Nestor Primecare Services Limited

Allied Healthcare Lincs Reablement

Inspection report

Unit 6, Apex Court
Spalding Office Park
Spalding
Lincolnshire
PE11 3UL

Tel: 01775723210

Date of inspection visit:
22 May 2017
23 May 2017
24 May 2017

Date of publication:
11 July 2017

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

The inspection took place on 22, 23 and 24 May 2017 and was announced.

The service provides care for people who live in Lincolnshire and who need support to regain their independence when they leave hospital. They are contracted to provide care over a four week period to support people with their care needs and their ability to access the community. There were 256 people using the service on the day we inspected. The service is not provided at set times or for set durations but is provided flexibly to reduce as people regain their abilities to live independently.

There was a registered manager for the service. 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.

The provider had effective systems in place to monitor the workload of care workers and to enable them to provide flexible responsive care for people. Office staff were able to identify when there was capacity to provide care for people new to the service. Staff were provided with training and support which enabled them to provide safe care and to maximise people's independence. Staff knew how to keep people safe from abuse and knew how to raise concerns.

The care was tailored towards supporting people to regain their independence in all areas of their lives. Care workers ensured that the equipment and support was in place so that people could remain independent after the service was withdrawn. People received the support needed to manage their medicines and to access food and drink. People were encouraged to continue the social activities they enjoyed before they were ill.

While the care provided was for a defined period of time the provider had systems in place to ensure that people were not left unsupported. Staff engaged with the local authority and other care agencies to arrange for ongoing support to be put in place.

Care workers were kind, caring and polite. They supported people to become and remain independent and ensured that people's dignity was respected while they were receiving care. Care workers had received training in the Mental Capacity Act (2005) and encouraged people to make their own decisions about the care they received and about their lives.

People had their views of the service they received gathered and the registered manager took action to respond to any concerns or complaints. The provider had structured the service and staff to manage the flexible and responsive service so that people received a high quality of care. They had invested in systems which supported their staff to deliver the care people needed. The registered manager had access to effective monitoring systems which allowed them to identify issues and make changes ensure people

received a service which met their needs.

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.

Staff had received training in keeping people safe from abuse and knew how to raise any concerns within the organisation and with external providers.

Risks were identified in people's care plans and care and equipment was out into place to keep people safe.

The provider had systems in place to manage their capacity and to monitor that the staff had time to support people. Appropriate checks were completed to ensure staff were safe to work with people using the service.

Medicines were safely managed and any medicines errors were investigated and learning shared with the staff.

Is the service effective?

Good

The service was effective.

Care workers were provided with effective training and support to ensure they had the skills to care for people safely.

Care workers had received training in the Mental Capacity Act (2005) and knew how to protect people's rights.

People were supported to be independent in preparing and eating their food.

There was good liaison with other healthcare providers which supported people to regain their skills and confidence in living at home.

Is the service caring?

Good

The service was caring.

Care workers were kind and caring and supported people's privacy and dignity.

People were able to make decisions about their lives and how they wanted to return to being independent.

Is the service responsive?

Good

The service was responsive.

People were able to plan their care and set their own goals on the outcomes they wanted to achieve.

Care plans contained the information staff needed to provide safe care and support people to regain their independence.

Complaints were monitored and fully investigated.

Is the service well-led?

Good

The service was well led.

There were systems in place to monitor the quality of care people received.

People's views on the care they received were used to develop the service.

Staff were happy that the management structure in place supported them and they were able to raise any concerns they had.

There were systems in place to support the service to provide care which met relevant best practice guidance.

Allied Healthcare Lincs Reablement

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.

The inspection team consisted of an inspector and an expert 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. The inspection was announced in line with our methodology for inspecting domiciliary care agencies. This allowed the provider time to arrange for staff to be at the office to speak to us. The expert by experience contact people using the service by telephone on 22 and 23 May 2017 and the inspector visited the office on 24 May 2017.

Before the inspection we reviewed the information we held about the service. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commissioned all the care provided by the 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.

During the inspection we spoke with 15 people who used the service and three family members of people who use the service. We spoke with seven care workers and five people who worked in the office. We also spoke with the registered manager.

