Nestor Primecare Services Limited

Allied Healthcare Peterborough

Inspection report

Unit 18, Tesla Court
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Tel: 01733233484

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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 Peterborough is registered for, and provides, personal care and treatment, disease, disorder and injury for people living in their own homes and children in Peterborough, Cambridgeshire and Lincolnshire. There were 117 people being supported with the regulated activity of personal care at the time of this inspection.

This announced inspection took place on 30 January 2017.

The service had a registered manager in place. 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.

The registered manager told us that no one using the service lacked the capacity to make day-to-day or important decisions. Staff received training and staff understood the basic principles of the Mental Capacity Act 2005 (MCA). This meant that there was a reduced risk that any decisions made on people's behalf by staff would not be in their best interest and as least restrictive as possible.

People were supported by staff in a kind, caring and respectful manner. People's privacy and dignity was respected by staff when assisting them with their personal care.

People had support and care plans in situ which provided staff with prompts that they needed when providing support and care to people. These plans contained information such as how people wished to be assisted, their likes and dislikes and what was important to them. People and/or their relatives were involved in the setting up, agreement and review of their/ their family member's plans of care.

Arrangements were in place to make sure that people, where needed, were supported safely with the management of their prescribed medicines by staff. There were guidelines in place for staff regarding the administration of 'as required' or 'time sensitive' medicines.

Plans were put in place to minimise and manage people's identified risks and to assist people to live an independent life as possible and remain in their own homes.

Staff meetings took place and staff were encouraged to raise any concerns or suggestions that they may have had and provide feedback on any improvements to be made. Staff understood their responsibility to report any suspicions of harm or poor care practice.

Pre-employment recruitment checks were undertaken before new staff were employed. Documented evidence showed that there was a sufficient number of staff available to support people with the care that they required.

People were assisted to maintain their health and well-being and were supported to access external health care professionals where needed. Where this support was required, people's health and nutritional needs were met.

Staff were trained to provide effective care which met people's individual support and care needs.

Staff were supported by the registered manager to develop their skills and knowledge through supervisions, spot checks, and observation checks to review their competency and training.

The registered manager sought feedback about the quality of the service. They had in place quality monitoring checks to identify areas of improvement needed. These checks and corresponding actions were in place to identify and drive forward improvements required.

There was an 'open' culture within the service. People and their relatives were able to raise any concerns that they might have with staff and the registered manager. Records showed that these were responded to and resolved, where possible, to the complainants' satisfaction.

Notifications are information on important events that happen at the service that the provider is required to notify us about by law. Notifications were sent to the CQC by the registered manager in a timely manner.

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.

Checks were carried out to make sure that only suitable staff were employed to work with people.

People's prescribed medicines were managed and administered in a safe manner.

Risks to people had been identified and plans were in place to reduce these risks.

There were enough staff to provide the necessary support and care for people. People were protected from harm.

Is the service effective?

Good

The service was effective.

Staff were trained to meet peoples care and support needs.

The majority of staff had been trained and staff understood the basic principles of the MCA 2005. At the time of this inspection no-one lacked capacity to make day-to-day decisions.

People's health and nutritional needs were met.

Staff had supervisions, appraisals and observation checks to make sure that they carried out effective support and care.

Is the service caring?

Good

The service was caring.

People's dignity and respect was maintained

People said staff were kind, caring and respectful.

Records showed that people were involved in the decisions about their care and support needs.

Is the service responsive?

Good

The service was responsive.

Pre-assessments of people's care and support needs were carried out to make sure that the staff could meet people's needs.

People's care and support needs were then planned and evaluated to make sure that they were up to date.

There was a system in place to receive, manage and resolve where possible people's suggestions or complaints.

Is the service well-led?

Good

The service was well-led.

The CQC had received notifications about important events that they were legally obliged to be notified of by the registered manager.

There were systems to monitor the on-going quality of the service provided to drive forward any improvements needed.

People who used the service and staff were asked to give feedback on the quality of the service provided.

Allied Healthcare Peterborough

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 30 January 2017 and was announced. The inspection was announced so that we could be sure that the registered manager and staff would be available during our inspection. The inspection was carried out by two inspectors.

