AliMo Care Ltd

AliMo Care Ltd

Inspection report

Suite 16/17 Kingswood House
South Road
Kingswood
Bristol BS15 8JF
Tel: 0117 957 1195
Website: www.alimocare.co.uk

Date of inspection visit: 27, 28 and 29 May 2015
Date of publication: 17/07/2015

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?	**Requires improvement**

Overall summary

The inspection was announced. We gave the provider 48 hours' notice that we were starting our inspection because we wanted key people to be available.

AliMo Care Ltd provides a domiciliary care service to people in their own homes who live in Bristol and South Gloucestershire. They predominantly provide a service to older people but do support some younger people with physical disabilities. At the time of the inspection the service was providing a service to 37 people and there was a team of 31 care staff.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We have recommended that the registered provider seek advice and guidance from a reputable source in order to ensure that the voice of people being supported and the staff team is heard and used to plan on-going improvements to the service. The registered provider had

Summary of findings

a plan for expanding the service however the current arrangements for assessing the quality and safety of the service was inconsistent and did not include all aspects of the running of the service.

People said they felt safe with the care staff who visited them. Care staff received safeguarding training as part of their mandatory training. They were aware of safeguarding issues and knew to report any concerns they had to the registered manager, the local authority or the Care Quality Commission. Care staff were recruited using safe recruitment procedures and this ensured that unsuitable staff were not employed. Management plans were put in place where risks had been identified in order to reduce or eliminate that risk.

People were looked after by care staff who had received the appropriate training and support. Staff were supported to undertake their roles effectively and were monitored regularly to ensure they provided a service that met people's needs. People were involved in setting up the service and received the care and support they expected. Care staff were knowledgeable about the people they visited and spoke about them respectfully. People were provided with the support they needed with nutrition and fluids and were supported to access health care services if needed.

People were looked after by a small number of care staff because of the way the visits were organised. The care staff had good working relationships with the staff that supported them. People were treated with kindness and respect and were always included in making decisions about their daily lives.

Assessment and care planning processes ensured each person received the service they needed and met their individual needs. Their preferences and choices were respected. People were provided a copy of their care and support plan. People felt able to raise any concerns they may have and had been provided with a copy of the service's complaints procedure.

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?

Good

The service was safe.

People were protected from abuse and staff had a good awareness of safeguarding issues and knew how to report any concerns. Safe recruitment procedures were followed to ensure unsuitable staff were not employed.

Risk assessments were completed to ensure people could be looked after safely. People's homes were assessed to ensure they were a safe place for staff to work in.

There was an on-going recruitment drive to employ new staff in order to support more people in their own homes. New people would not be offered a service if staff were not available to provide the level of care and support required.

People were supported with their medicines where required. Staff were competent to support people with their medicines.

Is the service effective?

Good

The service was effective.

People were supported by staff who were competent in their roles. They were well trained and supported to carry out their jobs.

Staff were familiar with the Mental Capacity Act (2005) and the need to ensure people consented to care and support. They knew of the importance for people to make their own choices.

People were provided with the agreed level of support to eat and drink and maintain a balanced diet. People were supported where necessary, to access the health care services they needed.

Is the service caring?

Good

The service was caring.

People had good relationships with the care staff who visited them. The care team were kind, caring and respectful. People were looked after by a small number of staff. People's preferences about how they wanted to be cared for and support was respected.

Staff spoke well about the people they were supporting and knew the importance of good working relationships.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People were provided with a service that met their care and support needs. Assessments and the delivery of the care and support was personalised to each person.

People were provided with a copy of the complaints procedure that enabled them to raise concerns if they needed.

Is the service well-led?

Requires improvement

The service was mostly well-led but improvements were required.

We have made a recommendation about using the voice of people they support and the staff team to formulate a plan of improvements. Feedback from people who used the service was inconsistently sought and the information provided was not used to measure how the service was doing. Feedback was not sought from the staff team.

There was no learning following any accidents or incidents to prevent reoccurrences.