We looked at six care plans and other records which recorded the care people received. In addition, we examined records relating to how the service was run including staffing, training and quality assurance.

Good

Is the service safe?

Our findings

People told us they felt safe when using the service. One person told us, "I do feel safe, the staff are gentle and respectful. The staff and I laugh and joke and have a good chatter." Another person said, "Oh yes I felt safe the staff were brilliant." In addition, some people told us that staff had used a key safe to get into and out of their home and had always left the home secure. One person said, "I had just started using a key safe, the staff used it beautifully and there were no problems at all. Another person told us, "There is a key safe and the staff lock up afterwards."

Care workers told us they had received training in how to keep people safe from abuse. They were able to tell us about the different types of abuse so that they would be able to recognise it if they saw it. They were clear on the actions they would need to take if they had any concerns. For example, documenting what they had seen. Although they were also aware that they may need to be careful about what they would write in case the abuser looked at the records. Care workers knew how to raise concerns with their line manager and with external organisation.

Care plans had identified all the risks to people. Records showed that risk assessments had been completed by care workers when the person started to use the service and covered areas such as people's skin condition and if they were at risk of developing pressure ulcers. Where people needed equipment to help them stay safe, care coordinators were able to arrange this immediately. This was because the staff had been trained to be assessors and were able to request equipment directly instead of having to go through a healthcare professional.

Most people using the service had been recently discharged from hospital. As part of the initial visit care staff monitored people's environment to ensure that it was safe for them while they were rehabilitating. Care workers were then able to make changes to people's environment to keep them safe while they were regaining their independence. For example, staff checked if there were any rugs that were a trip hazard.

The provider had systems in place to ensure that any accidents and incidents were fully investigated by the registered manager. Where needed actions were taken to keep the person safe from further accidents and learning was shared with staff at team meetings.

The service was designed to provide support for people over a four week period to help them regain their independence following a stay in hospital or ill health. The amount of support people needed would gradually decrease over the four weeks. Therefore, the service was not run on a timed basis but structured to enable staff to stay with a person for as long as needed at each visit. Therefore as agreed with the local authority who commissioned the service people were given a two hour window in which their call would occur. Most people we spoke with told us that they had been happy care workers had attended as required. One person told us, "I know it would be a morning call, and this was a general time, as I got more independent the call was later. I was never missed." Another person told us, "The time varied, depended on what the carer had to do before me. They called between 7am and 9am. That was fine; it made no difference to me. The carer never missed me."

As the service was planned to be a four week package of care there was a high number of people starting and leaving the service each week to be managed. For example, in the week prior to our inspection the service had taken on 81 new people. The roster systems were managed by a team of five staff in the office who looked after the care staff in different areas in Lincolnshire. Care staff used smart phones to check in when they entered a person's house and to check out when they left. This allowed office staff to monitor their rounds and to identify when capacity was available for new people to be taken on. The provider's computer system automatically calculated travel time from one call to the next.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the service. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who live at the service.

People told us they received varying amounts of support to manage their medicines. This was dependant on their own abilities and if they had family members who could support them. One person told us, "I do my own medication, but the staff did ask if I had taken it and would ask if all was ok with my medication." Another person told us, "The carer went to the doctor surgery to get my medication but I don't need help to take it."

Care workers told us that as the aim of the service was to encourage independence they supported people to manage their own medicines. People's abilities to manage their medicines were assessed when people started to use the service and if needed care was planned to increase people's abilities. For example, care workers might arrange for a person to have their medicines delivered to their home instead of having to fetch them or to have them in a package that was easier to open. This meant that the person would be self-sufficient when the service stopped. However, they also said that while they supported people's independence they also kept a watchful eye on the situation. For example, one member of staff told us how they had noticed that one person was running low on medicines and they had contacted the doctors.

Records showed that where staff needed to administer medicines the appropriate medicines administration records had been fully completed. Records were returned to the office and checked by the medicines management lead. If any medicines errors occurred they were fully investigated and action taken such as staff receiving more training.