Before this inspection we looked at information that we held about the service including information received and notifications. Notifications are information on important events that happen in the home that the provider is required to notify us about by law. We also received feedback about the service from representatives of a local authority commissioning team; this helped with our inspection planning.

During the inspection we spoke with the registered manager, operations support manager, lead nurse/clinical services, and a field care supervisor. We also spoke with four support workers, 10 people and three relatives of people who use the service. We looked at seven people's care records; four staff recruitment files; staff meeting minutes; quality monitoring documents and their corresponding action plans; medication administration records; and records in relation to the management of staff.

Good

Is the service safe?

Our findings

People and relatives of people using the service said that they/ their family member felt safe. This was because of the care and support provided by staff members. A relative told us, "We are happy with what they (staff) do and have no concerns as they provide safe care."

Staff confirmed that they had undertaken training in safeguarding people from harm and poor care. They were able to explain to us the process to be followed when incidents of harm happened. Staff members said that they would report any concerns to their line manager or registered manager. We saw notices within the service's office that prompted staff about their 'duty of care' to report any suspicions of harm and poor care. Training records we looked at confirmed that staff received training in respect of safeguarding adults and safeguarding children. This demonstrated to us that there were processes in place to reduce the risk of harm to people who used the service.

Staff told us that they were aware of, and understood, the whistle-blowing procedure and that they would raise a concern as they had a duty to do so. One staff member confirmed to us that, "I have no whistle-blowing concerns, I would report (if I did), but I have not seen any poor care practice."

Accident and incident records were kept; we saw that these documented incidents and detailed the actions that had been taken and learning points from the incident to reduce the risk of recurrence. Actions included the de-escalation and distraction techniques used by staff members to reduce a person's anxiety when they became anxious during a care call.

Care records we looked at had assessed each person's needs and this helped determine how many staff a person required to assist them at each care call. The registered manager told us, and documentation showed that there were enough staff available to work and to meet people's care and support needs. They said that recruitment of new staff was getting better and retaining staff had improved since the last inspection. They told us that this was because they felt that the provider was more supportive and as such there was more stability. They said, "The organisation (provider) seems more focussed towards the people they employ."

We saw that there was an electronic call monitoring system in place. This system meant that each staff member attending the care call had to 'log in' as soon as they arrived and 'log out' when they left. This system then monitored and alerted office staff on whether staff had arrived on time (including the agreed plus or minus tolerance of either 15 or 30 minutes each side of the care call time). The system was used as part of the registered managers monitoring of the service and was also used to flag up whether staff had stayed for the full length of time of the care call.

People and their relatives had positive comments to make about having consistent staff members attending their care calls and accurate staff rotas. Rotas are issued to inform people and/or their relative of the named staff member(s) that would be attending their care calls. One person said, "I get a rota each week and they (staff) are usually on time." Another person told us, "I get a rota every week and so I know who will be

coming to see me, which is good." A third person told us, "(Staff) are usually on time, they send me a rota but sometimes this changes." A staff member confirmed to us that, "Our rotas are well managed every week, we stick to the rota but these can change depending on need (to cover staff sick leave)." However, staff told us that there was not always travel time for staff between each care call. This meant that there was an increased risk of staff not being able to arrive at their care calls on time.

People and their relatives told us, and records showed there were enough staff to safely provide the required care and support needed. One person said, "They (staff) are always on time and (the office staff) will let me know if they are running late." Another person told us, "They (Staff) are mostly on time, no missed (care) calls. They let me know if they are running late and can be 15 minutes late." A third person said, "They (staff) are on time usually. I'm not always rung by the office (if a staff member is running late), but this has improved in the last six months."

People had risk assessments and care and support plans in place that they had agreed. These records gave information and guidance to staff about any risks identified and the support people needed, including what personal protective equipment to be used, in respect of these risks. Examples of risks included; people at risk of any slips, trips and falls; nutritional risks; poor skin integrity; risks when taking their prescribed medicines; and finances management. We also saw individual risk assessments for people at risk of, their moving and handling needs; communication; behavioural risks; any mental health needs, their continence and where appropriate a clinical risk (health condition) assessment. For those people with more complex care and support and health needs we saw detailed, step-by-step information within the persons care and support plans. These, including people's individualised risk assessments, detailed for staff what equipment, was to be used and when. These guides for staff indicated to us that there was information in place for staff to support a person safely.

