consent and we saw consent was recorded within care plans. However, for some people who did not have the capacity to consent to their care the provider had recorded 'no capacity' this was not decision specific and therefore was not in adherence with the Act.

We recommend that the provider research best practice around best interest decision making in line with the Mental Capacity Act 2005 Code of Practice.

The service had good links with health and social care professionals. People were confident care staff sought appropriate medical advice as needed. One person said, "On Bank Holiday Monday they called out the McMillan Nurses. Now I am on steroids and antibiotics." Another said, "When I was unwell they phoned 111 and got an out of hours doctor to contact me. They also contacted an Occupational Therapist for me and now I am getting a hospital bed." A relative told us the care staff were, "Very observant. They quickly responded to a change in my relative's condition and called their doctor."

We looked at the support people received with their nutritional needs. Care plans contained information about whether people required assistance with food shopping, meal preparation or support to eat and drink. There was also information about any special dietary needs. People we spoke with were happy with the support they received in this area. A relative said, "They [care staff] prepare all my relative's food, they are excellent at food preparation and have good standards of hygiene. All food intake recorded in their daily care plan."

Good

Is the service caring?

Our findings

All of the people and relatives we spoke with were positive about the relationships they had with the care staff. People described kind and compassionate staff. Comments included; "I have a really good relationship with the care workers. We have mutual respect. They are caring and very compassionate towards me", "I am extremely happy with the care workers. They are kind, considerate and are always happy and jolly. We have a good relationship" and "They are kind and they go the extra mile for me." Relatives said, "One member of staff talks to my relative in French and they sing together in French, which my relative loves. There is always a good atmosphere when they are there", "The care workers themselves are great. They are kind and caring and they do their best" and, "They have a great relationship with my relative. They really gel together. They always give full dignity and respect to her."

Staff give us examples of how they maintained people's privacy and dignity and the care plans we reviewed contained detailed guidance for staff in respect of maintaining people's dignity. A relative told us, "If I am in the room they explain 'we are going to do this' and I leave. They [care staff] always ensure the curtains are closed before carrying out any personal care. My relative loves spending time with them." Another said, "[Care Staff] always knock before entering. They talk to my relative, greet them when they enter and always close the door when doing any personal care. I do not think they could do any more to make my relative comfortable."

People told us care staff involved them in decisions, asked for their consent and respected their choices. One person said, "They [care staff] always say, 'Hello' and ask how they should address me. They are very respectful. Before they leave they always say, 'Anything else you want me to do?'"

Care files contained information about people's preferences, including their likes and dislikes. One care plan we reviewed contained very detailed information about how care staff could support the person to be as independent as possible during the delivery of care. It was evident they had been involved in planning their support.

There were clear records about people's communication skills and the support they required to communicate their needs. For example, one care plan we reviewed referred to singing with the person whilst undertaking their personal care. Another provided care staff with directions about how best to support the person to articulate their views and wishes. It read, "Because of [name of medical condition] my speech is affected and can be difficult to understand. It is important for carers to listen carefully and maintain eye contact."

All of the care staff we spoke with said they would be happy for their relative to receive care and support from Allot Healthcare Services should they need this type of support. A member of care staff said, "You see people improve and come back to life because of the support we give."

The management team carried out observed practice observations with care staff. These considered the practical delivery of care, such as whether staff had the required skills to safely administer medicines, but

they also considered how care staff interacted with people who received support.

Good

Is the service responsive?

Our findings

People told us they received a responsive service. One person said, "I do see [name of care co-ordinator], she came yesterday, we have been through the care plan. They check if I am okay and happy with the care workers." Another person said, "I have a Care Plan set up to suit me. I have every trust in these carers."

People's needs were assessed before they started to receive a service. Each person had a care plan which detailed their needs in a variety of key areas, such as medication, nutrition and hydration, mobility and personal care, along with a profile of the key information staff needed to know. Plans were also checked to ensure they reflected any requirements from the person's local authority social care assessment.

We saw some care files contained details about people's likes and dislikes and their personal care routines. This helped staff understand how to provide person centred care and meet the person's needs. However, some of the care plans we reviewed were generic and did not contain the level of information required to provide person centred care. This issue had been raised with the provider by the local authority during a recent quality assurance visit. The provider explained they had a new care plan format. We reviewed some of the more recent care plans which were much more detailed and person centred. None of the people or staff we spoke with raised any concerns about the content and quality of the care planning documentation.

The provider explained that all new people receiving a service would have a new care plan. They explained they had a plan in place to transfer existing people onto the new paperwork but that this may take a few months.

Care plans contained evidence of regular care reviews involving the person, care staff, their relatives and where appropriate supporting health and social care professionals. This gave people the opportunity to give feedback on their care and to suggest any required changes. Relatives said, "The office [staff] are excellent. We met to go through the care plan and they keep in touch with us at least once a month. They enquire whether we are happy with the care workers and what is going on." And, "I have met the [management team] once with my relative, we went through their care plan. They [office staff] will call us during the month and we have a good relationship."

The provider employed a field supervisor whose role was to problem solve. They told us, "I assess situations and then trouble shoot. For example, a care worker might ring me and say they are struggling to support someone because their mobility has reduced. I can go out and support the care worker and assess the situation. Then I would liaise with the relevant health and social care professionals to get any equipment or additional resources which may be needed." This demonstrated a responsive and flexible approach to people's changing needs.

