Nestor Primecare Services Limited

Allied Healthcare Exeter

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

The inspection took place on 17 and 18 October 2016 and was announced.

Allied Healthcare Exeter is a domiciliary care agency which provides personal care to vulnerable adults and children in the community in Exeter, Barnstaple and Plymouth. The registered manager told us personal care support was currently being provided to 61 people in the Exeter area, 59 people in the Plymouth area and 69 in the Barnstaple area, totalling 189 people.

There was a registered manager in post. 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.

From 17 August 2016 the Barnstaple and Plymouth registered branches of Allied Healthcare had merged with the Exeter branch, which means they do not provide any regulated activity from those branches and are no longer registered locations. However they have retained a 'cell' office in Barnstaple and Plymouth for staff training and meetings. The new main registered 'hub' was run from the Exeter office. The Exeter branch was last inspected on 20 January 2014 and no concerns were identified. The Plymouth branch was last inspected on 16 February 2016 and no concerns were identified.

The Barnstaple branch was last inspected on 1 December 2015 where we found a breach of regulation. Suitable numbers of qualified, skilled and experienced staff were not always deployed in order to meet the needs of the people using the service. The service was rated as 'requires improvement' and the provider was required to submit an action plan explaining what they were doing to meet the legal requirement to improve the service. Whilst this service is no longer registered we still checked that improvements had been made around staffing. There had been some staff turnover in the North Devon area but new staff had been employed and this meant the likelihood of people experiencing missed or late visits had reduced significantly. Some people in other areas expressed concern about staff punctuality and staff being rushed. However, the agency had managed to maintain service provision despite high levels of sickness and recruitment difficulties. They had recognised when they did not have enough staff to provide a safe service and withdrawn from this area 'as a last resort'. There were systems in place to monitor staffing levels and minimise any risks caused by late or missed visits. The registered manager told us there was a 'permanent recruitment drive' underway, and was optimistic that staffing levels would improve.

In addition to the creation of a new 'hub', combining the Exeter, Plymouth and Barnstaple registered branches; the service was in the process of introducing a new structure with revised systems and processes, called 'One Best Way'. All staff were being retrained in their new roles. The registered manager told us the aim of the restructure was to achieve consistency across the service. They said, "Before, we were all doing the same thing in a completely different way". This was evident during the inspection, in the lack of consistency in the quality of risk assessments and care plans, and the experiences of people who were using

the service. For example some people were satisfied with the way their complaints had been handled, while one person told us they had tried to make a complaint but had not had a response.

At the time of the inspection some of the key roles in the new structure were yet to be filled, which meant some aspects of the service had not been effectively maintained. Risk assessments and care plans had not been consistently audited to ensure that they accurately reflected people's needs and were effective in supporting staff to care for people. Gaps in people's medicine administration records (MAR) had not been identified. Without regular and accurate auditing there was a risk that people may not receive medicines as prescribed.

Overall people told us they felt safe using the service. Comments included, "They always shut the door and lock it after them...If anything's wrong they'll phone the office and the doctor". They were protected from the risk of abuse through the provision of policies, procedures and staff training, and an effective recruitment process.

People who used the service and people closely involved in their care were involved and consulted, and people were asked for their consent before staff assisted them with any tasks. Staff promoted their independence and treated them with dignity and respect. People were supported to make choices about their day to day lives, for example how they wanted their care to be provided.

Each person had their needs assessed before the service began so that staff had access to the information they needed to support the person. The care plan was kept in a folder in the person's home, with a duplicate in the office for staff to refer to. Care plans contained information about people's physical and psychological support needs and any related risks. They were personalised and contained information about the person's preferences. People told us their care plan was regularly reviewed and updated.

People received care and assistance from staff who were well-trained and competent. They told us staff understood their health needs and supported them to keep well. There were good communication systems in place with local health professionals such as community nurses, and guidance was followed by staff.