People had environmental risks assessments of their home environment and utilities in place as a prompt for staff in the event of a foreseeable emergency. This showed that there was information in place for staff should an emergency occur whilst they were attending a care call.

The majority of people we spoke with did not require assistance with their medicines. People who were supported with this, had no concerns about the support they received, where needed, to take their prescribed medicines. Staff told us and records showed that staff had training to administer people's prescribed medicines and that their competency was checked. This showed that there were processes in place to make sure that people were supported, where needed, with safe medicines management.

People's care records contained information for staff about whose agreed responsibility it was, (e.g. staff, the person and /or their relative) to order and collect people's medicines. They also documented whether the person, a relative or a staff member was responsible for prompting or administering people's medicines. We noted that there were prompts for staff in respect of how and when medicines were to be administered safely, including medicines that were 'time sensitive'. There were guidelines in place for staff regarding how and when to administer medicines prescribed to be given as 'when required'. This meant that there was guidance for staff on how to manage people's prescribed medicines safely.

Four staff files we looked at showed that pre-employment checks were carried out. Recruitment checks included references from previous employment and a criminal record check that had been undertaken with the Disclosure and Barring Service (DBS). Proof of current address, a health declaration and photographic identification had been obtained, and any gaps in employment history explained. We noted that all documents provided by the potential new staff member for their pre-employment checks were either verified by the provider or documented that the original document had been seen. One staff member said,

"My references and DBS were in place, before I could do any care calls." This meant that the recruitment checks in place would reduce the risk of unsuitable new staff working alongside people.

Good

Is the service effective?

Our findings

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.

We checked whether the service was working within the principles of the MCA. We spoke with the registered manager about the MCA and Court of Protection (the legal body who can authorise a person to be lawfully deprived of their liberty). We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own decisions and choices. The registered manager told us during this inspection that no one using the service lacked the mental capacity to make day-to-day decisions.

Records showed, and staff confirmed, that staff had received training on the MCA. Staff were able to demonstrate to us that they had a basic understanding of the principles of the MCA and talked us through how they supported people to make their own choices. One staff member said, "It is understanding their (a person's) choices and assisting them with their independence and valuing what they want." Where people had capacity that fluctuated we saw clear instructions for staff within people's care records that any decision made on a person's behalf was to be made in their best interest. This indicated to us that there was a reduced risk that any decisions made on people's behalf by staff would not be in their best interest and as least restrictive as possible.

Staff told us about the training they had received to make sure that they had the necessary skills to provide the individual care and support needed. One staff member said, "I have had more training here (at this provider than any other)." A relative told us, "Carers (staff) have all their training with a nurse, they are very thorough." A lead nurse/clinical services said, "There are yearly competency checks and six monthly checks. If a staff member wants a training refresher, (the provider) never queries this and this (request) is supported by the company (provider). We are supported with additional training."

Records showed that training included, MCA 2005; management of medication; safeguarding adults; safeguarding children; dementia awareness; equality and inclusion; emergency aid; preventing the spread of infection; supporting people to eat and drink well and moving and positioning. Additional specialist training to meet people's complex health needs was provided. Examples included; ventilation; cough assist; enteral feeding tubes; nebuliser therapy; oxygen therapy and tracheostomies. Staff also told us how they were encouraged to undertake additional qualifications, such as national vocational qualifications in health and social care. This showed that staff were supported to develop and maintain the skills and knowledge necessary to meet the needs of the people they cared for.

Staff had an induction period which was in conjunction with the care certificate. The care certificate is a nationally recognised induction programme for staff. Staff member's induction included mandatory training

and the shadowing of a more experienced member of staff. This was followed by a follow-up supervision after a staff member's first shadow shift. A staff member said, "I am a care coach and support and mentor new staff before they work on their own. If there was a concern about new staff I would speak to the (registered) manager." All new staff had to complete an induction period until they were deemed competent and confident by the registered manager to deliver effective care and support.