There were measures in place to monitor the quality of the service to individuals and to monitor staff work performance.

AliMo Care Ltd

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, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of one adult social care inspector. The service was last inspected in January 2014 and we found no breaches in regulations at that time.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had not asked for the Provider Information Record (PIR) to be submitted.

We contacted three social care professionals as part of our inspection and asked them to provide feedback on their experiences of working with the service. The comments we received have been included in the body of the report.

During the inspection we visited four people in their own homes and also spoke with four relatives of people who received a service. We met with the provider, the registered manager, the office manager and two field supervisors. We received feedback from five care staff.

We looked at five care records, six staff recruitment files and training records, and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People said "I have never worried about my safety and the girls are very kind to me. They treat me well and with respect", "I have no worries", "They look out for me and make sure I am safe" and "Before they go they check that I have my alarm with me". Relatives said "The staff are very competent at using the hoist and complete the tasks safely" and "I have no concerns about the staff who visit".

Staff completed safeguarding training as part of the induction training programme for all new staff and then on a refresher basis. Staff completed an on-line training session but also attended face to face training arranged by South Gloucestershire Council and Bristol City Council. Records evidenced that six staff were due for refresher training in July 2015. They understood what was meant by safeguarding people, what constituted abuse and what their responsibilities were to keep people safe. Care staff said they would report any concerns they had about a person's safety or welfare to the registered provider, the registered manager or the field supervisor. The agency had on-call arrangements in place if concerns were raised in the evenings and at weekends. Staff were aware they could report directly to the local authority, the Care Quality Commission or the Police. One staff member told us they had reported concerns directly to the person's social worker and had then attended a planning meeting to discuss the concerns. People were given information in their care folders regarding organisations they could speak to if they were concerned about their safety and how they were being treated. The registered manager had raised safeguarding concerns with the local council on two occasions where there had been concerns about a person's wellbeing.

An environmental risk assessment was undertaken of each person's home in order to ensure it was a safe place for the care staff to work . These risk assessments included an assessment of all the service utilities, electrical equipment, access in to and out of the property and the presence of pets and other people in the home. This was undertaken as part of the initial setting up of the service and ensured staff were not placed at risk. Moving and handling risk assessments were completed where people needed to be assisted by the care staff. The support plans set out what moving and handling equipment was to be used.

The provider had a business continuity policy and procedure in place to follow in the event of any unplanned event. This set out the arrangements in place in the case of flooding, loss of utility supplies, theft, IT failure and staff unavailability. The provider also had a policy in place for the staff to follow if they failed to gain access to a person who they were expecting to provide support to.

Where people were supported with shopping, collection of money or the payment of bills, the care staff were required to complete financial transaction sheets. They had to record how much money they had been given, how much money had been spent and how much money had been returned to the person. Both the person and the care staff then had to sign these forms.

Staff files showed that safe recruitment procedures were followed at all times. Appropriate checks had been completed and included written references and a Disclosure and Barring Service check. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people.

AliMo Care had a team of 31 care staff and would only consider taking on new work if they had the capacity to be able to provide the required service. The registered provider and registered manager had an on-going recruitment drive in order to be equipped to take on new packages of care.

People retained responsibility for their own medicines where this was practicable and safe. Where people needed to be assisted they were protected against the risks associated with medicines because measures were in place to ensure they were supported safely. The level of support people needed with their medicines was assessed and recorded in the support plan. If people needed support they provided written consent to be assisted. Staff had to complete safe administration of medicines training and be assessed as competent before they were permitted to support people with their medicines. Staff completed a medicine record when they had supported the person with their medicines.

Since our last inspection some concerns were raised with us regarding medicines management. The registered provider was asked in February 2014 to provide us with evidence in response to the information we had received. This was done and a copy of the medicines policy was also

Good

Is the service safe?

submitted as part of that response. We asked the registered provider to review that policy because the legislation referred to was incorrect. The medicines policy we saw on this inspection referred to the correct legislation.