Staff told us they were well supported. They received regular supervision and support, either face to face, over the telephone or at team meetings. They also received regular monitoring checks by a senior member of staff while they were working directly with people. A comprehensive induction and training programme was in place to support them to do their jobs effectively and meet people's individual needs. On-going professional development was encouraged for all staff members, with career progression throughout the company.

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

The 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

Some aspects of the service were not safe.

People were not always fully protected because of the lack of written information provided to staff. People were placed at risk of not receiving their medicines as prescribed because of inconsistent recording.

The service protected people from the risk of abuse through the provision of policies, procedures and staff training.

People were assured they would receive their care because there were systems in place to monitor staffing levels and minimise any risks caused by late or missed visits.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to meet people's needs and received regular training to ensure their skills and knowledge were maintained.

People's legal rights were respected and protected

People were supported to maintain good health and to access health and social care professionals when needed.

Is the service caring?

Good

The service was caring.

Staff were respectful of people's privacy and dignity.

Staff were committed to promoting people's independence and supporting them to make choices.

The agency was able to offer effective care to people at the end of their lives.

Is the service responsive?

Good

The service was responsive

People were involved in drawing up their care plans. This meant care plans were personalised to each individual and helped staff understand how they wanted their care to be provided.

Most people told us the agency were responsive when they contacted the office.

There was a complaints process which people were encouraged to use if necessary.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The providers' quality assurance system had not been maintained, which meant there was a risk people's needs would not be met safely and effectively.

Most people told us the agency sought their views on the service regularly.

People were supported by a motivated and dedicated staff team and accessible and approachable management.

The service encouraged all staff members to continue to develop their skills, knowledge and experience, in order to deliver a high quality service to people.

Allied Healthcare Exeter

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 17 and 18 October 2016 and was announced. We gave the service short notice because we wanted to meet the registered manager and needed to be certain they would be available during the inspection. This also gave the registered manager sufficient time to ask some people if they would be willing for us to contact them by telephone or visit and speak with them in their homes. The inspection was carried out by two inspectors and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

During this inspection we spoke with 13 members of staff including four care staff, the registered manager, area manager, transformation lead, trainer, scheduler, administrator, care delivery manager, regional recruiter, trainer and care quality supervisor. We visited five people with their permission in their own homes and spoke with 14 people who used the service and one relative on the telephone.

We looked at a range of records the provider is required to maintain. These included eight service user support plans, risk assessments, medicine administration records and daily reports, staff rotas, four staff recruitment files, staff training records and quality monitoring records. We also looked at records of accidents, incidents, compliments and complaints and safeguarding investigations.

Requires Improvement

Is the service safe?

Our findings

Some files we looked at contained evidence that risks to the person's health and welfare had been assessed, along with guidance for staff about how to manage these risks, however this was not consistent. For example, we looked at the care records of a person with complex support needs which identified risks to both the person and the staff who supported them. Staff told us this person could be challenging to care for. They had not been made aware of this when they began to work with them, and the information in the care plan was out of date and unhelpful. The person's file contained a report from a health professional with clear guidance for staff about how to support the person safely, however, part of the report was missing and the information had not been transferred to the care plan for staff to follow. This meant staff did not have access to the information they needed to support the person safely and effectively.

One person's care plan file did not contain risk assessments or a care plan. The only information held in the file was the local authority's assessment document entitled 'My plan' that had been drawn up before the person received a service. This meant there was a risk that care staff would not have access to up to date information about how to support the person. On this occasion the risk was reduced because the care had largely been provided by the same two care workers. The person told us the staff knew them well and knew how they wanted to be assisted.