Records we looked at also showed that staff had appraisals, supervisions and observation spot checks where they would discuss their performance and on-going development. A staff member told us, "We (staff) get spot checks on everything, medicines and infection control…I get a supervision every four months…and an appraisal." Another staff member said, "We get a supervision by a field care supervisor … I do people's medication and get a competency check (carried out on me) and other checks." This showed us that there were effective checks in place to monitor staff confidence, knowledge and competency.

Care records we looked at documented whether the person required assistance from staff with their food and fluid intake and meal preparation. Prompts included staff checking to make sure that food was not out of date and as such safe for the person to eat. The majority of people we spoke with were either able to prepare their own meals and drinks or were supported by a family member. One person told us, "They (staff) give excellent care and help with meals and drinks." Another person said, "At 16.30pm they (staff) prepare meals for me."

Records showed where people were also supported by external health care professionals and that where appropriate the lead nurse/clinical services from the office established links with these. We saw links with district nurses, physiotherapists, occupational therapist, speech and language therapists, GP's and paediatric nurses where necessary. This showed us that external healthcare advice, support or input was sought by the provider when needed.

Good

Is the service caring?

Our findings

People told us that the assistance from staff members helped them maintain their independence. They said the support from staff meant they were able to stay in their own home and that this was their wish. Records we looked at prompted staff on what a person was able to do for themselves and where a person needed some assistance. Prompts included reminders for staff to encourage and maintain people's independence where appropriate. We noted that people had individualised goals that they wished to achieve and how support from staff could help them achieve these wishes. A person confirmed to us, "I am very happy with them (staff)." Another person said, "The carers (staff) are cheerful, patient and never rush (me)." A third person told us, "They (staff) are very kind to me and make me feel comfortable."

People and their relatives made a number of positive comments about the staff who provided their support and care. They told us that staff spoke to them/ their family member in a respectful and kind manner. One person said, "I have some lovely carers (staff) and they all treat me very well." Another person told us, "Staff are always polite." A third person said, "They (staff) are very good."

People and relatives of people using the service told us that their/ their family member's privacy and dignity was valued by staff. This was also confirmed from conversations with staff and we noted prompts for staff in people's records reminding them to be respectful or people's dignity and privacy at all times when supporting them. This showed us that staff were aware that they needed to promote the dignity and privacy of the people they were assisting.

We saw that care records contained information about people's personal history. Staff had taken the time to document the goals and outcomes that people wanted to achieve. These were then taken into consideration when planning the aspects of their care. Records showed, and people and/or their relatives confirmed, that they were involved in the development and review of the care that they/ their family member was provided with. One person said, "(They) have just reviewed the care plan with me and I am very satisfied." Another person told us, "I agreed the care plan and we reviewed it last week." This meant that there was a decreased risk that people's care and support plans were not up-to-date or met their current needs.

Information in care records included how people wished to be supported and people's end of life care wishes. These included a person's funeral wishes and/or their wish not be resuscitated. This indicated to us that there were processes in place to respect people's end of life wishes.

Advocacy information for people to refer to should they wish was on request from the registered manager. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Good

Is the service responsive?

Our findings

Commissioning authorities provided details of people's needs before the provider agreed to provide a service. This was so that the provider could make sure the service could meet the needs of people they were to support. A staff member said, "We get information (about a person) prior to going out, care plans are always in place before we start a care package." People we spoke with and records confirmed that people and/or their relatives agreed to the care and support that was to be provided.

People's preferences and wishes were recorded in their care plans and these provided guidance and prompts for staff as to how the person wanted their care to be provided. This information included how staff were to encourage people's independence where possible. Individualised prompts included guidance for staff on how to interpret people's facial expressions, body language and vocalisations for people who were unable to verbally communicate. People and relatives of people using the service told us that they had care plans and risk assessments in their/their family member's home. These records were used by staff to understand the person they were supporting needs and to document the support and assistance given during each person's care call.