The provider complied with the accessible information standard through asking, recording and sharing communication needs people had. People's communication needs were recorded in some care plans. The level of detail varied but was improved on the new care planning documentation.

People told us they knew how to make a complaint. The provider had a complaints policy in place and when complaints had been made these were investigated and a response was provided to the complainant. The provider kept a log of complaints. One person told us, "I know how to make a complaint and have done. The company always get back to me."

We saw the provider had recorded a number of compliments. A social care professional had written, "I have nothing but praise for the great care and compassion shown by your care staff."

The provider supported people at the end of their lives and had developed links with supporting health care professionals. We saw a compliment the service had received, from a relative, in relation to the end of life care they had provided for one person. It read, "I wish to thank you so very much for your commitment and kindness. He was fortunate to be able to stay at home during his illness thanks to the care you gave."

Requires Improvement

Is the service well-led?

Our findings

People told us the service was well managed. One person said, "It is probably well led, I know who is in charge, they phone me regularly, every few weeks. On the whole, it's a top-quality service." A relative said, "I know who is in charge. Any concerns, they call me. They provide high quality care. I have observed very good social interaction with my relative. They are so nice to my relative, very calm and caring. We have had bad experiences with other agencies in the past but these carers are excellent."

Whilst we received positive feedback about the management of the service we identified some areas for improvement. A range of audits were undertaken but these had not always been effective in identifying required improvements. For example, some care plans and risk assessments were generic and did not always contain the detail required to ensure people received a high standard of care. Whilst we did not see any evidence of this impacting on the quality of care people received the potential was there. This was increased by the fact that there was some inconsistency of care staff for people.

The provider had a plan in place to improve care planning documentation and we identified a significant improvement in the records for new people starting to receive support.

When improvements had been identified as being required, via their quality monitoring systems, it was not always possible to see whether the actions had been taken to ensure these were implemented. For example, it had been identified that care staff had left key code numbers visible on a key safe. The action the provider had taken stated, 'carers must mix up numbers.' However, there was no record of what action had been taken to implement this or how the information had been communicated with care staff.

People told us that staff always sought consent before they delivered care. However, records in relation to people's ability to consent to care required improvement. For example, some care documents referred to people having 'no capacity.' The MCA refers to assessments of capacity being made in relation to specific decisions. We have made a recommendation about this. However, this issue had not been identified via the providers own quality assurance systems. This meant that the systems in place for making identified improvements needed to be more rigorous.

Log books which contained daily records completed by care staff at each care visit were reviewed, by the provider, at least every month. They contained clear instruction for care staff about the standard of record keeping expected. During a home visit we identified that log books contained gaps in the entry and exit times of care staff and care staff were not consistently recording the care provided. We spoke with the provider about ensuring care staff also considered and recorded information about people's emotional well-being.

We identified that records needed to be improved to ensure they provided care staff with detailed guidance about how to provide person centred care. Quality assurance systems needed to be more robust to ensure improvements were made.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A PIR had not been submitted by the provider. This was due to a technical issue which was being dealt with during the inspection. We asked for a copy of the PIR but it had not been completed. The provider told us this was because it was their first inspection and they were not clear about the expectation.

The service was on enhanced monitoring by the local authority commissioning team. The local authority told us this monitoring came about because of outstanding actions from a previous quality visit. In respect of concerns about recording call times. It was also a way to support the provider which had recently expanded and supported a large number of local authority funded people. The provider told us they received excellent support from the local authority and were utilising this to ensure they continued to improve.

There was a registered manager who was also the nominated individual. They were supported by the compliance manager, a team of care co-ordinators, a field supervisor and administrative staff. A member of staff told us, "The registered manager communicates well, there is a relaxed atmosphere, flexible and we get along well. They are supportive both professionally and personally."

Staff surveys were undertaken annually. The most recent staff survey results had been analysed by the provider and showed 95 percent of the staff team were satisfied with the support the management team provided.

Customer surveys meant people who used the service had an opportunity to give feedback. These were undertaken quarterly which demonstrated the provider was keen to seek people's views. We reviewed the last survey results and saw largely positive feedback from people. When issues for improvement had been identified it was not always clear to see what action had been taken. We spoke to the provider about improving the analysis of surveys to provide more effective monitoring.

A member of the office team completed 'Quality Calls' every week, they contacted between 20 and 25 people each week which meant that everyone who used the service was contacted monthly to ask for their feedback. Set questions were asked and recorded on a spreadsheet which was reviewed by the provider.

The provider had effective systems in place for communicating with the staff team. We saw evidence of regular staff meetings which were well attended. For staff unable to attend they read and signed meeting minutes. The provider sent out 'memos' to staff which contained key information and updates about the service. In addition to this information about changes to people's care needs or calls could be sent via smart phones which were given to staff by the provider. When improvements were identified, in terms of individual staff conduct, reflective meetings took place and were recorded within staff files. This demonstrated a commitment to improving staff practice and conduct.

The provider had a range of systems in place to monitor the service they delivered however, they were still developing their knowledge of these. They told us they were keen to recruit a deputy manager who could bring some additional skills to the organisation. They provided company vehicles which could be tracked in real time to ensure care staff were visiting customers in line with the rota. Care staff had to sign in and out of people's homes using their smart phones and the provider used a system called 'quick plan'. The provider demonstrated a commitment to ongoing improvement.

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 17 HSCA RA Regulations 2014 Good governance Records were not always person centred or individual. Quality assurance and governance systems were not robust as they did not identify and rectify shortfalls.