The service had systems in place to ensure the safe management of medicines; however, at the time of the inspection these systems were not always effective. We found that staff had not always recorded on the medicines administration record (MAR) when people had taken their medicines. One person we visited administered their own tablets but received assistance from the staff for the administration of prescribed creams and lotions. Their care plan file contained no specific recording sheets for the creams, although the daily records completed by staff showed creams had been administered. Another person required prompting to take their medicines; however there were unexplained gaps in the MAR chart. This meant it was not possible to determine whether the person had taken their prescribed medicines.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

We spoke with the registered manager about these issues. They told us it was the role of the care quality supervisor to review and update risk assessments and care plans, and to audit the MAR charts. However these posts were still in the process of being filled across the three branches under the new structure, and the agency had fallen behind with these audits as a consequence. Once the care quality supervisors were in post and appropriately trained, audits were planned to ensure all records were up to date.

At the last inspection of the Barnstaple location we found there were not always enough staff to care for people safely and in a timely way to meet their needs and preferences. During this inspection we heard there had been some problems earlier in the year in the North Devon area but the problems were beginning to ease. There had been some staff turnover but new staff had been employed and this meant the likelihood of people experiencing missed or late visits had reduced significantly.

All the people we spoke to during the inspection confirmed they received a rota which staff adhered to, and the office contacted them to tell them if there was going to be a missed call and check whether they needed alternative cover. One person told us, "I've only ever had one [missed call] and they called me to tell me they couldn't cover, this was some months back". Another person said they rarely had missed calls, "but it's bound to happen" and told us they would be notified. "I agree with them if [the visit] isn't necessary. I help them out if I can, they are good to me…It's only every now and then". However some people expressed concern that staff were 'overworked' and there wasn't enough travel time between visits which meant they were sometimes late. One person said, "I've heard them (agency office) ring up and ask them if they can squeeze in an extra two more people. The carers care so much and won't leave people without help, they do it". ` Another person thought care staff were rushing so they could get to the next visit on time. They told us, "Sometimes they are in a hurry and I nearly choke. They should stay with me. As I can't take my plate into the kitchen I hurry my dinner so they can clear up. If I hurry I swallow lumps`. This put them at risk of choking because they rushed their meal. Other people told us that they had missed hospital appointments because the care staff arrived too late to take them.

The member of staff responsible for devising the visit schedules told us high levels of sickness and recruitment difficulties had impacted on the service, although they had managed to maintain service provision overall. Where they hadn't been able to maintain safe staffing levels in a particular area they had withdrawn the service as 'a last resort'. The registered manager told us there was a 'permanent recruitment drive' underway, and was optimistic that staffing levels would improve.

There were systems in place to monitor staffing levels and minimise any risks caused by late or missed visits. When care workers arrived at a person's house they had to ring a number that connected them to the local authority commissioning team's computer to confirm they had arrived. Before they left the person's home they rang the number again to confirm the time they had finished. This meant both the local authority and the provider could monitor the times of arrival and departure. In the Provider Information Return (PIR) the registered manager stated, "If a carer does not log in or out of a visit we can phone them to find out where they are and if everything is OK. We can also use this to monitor the carers punctuality and identify extra time needed in care packages and if extra travel time is needed". In addition office staff met regularly throughout the day to share information about staffing levels, which was recorded on a white board. This meant that any gaps in service provision were identified promptly and action taken to fill them. In addition, the service prioritised 'time critical' visits, which minimised the potential risk of a late visit to people who needed support or medicines at a specific time.

People received a timetable every week letting them know the names of the staff who would be visiting them the following week and the times of their visits. They had small teams of carers who visited them each week and this meant the carers knew each person well and understood the care they needed, and any risks to the person's health and safety. One person told us they received one visit a day and these were mainly covered by two care staff. This meant they had been able to build up a relationship of trust with the staff. One person told us, "With new people they usually come around with more senior staff beforehand, then when I see their names on the roster I know who it is".

Overall people told us they felt safe using the service. Comments included, "We have a little giggle together. I don't think I have ever 'snapped' at anyone and they have never 'snapped' at me. They have been marvellous", and, "They always shut the door and lock it after them...If anything's wrong they'll phone the office and the doctor".