Good

Is the service effective?

Our findings

People told us that they had been happy with the staff's level of skill. One person told us, "The staff did a very good job, and are trained in what I want them to do." Another person told us, "The staff seemed to know what they doing so yes I think they were trained."

There was a training manager in post who supported staff with induction and refresher training. We saw that they were enthusiastic about their job and were approachable and supportive for staff. The induction for new staff consisted of five days training in a class room followed by shadow shifts with an experienced, confident member of staff who became their care coach. The care coach supported the new member of staff through their induction period offering guidance and support. The training manager explained that they liked everyone to complete seven shadow shifts but were happy to support people to do more if needed. All the new staff we spoke with told us how supportive the training manager had been. In addition, if after their induction period care workers were asked to go and support a person with some aspect of care that they had not provided before they would be supported by a care coach.

During the induction period care workers received ongoing support from the training manager in the form of telephone calls and supervisions. In addition, their care coach undertook observations to ensure they were competent in assigned tasks. Care workers were line managed by care coordinators and following a successful induction the coordinators would complete spot checks to monitor their performance and ensure they did not need any further support.

There were also robust systems in place to monitor the ongoing training staff received. The ongoing training consisted of mandatory training in the basic skills all staff needed and more advanced training in specific areas if staff wanted to gain specialist knowledge. The mandatory training was linked into the staff roster systems and if staff failed to attend the required training they would be removed from caring for people until the training was completed.

Care workers were also supported with an ongoing system of supervisions with their line manager. These took the form of face to face meetings and spot checks. Supervisions were again linked to the roster systems and care workers would be stopped from providing care until their supervision was up to date. Care workers also confirmed that they received annual appraisals.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

People told us that staff always asked for their consent before providing care. One person said, "Yes the carer always asked, they were brilliant." A family member told us, "The staff would ask [my relative] what they wanted done."

Records showed and staff told us they had received training in the MCA. One member of staff told us how they had been worried about a person who had chosen to live isolated and who kept their blinds shut. They explained how they had supported the person to continue their routines as this was their choice, but at the same time they had gently encouraged the person to take steps and make decisions which improved their lives. For example, the person had decided that they wanted to move house and the care worker had supported them to access a solicitor. They had also supported the person to access healthcare advice.

People told us how care workers had supported them to access their choice of food and drink. One person told us, "The carer would make sure there was a drink left for me and sometimes snacks. Sometimes they would make me a sandwich if my family member was going to be late back." Another person told us, "I always had fruit for breakfast. The carer would say to me would you like something else?"

Care workers were clear on the importance of ensuring people had enough to eat and drink and knew how to monitor for concerns. For example, one care worker was able to tell us how they would know if a person was dehydrated. Care workers told us how they would always make sure people had a drink with them when they left. Additionally they explained how if a person who needed support to access a meal told them they had eaten, they would look for evidence of this such as a dirty plate. Where people were at risk of being unable to maintain a healthy weight their food and fluid intake was monitored.

Individual care plans included all the information needed to support people's day-to-day health needs. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed.

Good

Is the service caring?

Our findings

People we spoke with told us that they had good relationships with staff. One person told us, "One carer couldn't do enough for me they were very nice." Another person said, "The carers were very polite and kind, they could not have been kinder, very respectful and keen to help." A third person commented how the care workers would help them to do their laundry and that the care workers had supported the person with anything they requested. People also told us how the care workers had been able to be flexible if they needed to change the time of the call for any reason. A relative told us, "I phoned the office to ask if the call time could be changed and the agency was happy to do that, I asked to have an extra call, I had to go out myself, and this also was arranged."

People told us that the staff had supported them to make choices about their everyday lives. One person told us, "They used to ask if I wanted tea or coffee as a drink, and they would also ask if I wanted a shower or wash my hair." Another person told us, "Oh yes the carer always ask what can I do today and I would say the help I needed." All the care staff we spoke with were clear that their role was to support people to move towards being independent. Therefore people were supported and encouraged to make choices in their lives so that they could continue to do so after the service was withdrawn.