Good

Is the service effective?

Our findings

People said, "I can depend on the staff, they may be a little late at times but I know they will always arrive", "The staff are very good at what they have to do for me", "Nothing is too much trouble" and "I could not manage without them. I can remain in my own home because of the help they provide". Relatives we spoke with were complimentary about the service provided. They said "The office keep me informed about how things are going and anything significant", "X gets three visits a day, seven days a week. They have never missed a visit" and "The care staff go over and above what they are expected to do".

Staff were provided with the relevant training to do their jobs, regular individual supervision meetings and group staff meetings. The field supervisors did spot checks on the care staff to ensure they were delivering an effective service. Records were maintained of all supervisions and spot checks. These spot checks did not include a medicine administration competency check but the supervisors felt this was an improvement they could implement. Staff told us, "I completed all my on-line training before I started the job and feel confident", "I have been on a moving and handling course. If I have any concerns about how to do something, I only have to ring the office and I get the advice I need" and "I am well supported to do my job". The written feedback we received from two members of staff conflicted with these views: one staff member felt the training on offer could be improved and the second member of staff said that not all staff were treated equally.

The registered provider told us in order to ensure that their training met the requirements of the Care Certificate, dementia awareness training was to be added to the mandatory training programme.

All but two of the care staff were enrolled on or had completed a recognised qualification in health and social care at level two or above. The two field supervisors were in the process of working towards level three and five and the registered manager had already achieved level four and was working towards level five.

The two field supervisors and the registered manager had completed two modules of a Mental Capacity Act (MCA) 2005 training package. All other staff completed basic MCA training as part of the on-line safeguarding training module. MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make decisions for themselves. During the assessment process consideration was given to each person's mental capacity and ability to make daily living decisions. The assessments were reviewed when there were changes in the person's needs. Care staff said they would always ask people to give their consent before assisting them with personal care tasks and allowed the person to make decisions about tasks that needed to be done.

The level of support each person needed with their food and drink was determined during the assessment and setting up of the service. The level of support people needed was detailed in the support plan. The care staff would feedback to the field supervisors or the registered manager if they had concerns about a person's dietary and fluid intake. One person said, "The girls always make me a nice cup of tea before they are on their way" and another said "My daughter buys me in ready meals and the girls heat them in the microwave for me to have at lunch time. They tell me what the choice is".

The name of the person's GP was recorded in their care files so that care staff would know who to contact in the case of medical attention was required. The same applied to district nurses or other health and social care professionals who were involved in the person's care. Where people needed to be supported to obtain on-going medicine supplies, this would have been agreed as part of the assessment process. Care staff liaised with occupational therapists and physiotherapists in order to make sure people were well looked after.

Good

Is the service caring?

Our findings

People said the care staff who visited them were “lovely”, “life savers” and “very caring”. Comments we received included, “The staff listen to what we want and help us”, “I have a very good relationship with my main carer” and “The girls are very kind to me and I always enjoy their visits”. One relative said, “They keep an eye on me too which is very nice”. Other relatives said, “I cannot fault the way the staff look after mum: she is not always appreciative of what is done for her” and “I was worried about having care staff in the house but have made some new friends. They are so professional and caring”.

Care staff told us about the people they visited. They spoke about people respectfully. One staff member said, “I like seeing the smile on people’s faces when they are pleased and happy with the care they have received”. Another staff member said, “The staff team work very well together. I have been able to build a very strong relationship with the people I visit regularly”.

When a support service was being set up people would be asked how they wanted to be supported and by what name they preferred to be called . People were asked about any choices and preferences that were important to them. Where appropriate family, friends or other representatives were involved. The views of the person receiving the service were always respected and acted on. Either a field supervisor or the registered manager would visit the person to complete the initial assessment and where possible the support package would be covered by the minimum number of care staff. This would enable the person to be provided with a consistent service.