The service had an 'early warning system', which identified people who were especially vulnerable and enabled staff to report any changes or early signs of deterioration for example in speech or behaviour, such

as the person refusing care. This meant action would be taken promptly to address concerns and keep people safe. In addition an 'on call system', ensured there was management support available to staff 24/7 which meant they could access guidance and additional support at any time.

The risk of abuse to people was reduced because there were effective recruitment and selection processes for new staff. Before commencing work all new staff were thoroughly checked to make sure they were suitable to work with vulnerable people. These checks included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Staff disciplinary procedures were in in place, and had been used effectively.

All staff received training on safeguarding adults at the start of their employment along with information about how to recognise and report abuse. Staff told us they were confident they would speak out if they had any concerns and knew how to contact the relevant agencies if they had any concerns that their managers would not take appropriate action. The provider had a 'whistleblowing charter' and helpline, and a member of staff told us, "If we have any concerns we are not afraid to speak out". Records showed safeguarding concerns had been managed appropriately, with Allied Exeter working effectively with other agencies to ensure the concerns were fully investigated and action taken to keep people safe.

Staff were issued with personal protection equipment (PPE) such as disposable gloves and aprons which reduced the risk of infection. Daily task sheets in people's care records prompted them, "Remember PPE, gloves and apron". We observed a member of staff put on gloves and apron before they provided personal care, and before they cooked and served a meal. However, one member of staff wore gloves but no apron when emptying a commode. They told us they understood the importance of this from their training, and would ensure they wore the apron from now on.

Staff followed safe procedures to ensure people's property was protected. If a person was unable to open their door to visitors they usually had a key safe fitted. A member of staff told us key safe numbers were held securely and only given to staff on a 'need to know' basis. Staff wore identity badges and ensured people were shown their badge before entering a house.

Good

Is the service effective?

Our findings

People received care and assistance from staff who were well-trained and competent. One relative told us the care staff used a hoist when supporting their family member. They felt they were well trained and had the knowledge and skills required. One person told us how the care staff encouraged them to mobilise, saying, "Well I can't walk very well and have a frame and a trolley and all that. The carer that comes in the morning is very good and encourages me to do things for myself, such as push my trolley. They are perfect". Another person told us their care staff were, "pretty good". They explained, "When they first start they come with an experienced carer, and the experienced carer tells them what to do and they do it".

The agency had introduced a 12 week induction for new staff. During our inspection we met a trainer employed by the agency who was providing induction training to two new members of staff. They told us all new staff received three full days of classroom based induction training. They showed us their training manual showing the range of topics covered during the induction. The induction combined verbal instruction and discussion, videos, and practical training (for example first aid and moving and handling). Staff also received copies of the agency's policies and procedures. We spoke with two staff who were attending the induction training that day and they told us they felt the quality of the training was high. They had both previously worked in the care industry, but said they had learned a great deal from their induction. Following the initial three days, staff spent two weeks shadowing other staff and being observed. They were then supported through regular supervision until they were 'signed off' as competent at a 12 week probation review.

Once staff had successfully completed their induction they went on to receive further training and regular updates on all mandatory health and safety related topics. For example, staff received training on the safe administration of medicines, and were signed off as 'competent' before being allowed to administer medicines unsupervised. Their continued competency was assessed every 12 months and at unannounced spot checks. Two members of staff told us they felt the standard of training they had received was high. One member of staff said "Training is a high priority." Staff were encouraged to achieve a relevant qualification after they had worked for the agency for three months. One member of staff told us they were in the process of completing a nationally recognised qualification for care staff known as a National Vocational Qualification (NVQ) at level two. They then hoped to carry on and gain a higher qualification. Another member of staff told us they had completed all of their mandatory updates earlier in the year, and said if there were any changes, for example if the agency changed their medication policy, "They will get us in as soon as they can for training." Additional courses were available on-line to staff via the providers 'e-learning portal'. Bespoke training was arranged as required to support staff to meet people's individual care needs. The agency employed two nurses across the South West to provide specialist training to staff on care procedures such as caring for people with a tracheotomy, and for people who were fed through a tube – this is a process known as percutaneous endoscopic gastrostomy (PEG). Specialist training in stoma care was in the process of being arranged.