The registered manager explained that as people were receiving care to help them regain their independence it was important for them to have consistent care workers, who could monitor their progress. Therefore care workers were allocated rounds and alternated shift for the round with a colleague so that there were a limited number of care staff visiting the person. One person told us, "I had one person each morning. There was a rota team of two carers." Another person said, "There were two carers, one male and one female, both very nice. Just one per call."

The registered manager and care workers were clear that the end point of the care was that people regained their independence. The care provided was planned to be on a sliding scale so that as people became more independent care workers visits were shorted. People told us that this had happened. One person told us, "First the staff used to do my tea and toast and then I did it while they watched me. I did think the staff would support me more than they did. Once I did my shower on my own the carer said you can do it yourself now." Another person told us, "I have a stick now to support my walking, the carer took me out to the shops and post office to give me confidence, we had some nice chats when I was walking."

People had not been offered a choice about the sex of their care worker but had never had problems being supported by a member of the opposite sex as they had respected people's privacy and dignity. One person told us, "The male carers are very discreet, when I went in the shower they would sit on a chair outside the door, which was slightly open. I did not mind that I had male carers."

Good

Is the service responsive?

Our findings

All the people using the service had their care paid for by the local authority and the only way to access the service was to have a referral from a healthcare professional. Most of the people using the service had been discharged from hospital and the provider had two members of staff based at local hospitals to visit and assess people's suitability while they were still on the ward. However, as these members of staff were required to have NHS name badges most people did not realise they had been assessed by a member of the provider's staff. One person told us, "No the manager did not come to see me, the hospital put the package in place before I left and the care started when I got home." Another person said, "I didn't know until I was coming out of hospital that the care had been set up, the night I came out the carer came to see me' 'Nobody had been to see me before that."

Dependent upon the capacity of the provider to take on the care for people in the area they lived people's care could be arranged very quickly. For example, the provider could take the phone call in the morning and by evening the person could be home and receiving care. To facilitate this all the care workers had been trained to complete the required paperwork and assess people's environment for safety. In addition, they would discuss what people wished to be able to achieve with the four week care package and identify if they needed any equipment for safety or to improve their independence. Then within 48 hours people would also receive a visit from a care coordinator who would complete the appropriate risk assessments and care plans. People told us they were happy with their care plans. One person said, "Yes there is a care plan here and I am happy with what is written at each call." Another person told us, "Yes I approved of what was written up." Care plans we looked at had all been completed within the 48 hour window and recorded people's expectations of their care needs.

People told us that the care provided had helped them regain their independence. One person told us, "When they first came it was four times a day but as I could do things for myself they reduced the care and eventually there was none. The staff used to walk behind me when I went upstairs, and then sit on the stairs, to make sure I was safe, while I did my shower." another person said, "As I was able to do more for myself the staff dropped off and I did more. It started that I could wash my face and then I could wash the upper part of my body and so it went on."

Care workers were clear that the aim of the care was to increase independence and that at times they would have to stand back and let people try to do things for themselves. This was because people needed to be able to care for themselves when the care package finished. Where people were struggling to manage certain tasks care workers identified different ways that the task could be done. One person told us "I can't bend down, the carer asked if I would like to try equipment to help put on my socks, they organised that for me."

The care provided was to help people to continue to live as they had before going into hospital. This meant that they were supported to access the community and social activities as they had before they were ill. One person told us, "The staff helped me, one went to the shops and used to make me a cup of tea, when you live on your own that is wonderful. Then another carer would take me out and help me walk. I now have a

stick so I can walk myself, When I had to go to a hospital appointment the carer booked the transport." A care worker told us how one person had discussed how they used to regularly go to church. They explained how they had contacted the vicar who had arranged for a member of the congregation to provide transport for the person.

As people moved through the four week care package they were continually assessed to see how they were improving. When care workers thought people were at a stage where they were able to be independent they requested that the care coordinator visit. The care coordinator would formally assess the person and discuss with them the withdrawal of the service. Service withdrawal happened over a three day period so that care workers could monitor to see if the person was coping on their own and step in if further support was needed. One person told us, "I know how long the agency would be calling, I was asked if I wanted to continue, kept on for longer, but I felt it was adequate."