Social care professionals who responded to our request for feedback about AliMo Care said “I have knowledge of AliMo Care because they provide a substantial support package to a person. The family are very positive about the quality of care provided” and “I have found AliMo Care to be a very professional and caring agency”.

Good

Is the service responsive?

Our findings

People said "I get the help I need and expected to receive", "My husband would have to go into a nursing home if it wasn't for the help we get. Care staff come and help twice a day" and "I have two main care staff and they know what to do. I don't like seeing too many new faces because I feel very bossy telling them what they have to do". Relatives said, "It is great now that there are regular carers allocated because they know exactly what has to be done", "Two agencies visit twice a day each, the other agency send us a weekly list and we know who is coming. It would be nice if AliMo did that".

We looked at the care files held in both the AliMo Care offices and in the homes of the people we visited. Where the package of care and support had been arranged by the local authority, copies of their assessment and care plan were kept in the office file. AliMo staff also did their own assessments and prepared a personalised support plan and 'task sheet'. New care planning documentation was in the process of being introduced: the new format provided clear information for staff to follow. Staff said that the new plans were clear and easy to work with. Those plans we looked at were informative and detailed the specific support the person needed. They said how the planned care was to be provided. It was evident that the person had been involved in setting up the service and had been asked to say how they wanted things done. We received feedback from one healthcare professional who said they had recently reviewed a person's care plan and had been "impressed" with the record keeping, adding "the best I have seen in a long time".

One staff member said there had been occasions where, people they were supporting did not have a copy of their up to date care plan in their home. However this conflicted with what we were told and what we saw in the homes of the people we visited.

Care staff were expected to read the person's support plan at the start of their call if they hadn't been to that person before or if they had not been there for a while. This ensured they were aware of any changes that had taken place since the last time they worked with that person. The care staff we spoke with confirmed they always read the care plans where they needed to. Care staff were expected to report any changes in people's health or care needs to the office staff and to liaise with health or social care professionals as appropriate. This ensured that the service being provided remained appropriate and people received the support they needed. The field supervisors regularly reviewed each person's care plan and amended service delivery where needed.

People were supported by the same members of care staff where possible. Some people were supported by two care staff working together whilst others were supported by one. Care staff always tended to work on the same 'care runs' and for some there was a two week shift pattern. This meant that people were looked after by the least number of care staff. The registered manager and field supervisors were in the process of reviewing the care runs in order to make them more efficient.

Care staff wrote an account of their visit each time they visited. The field supervisors collected the records on a regular basis and they were returned to the office, checked and then archived. There was an expectation that the reports were legible, accurate and detailed the care and support provided each time care staff attended. Care staff were also expected to complete other records as appropriate for example, medicine administration charts and financial transaction sheets.

People were given a copy of the service user guide and this provided information about the service provided, relevant contact telephone numbers and the complaints procedure. People said, "I only have to ring the office if I want to say something and they will sort it out", "The person I want to speak to in the office may not always be there but they get back to me" and "I don't have any complaints but if I did I guess I would ring the office. I am sure I would be listened too".

The service had not received a complaint since March 2014. The records evidenced that the appropriate action had been taken and that measures had been put in place to prevent a reoccurrence. The registered manager said that they did not have any complaints because any comments received were acted upon and they provided the service people expected. The Care Quality Commission have received no complaints about this service in the last 12 months.

Requires improvement

Is the service well-led?

Our findings

We asked people if the service was well-led and they made the following comments: "We have had a letter from the council telling us there are going to be changes to our home care provider. We would like to stay with AliMo but we don't think we can. We are used to them now" and "I am quite satisfied with AliMo. I can depend on their times". One relative said "Because the supervisors do some of the care calls, they have a better understanding of what needs doing".

There was a management structure in place lead by the registered provider and registered manager. There was an office manager and two field supervisors, each leading a team of care staff. Staff were concerned about their jobs in view of the forthcoming changes in Bristol City Council commissioning arrangements. Not all care staff said "the director (the registered provider) was approachable" whereas others said they "got on well with them and the office staff". Similar concerns about the registered providers approach had been raised in February 2014 when a whistle blower raised concerns about how the service was run. These concerns were discussed with the registered provider after the inspection.