Staff told us they felt well supported. Comments included "They have been absolutely lovely. [Senior care worker's name] is very friendly", and, "The support is definitely there." Staff felt well supported in their own

health and well-being. They told us the senior staff understood their health and family problems and were supportive and willing to adapt their rotas to accommodate appointments or health issues. The service kept staff informed about any changes or developments via memos sent out with the weekly rotas, text messages or a telephone call, depending on how quickly action was needed. Senior staff alternated unannounced spot checks of staff practice with 'face to face' or telephone supervision every three months. This enabled staff to receive individual support and feedback about what they did well, and identify areas for further development and training. They also received an annual appraisal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. We found the service was working within the principles of the MCA. Staff had received training and had an understanding of the requirements of the MCA. One person's care plan stated, "I would like to be able to make day to day decisions. Carers always to gain consent and offer choice wherever possible". When people new to the service had been assessed as lacking the mental capacity to make certain decisions, their care plan stated it was the assessor's responsibility to "ensure clear instructions are provided to the carer in best interest decisions".

People told us the agency understood their health needs and supported them to keep well. For example, one person told us about an illness and period in hospital before they returned home and began receiving a care service from Allied Healthcare. They said "I am being looked after very well. If it wasn't for the carers I wouldn't have pulled through. I don't have to do anything – they say, 'don't worry, I'll do that''.

There were good communication systems in place with local health professionals such as community nurses. For example, one person told us their GP had written some guidance regarding their personal care and maintaining their skin integrity. This information had been placed on the top of their notes and was followed by care staff. A relative told us how care staff followed guidelines from the speech and language therapist, (SALT) to minimise the risks for their family member related to swallowing. In one person's home we saw the community nurses had left a file containing their records and assessments next to the agency's care plan file. This meant information was shared between care staff and community nurses. Care staff told us if they had any concerns about the person's health they would not hesitate to ring the community nurses.

Good

Is the service caring?

Our findings

In the Provider Information Return (PIR), the registered manager stated, "Person centred care planning must reflect the customer's needs, preferences and be appropriate to their specific needs and with their consent. Customers must be treated with dignity and respect, adhering to any ethnic, cultural and religious preferences" .They told us how the induction and training emphasised the importance of working in a person centred way. They said, "We are supporting people to live within their own homes, we're not taking over".

All of the people we spoke with told us the staff were kind and caring. Comments included, "The care is absolutely fantastic! All the girls and boys are wonderful, they really cheer me up. I look forward to them coming", and, "They are brilliant, I can't fault the girls. I find them so helpful, if I want anything done they will do it for me, I can't fault them…If it wasn't for the girls, some days I wouldn't talk to anyone".

We observed a care worker supporting a person. The care worker was cheerful, friendly and caring. They showed concern for the person's welfare asking "Is that alright?" and "Does that feel alright for you?" They were aware the person had recently injured themselves and asked, "Is your arm alright now? How is your finger?" and "Are you comfortable?" The person told us, "They are all very nice." There was warm and friendly chatter between the member of staff and the person. The care worker was not rushed, and supported the person in a calm and relaxed manner.

Staff were committed to promoting people's independence and supporting them to make choices. Care plans contained a signed consent form to say the person consented to care provision as outlined in their care plan, and we saw staff asking for people's consent before providing support. One person said, "They always ask before doing anything". During the inspection we observed a care worker supporting a person with their lunch. They constantly checked the person was comfortable and happy, giving them choices such as, "Do you want your mousse here?", "Do you want some water?" and, "Do you want a little brown sauce on your plate with your sausage and chips?" The person told us the staff, "…always speak nicely to me. Like when they are speaking to their own family".