Where people had not progressed to independence within the four week period the care coordinators would visit again and assess if they were going to be able to achieve their goal. If with further support that was possible then the provider would lengthen the care package and continue to support people. Where it was assessed that people would be unable to become independent the provider would liaise with the local authority to arrange a permanent package of care with another care provider. However, until that care was in place the provider would continue to support the person with their care needs.

When people started to use the agency they were given a care folder which along with their care plan contained information about how they could make a complaint. It included the contact details for the provider, the Care Quality Commission and the Local government ombudsman. People we spoke with told us they would complain to the care coordinator if needed but that they were happy with the care provided. Comments included, "I do not have any complaints," and "No complaints at all, none whatsoever."

The provider had a complaints policy which detailed how they would respond to concerns and within what timescales they would respond. Records showed that they had fully investigated complaints and taken appropriate action if needed.

Good

Is the service well-led?

Our findings

People told us they had been happy with the quality of care they received. One person said, "I would have liked to keep them they did a wonderful job." Another person told us, "If everyone gets the service I had, they would have nothing to complain about." A relative said, "I would recommend this agency, the carers are kind and would do anything for [my relative], nothing is too much trouble."

People had been asked for their views of the care they received. There was a feedback form included in the paperwork left with people at their home. They were encouraged to completed this information and send it to the office at the end of their care. One person told us, "There has been a tick box sheet asking for details about the care." Another person said, "There was a form sent to fill in, and I was also asked for verbal feedback." Records showed that the registered manager had reviewed each form to see if any action needed to be taken to improve the quality of care they received. If people had been unhappy with anything the registered manager would start a complaint and complete a formal investigation of the concerns.

The service provided covered the county of Lincolnshire which is a large geographical patch. To manage this the registered manager had spilt the county into 12 zones. Each zone had a care coordinator whose responsibility it was to manage and provide support to the care workers and complete the assessments for people at the beginning and end of their care. In addition, the registered manager had a number of staff in the office to plan care rounds, receive referrals for care, to investigate incidents and complaints and to be an initial point of contact for people using the service. This clear identification of roles and responsibilities all supported the registered manager to effectively manage the service and to provide a quality service to people.

Care workers told us that they felt supported by their care coordinator, colleagues, staff in the office and the registered manager. They told us how important good communication was to the service given that there was a high and relatively fast flow of people through the care process. Care workers explained how their key contact was the care coordinator with who they could discuss length of calls and peoples' progress and would receive good advice and support. As well as support from local colleagues the provider had a national on call centre which staff could contact for guidance when the office was closed. Care workers were also supported with regular staff meetings within their zone so that they were kept up to date with changes to the service, care and best practice guidance.

The provider had invested in technology to support staff to provide a high quality system. All the staff had a smart telephone which enabled them to access people's information on their phones. For example, they were able to schedule a new person into a care workers round, when the care worker had already started the round. The information would update on their telephone and allow them to access details on people new to the service before the initial visit. Staff in the office were able to monitor a care workers progress on their round and identify if they had any problems. The on call systems also had access to the same computer program so information entered by them was immediately available to the care workers locally.

The provider had put systems in place to support staff and to recognise when staff performed well. The

registered manager told us how the care coordinators were able to nominate a member of staff for care worker of the month and care coach of the months. In addition, the provider recognised the efforts of staff with a quarterly national shining star award.

The registered manager had a suite of audits in place which supported them to manage the quality of care that people received. We saw that this allowed them to monitor information relating to staff training and supervision, incidents and accident and complaints. The system supported the registered manager to process and investigate incidents, accidents and complaints. Records showed thorough investigations had been completed and where needed actions taken to keep people safe. For example, change to care or further training for staff. In addition, the provider's head office could monitor the systems and identify if trends in concerns were local to an office or were a national issue.

The registered manager regularly attended meetings with the provider's other registered manager to discuss the care provided and how improvements could be made. In addition, the provider arranged training and advice to ensure the registered managers kept up to date with changes in best practice guidance.