Questionnaires were sent out to randomly selected people on a three monthly basis. People were asked about the timings of their visits, whether care staff stayed the agreed length of time, whether they were treated with respect and dignity, their support plan and whether they would recommend AliMo Care to others. Seven questionnaires were sent out in October 2014, one in November 2014 and two in January 2015. No questionnaires had been sent out since January. There had been no analysis of the results. It was unclear what actions were taken as a result of any feedback because the registered provider said they did not generally receive unsatisfactory comments.

A staff survey had never been completed. The registered provider did not feel this was necessary as there were good communication systems in place. A combination of text messaging, emails and telephone calls and the field supervisors were used to relay information to the care team. This however only allowed for the 'office' to pass information to the care staff. There was no way that care staff could have a say about what it was like to work for AliMo Care. In light of the comments made to us, a staff survey would give them the opportunity to have their say so the registered provider could then take any relevant action.

There had only been one formal complaint made since the last inspection in January 2014 and this had been made directly to the Care Quality Commission. We looked at the records of accidents and incidents and although there had only been a minimal number, there was no analysis of the event to look for trends. This meant that the registered provider and registered manager could not ensure that preventative actions had been taken.

There was an on-call system for management support and advice out of hours so those staff working at those times always had someone available that they could call upon. The monitoring system used by South Gloucestershire Council occasionally failed to provide alerts to on-call staff however calls had not been missed as a result. The registered provider felt that we had been given incorrect information.

In order to check that people received the service they expected, regular care plan reviews were undertaken and records were kept of the review. The field supervisors also completed spot checks on the staff to ensure their work performance was in line with the organisations policies and procedures and met the expectations of the person being supported.

Staff meetings were held on a regular basis and led by the field supervisors. We saw the meeting notes from 7 May and 21 May 2015. Agenda items included the on-call arrangements, change's to rotas, shift swaps, medicine errors and confidentiality. In previous staff meetings there had been discussions about personal protective equipment, time sheets and the electronic call monitoring system. Other meetings were held with the registered provider, registered manager and office staff.

The aim of the service was "to ensure our clients are able to remain living safely and comfortably at home by providing support with daily living tasks". They planned a package of care that allowed people to continue living at home whilst their dignity and independence was retained. The support offered met people's individual needs and expectations. The care staff provide different levels of support ranging

Requires improvement

Is the service well-led?

from welfare checks to complex or end of life care. It was evident from speaking with the registered provider, registered manager, the field supervisors and care staff that this was an aim shared by all.

The registered manager was aware when notifications had to be sent in to CQC. These notifications would tell us about any events that had happened in the service. We use this information to monitor the service and to check how any events had been handled. In the last year no notifications had been sent in to CQC.

All policies and procedures had been purchased from a reputable source and were kept under review. The policies had been updated to refer to AliMo Care and adapted to reflect the aims and objectives of the service. Care staff were provided with a staff handbook which contained key policies. This ensured they carried out their duties safely to a consistently high standard. Examples of key policies included the handling of service user's money, safeguarding, unable to gain access, personal shopping and health and safety.

The registered provider had plans for the future. This included expanding the business to cover the North Somerset and Bath areas and to increase the numbers of people supported on a private basis (this would include those people in receipt of direct payments). The registered provider was planning to apply for accreditation with South Gloucestershire Council for inclusion in to their direct payment providers list. The registered provider was planning to use a nurse on a consultancy basis to provide additional training for the staff team. Training sessions were being planned in respect of tissue viability, record keeping, dementia awareness and catheter care. These improvements would enhance the care staff abilities and people's experiences of care.

We recommend that the registered provider seek advice and guidance from a reputable source in order to ensure that the voice of people being supported and the staff team is heard and used to plan on-going improvements to the service.