Overall people told us staff treated them with respect and dignity. Positive comments included, "The carer was very, very lovely, better than my own mother. I really loved her". A relative explained how care staff closed the bathroom door to ensure privacy when providing personal care to their family member. Care plans provided clear guidance for staff in this respect. For example, one care plan stated, "Always respect [person's name]'s privacy, dignity and respect. Always explain what you are going to do. If they are resisting [support], walk away and go back". Another care plan said, "Always offer a choice of clothing. [Person's name] loves to wear jewellery when they go out". However, one person commented that care staff had not always rung the door bell and waited to be let in, although this was no longer the case. They said, "It's fine, we've had a few ups and downs. It's our home and carers do what we want them to do and they are not here to tell us what to do. I think we've got it through to them at long last". Another person told us they had raised concerns with the agency about the attitude of a member of care staff. They told us the agency responded very quickly to the situation and this member of staff no longer supported them.

Staff meeting minutes showed that the agency was proactive in reminding carers of the importance of respecting confidentiality. For example, the minutes of one meeting stated, "It has come to our attention that carers are talking about customers in other customer's homes. This is a reminder to maintain confidentiality".

The agency was able to offer care to people at the end of their lives. The registered manager told us care plans contained a section where people's end of life wishes could be documented to ensure they were understood and respected. Training in end of life care was incorporated into the general training done by care staff, however specific training could be requested from the provider's training department if required.

Good

Is the service responsive?

Our findings

People told us they received support that met their individual needs and wishes. When asked if they were consulted about how their care was provided one person told us, "I say I can do it myself, I don't need help with that". The registered manager told us they could not support people safely and effectively without first consulting with each person and/or their families and representatives to draw up and agree a plan of their support needs. There was also input from health and social care professionals if required.

The care plan was kept in a folder in the person's home, with a duplicate in the office for staff to refer to. Care plans contained information about people's physical and psychological support needs and any related risks, including medication, moving and handling, eating and drinking, personal care needs, daily routines and social activities. This information enabled staff to meet people's needs. For example, one person was at risk of falls. The person had a pendant alarm that connected them with a community warden if they suffered a fall or sudden illness. Staff had been instructed in the care plan to check the person was wearing their alarm, and during our visit we heard a care worker carrying out this check with the person. MAR charts and daily records were also in people's folders for completion by staff. There were signed forms consenting to the provision of care, guidance about how to make a complaint and contact details so people knew who to contact at the agency for advice or support.

Care plans were personalised and contained information about the person's preferences, for example the name they preferred to be known by. People confirmed they had been involved in developing their care plan, and this was reflected in what was recorded. For example, one person's care plan said, "I require one carer to prepare and serve breakfast, lunch and tea every day for me. I would like fish and chips from the local chip shop on Wednesdays". Care plans contained a signed statement saying, "I have contributed to the development of the care plan and can confirm that an organisation representative has explained how I can contact the branch to discuss my care and support at any time".

People told us the care plan was regularly reviewed and updated, for example one person told us "Oh yes, I think she has been a couple of times this year." However, some face to face reviews had not been carried out because the care quality supervisors who had responsibility for this were not yet in post. The registered manager told us a new computerised system would allow the care quality supervisors to print off a report identifying which care plan reviews were due and overdue. In the meantime some reviews had been carried out by telephone to identify changes in people's support needs, but this was not standard practice.

People told us the agency was responsive when they contacted them. One person said, "If I have any problems I ring the office. They try and fit in with any request or alteration I've got. For example, I sometimes go to my daughter's for Sunday lunch; If I'm not back for the evening visit they change it. We work together. I have no complaints at all". It was the role of the care quality supervisor to keep care staff informed about any immediate changes in people's needs. This was usually done by telephone, which meant they were able to offer guidance and support about how any risks should be managed.

All complaints and incidents, and actions taken, were recorded on a computerised management system.