Reviews were carried out to make sure that people's current support and care needs were documented and up-to-date and documented who was in attendance. These reviews were also an opportunity for the person and/or their relative to feedback on their satisfaction of the quality of the service provided by staff. People and a relative told us that communication was good. One person said, "Everything is in order…Overall I am satisfied with my care." Another person told us, "I see my care plan and the daily notes and they are correct."

Staff told us that whenever a person raised a concern or complaint with them they would forward this to the registered manager to follow up and take the appropriate action to deal with the concern. They also told us that they would inform the person that this was the action they intended to help resolve the persons' concern.

People and their relatives told us they knew how to raise any complaint with the service should they need to do so. This information was also included in the provider's statement of purpose which was available to people. Records of complaints received showed that they had been investigated and the complainant responded to, to their satisfaction where possible. Any actions taken were also recorded to reduce the risk of reoccurrence. One person said, "We have the office (telephone) number and we know who to speak to if we had any concerns but nothing at present to complain about."." Another person told us, "No complaints with the care at all, they are very good to me."

Good

Is the service well-led?

Our findings

There was a registered manager in post who was supported by care and office staff. Staff spoke highly of the registered manager and/or the office staff. One staff member said, "I feel really supported and can speak to the (registered) manager and office staff. Our co-ordinators are really helpful and supportive." Another staff member told us, "I feel supported. The best I have had."

To motivate staff we saw that the provider offered staff a benefits/vouchers scheme which could be redeemed and there was an award scheme in place called, 'carer of the month.' We saw that staff from this service had been both nominated and successful. This showed us that the provider had schemes in place to motivate and reward the staff who worked for them for their contribution.

Within the office the provider displayed a poster to promote and remind staff of the values of the service and the services vision. This vision was; 'to be the choice for care that gives people the freedom to stay in their own home.' Staff were also able to tell us about the values of the service and how this impacted positively on the people they supported. They told us that their role was to give the best care to people that they could give. One staff member said, "We have been successful in getting (a person) out and about in the community, they are now doing a wide range of activities. (Person) now (with staff support) loves baking cakes and made a cake for their (family member), which was a great event."

Monitoring systems were in place to check the quality of the service provided. Areas reviewed during this included service/location self-audit. This asked the questions of whether the service provided was safe, effective, caring, responsive and well-led. We noted that the results of the audit were then rated red, amber and green depending on the level of risk. (Green is low risk, amber medium risk and red being high risk.) Areas checked during this audit included, people's daily notes (logs); MAR sheets; people's care plans; staff recruitment, staff training; and personal development. The action plan in place to drive forward improvement following this monitoring of the service included an action point that some staff members were behind on their mandatory training. We saw that plans were in place to make the necessary improvements This included speaking with the relevant staff member when it had been noted that they had not completed a MAR sheet correctly. This meant that there were processes in place to monitor the quality of the service provided and action taken to drive forward improvements.

The registered manager told us that the providers care delivery manager had a monthly meeting with the chief executive officer and that at these meetings any organisational branch/ service issues would be discussed. The registered manager confirmed that the service self audit fed into this meeting.so that the board members had an overview of the quality of the service provided at each of its locations/services. This indicated to us that there was organisation support of the service.
Records showed that meetings were held for staff. These were used to update staff on any 'key trends' found from recent quality monitoring, the areas of improvement needed and any actions taken as a result of any concerns. These meetings were also used to update staff about the provider organisation and the service. Staff told us meetings were held and were used for example to update staff on people's health, and discuss any issues. We also noted that staff regularly received a newsletter which again updated them on

organisational changes and the service. This demonstrated to us that staff were updated and involved in the service.

There was a positive response from people and their relatives when asked about any checks from the staff in relation to the quality of the care they received. One person said, "They (staff) check to see if everything is okay." Another person told us, "They (staff) check to see if I am happy with the care, I have no concerns about them."

The registered manager was aware of the incidents that occurred within the service that they were legally obliged to inform the CQC about. Notifications were received by the CQC in a timely manner. This showed us that the registered manager was aware of their role and responsibilities.

We saw that the CQC poster showing the rating from the last inspection was displayed on a communal notice board in the office and was on the provider's website. This was for people to view should they wish to do so.