This information went to the providers' customer services department and was reviewed by the registered manager who ensured an appropriate response. People told us they knew how to make a complaint and most were confident they would be addressed. One person said they had complained about a carer once or twice in the past and the agency had sorted it out. Another person commented, "Any worries I ring up the office and ask what is happening. They sort it out" However, one person told us they had tried to make a complaint because they were sent a male carer when they preferred female carers but had not had a response. The registered manager told us poor communication had been highlighted as an issue requiring action. It had been discussed at team meetings and emails had been sent to staff to remind them of their responsibility in documenting and passing on information correctly.

Requires Improvement

Is the service well-led?

Our findings

The provider had introduced a transformation programme called 'One Best Way', which the area manager told us had been successfully implemented in other locations. The aim of this plan was to achieve consistency across the service, thereby improving the quality of support provided to people. The programme had only recently been implemented, and it was therefore too soon to assess the impact of the changes. The provider's 'transformation manager' anticipated it would be fully embedded by the end of February 2017.

The agency was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. The registered manager, with the assistance of the provider's 'One Best Way' team, had been supporting the service through the introduction of the programme and a period of significant change. From 17 August 2016 the registered Barnstaple and Plymouth locations of Allied Healthcare had become 'cells' and merged with the registered Exeter location. This new 'hub' was run from the Exeter office. The registered manager talked about the lack of consistency in the way each location had previously been operating, and told us, "Before we were all doing the same thing in a completely different way". Consistency would allow failings and gaps in service provision to be more easily identified, and for staff to be able to work across all of the cells. They told us the challenge now was, "…understanding the structure, implementing it and embedding it".

The 'One Best Way' programme had introduced changes to the structure of the team, job roles and responsibilities. At the time of the inspection the provider was in the process of retraining all staff in their new roles. The service was not yet fully staffed within new structure, although they were still recruiting, and some posts had been recently filled. Although existing staff had worked to cover the shortfall, this meant some aspects of the service had not been adequately maintained. For example we found the providers' quality assurance system had not been effective in monitoring the quality of care to ensure the service continued to meet people's needs effectively. This meant people were not always fully protected because care plans did not always provide the information staff needed to support people safely, and people were at risk of not receiving their medicines as prescribed because of inconsistent recording

A full audit of systems and processes had been initiated by the provider to identify the inconsistencies and gaps in processes and service provision, and a comprehensive action plan had been developed. This included activities such as the auditing of every 'customer file', and people's medicine administration records, however at the time of the inspection these activities had either not been started or were still in progress.

Some people told us the organisational changes had impacted on the quality of the service they received. "We used to have a lot more contact. We have noticed the difference now. They used to visit monthly and check MAR charts and sit and have a chat which was really nice. This has not happened for a long time. We have very little contact with the people in the office. If there is a problem we ring up and we get shunted through a call centre. Geographically they do not know where we are". Some staff felt the closure of local offices and the move to a central office in Exeter had not been successful. One member of staff told us,

"Recent changes have been tough. It has settled down a bit now." They went on to say they needed more senior care staff, but they were aware the agency was in the process of recruiting staff to these posts.

The registered manager was confident that the changes were positive and the new structure would ultimately be successful. They told us they had inherited some problems from the other areas due to gaps in staffing and management, and this had made the merge more difficult. They told us, "We are doing everything we possibly can to recruit" The provider had a 'regional recruiter' who was 'out there all the time', going to the job centre, linking with back to work providers, colleges and community groups. They added, "The structure is good, the roles are good roles. It will work well once all the positions are filled and people are trained correctly".

The service had a clear leadership structure and the new staffing arrangements provided clear lines of accountability which meant all staff would be supported and monitored effectively. The registered manager had overall responsibility for the new 'hub' and was accountable to the area manager. Each cell had a 'care delivery manager', with responsibilities including staff supervision, spot checks, team meetings and organising the diary for the care quality supervisor. The care quality supervisor's responsibilities included meeting new 'customers', drawing up care plans, doing reviews and dealing with medication. In addition each cell had a 'scheduler' with responsibility for organising the rotas, and an administrator. Staff told us the registered manager and area manager were both very 'hands on' and accessible.

Staff spoke positively about the management of Allied Healthcare Exeter and the support they received. A member of staff told us "There's a good team. The manager knows what they are talking about – it helps." They also told us that one of the care directors had also given them their phone number and assurances they could be contacted at any time if they had any concerns. Other staff commented; "They are a good manager… They handle things professionally and well. They can be tough but they need to be", and, "[Manager's name] is fantastic…they are doing the absolute best they can". The registered manager was working to develop an open and transparent culture. They told us they wanted staff to feel they could ask them for support if they needed it, saying, "I would actively say to my staff, if they are not happy with anything they can speak to me. If they're not happy with me they should go to my manager. This is their number and email address". They emphasised the importance of honest communication, saying, "They [staff] need to know how well they are doing, to understand where further training is required". They wanted to show staff they were valued and appreciated, and made sure any feedback was passed on, "…especially good feedback. They work so hard. 'It's easy for them to become demoralised by negative news about the care industry". A member of staff was nominated as 'star of the month 'at the team meeting, and rewarded with vouchers or flowers.

There was an emphasis on continual professional development, with staff completing national vocational qualifications (NVQ) relevant to their roles. NVQ's are work based awards achieved through assessment and training. The registered manager told us care staff were 'upskilled' to enable them to progress and take on different roles. The registered manager had worked for the agency for 10 years and "done every single job within the branch", which gave them a detailed knowledge of the systems and different roles. They told us this kind of career progression was very common within the organisation and applied to most of the office based staff. The area manager told us, "I'm proud of Allied because they give people chances. They recognise the potential in people. I always believe a good branch manager comes up from the ranks".

Quarterly staff meetings were held where staff were able to raise issues and discuss their roles. A member of staff told us, "There is lots of discussion and note taking. We can talk about if we are worried about anyone. It really does clear the air". Two team meetings were held on the same day to make it easier for staff to attend, and minutes distributed so that all staff were kept up to date. A member of staff gave an example of

a suggestion they had raised in a staff meeting – they had suggested a record should be kept in each care plan file of the name and date the daily records were removed from the file to be returned to the office. They had found in the past some staff had kept the records in their homes for several weeks before handing them into the office. When managers tried to find out where the records were it had been hard to trace the member of staff responsible. The suggestion had been taken up and there was now a recording sheet in each person's care plan file providing evidence of the date and the name of the staff who had removed the record.

Most people told us the agency sought their views on the service regularly; however one person said they had not been involved in any form of feedback, either by phone or questionnaire. The registered manager told us 'customer surveys' were sent out annually and audited centrally by head office, with the findings available for all staff to see via the providers' website. Any necessary actions were identified and passed on to be followed up as appropriate. One person said they had received three questionnaires in the past. They said they had completed the first two questionnaires but they did not complete the most recent one because "Nothing had changed – everything is fine." Staff views were sought via a quarterly 'care worker colleague survey'. This was anonymous, and stated, "Survey feedback shapes our actions and how we communicate with care colleagues".

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The provider supported the registered manager and staff team to keep their knowledge and skills up to date. At the time of the inspection the focus was very much on the 'One Best Way' programme with its new roles, responsibilities, policies and processes. We spoke to the provider's 'transformation manager', who was supporting the team, delivering training which they described as a 'blended learning experience' comprising webinars, e-learning and taught face to face sessions. This was supplemented by an on line support system, which contained a 'library' of resources and up to date information for all staff about the programme and best practice The registered manager participated in weekly conference calls and three monthly managers meetings where issues such as the introduction of the programme, recruitment, sickness and training were discussed. They also had face to face supervision every three months with the area manager.

As far as we are aware, the provider met their statutory requirements to inform the relevant authorities of notifiable incidents. They promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

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 The service did not assess, monitor and mitigate the risks related to the health, safety and welfare of service users. 17(2)b The service did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided and decisions taken in relation to this.17(2)c