Care Quality Commission

Allied Healthcare Group Limited

Allied Healthcare London

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

The inspection took place over three weeks. On October 28th and 30th we conducted a site visit to the office. This was followed up over the following three weeks by phone calls to care workers and people who used the service. We gave the service two working days' notice of the inspection, therefore it was announced.

A brief follow up inspection had been made in September 2014, where we found the service was not meeting the regulation for assessing and monitoring the quality of service provision. It was too soon for the provider to be able to demonstrate major improvements to the service, but we saw a transformation plan "One Best Way" was in the early stages of implementation.

Allied Healthcare London was established in April 2014, from the merger of three Allied Healthcare services. Approximately 900 people use the service, supported by around 360 staff members. Care workers from the service make over 9,000 home visits each week. The majority of those who use the service are older people, some of whom are living with dementia, but there are also specialist teams within the branch, supporting

Summary of findings

re-ablement, which is assisting people with their recovery after a stay in hospital, and children and young people with complex needs. Staff from the service also support people living in four extra care housing schemes.

The registered manager had recently left, but a registered manager from another Allied Healthcare service had started to cover the post on the first day of our inspection and was in the process of applying for their registration to be completed. 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.

Although the provider was investing heavily in improvements, at the time of the inspection we found that the service was in breach of five regulations covering staffing, medicines management, care and welfare, consent to care and assessing and monitoring the quality of service provision.

Our concerns did not extend to the specialist contracts held by the provider. However, there were insufficient staff numbers in place to cover the non-specialist work without staff members working excessively long hours. This had an impact on their ability to deliver a high standard of care.

Some assessments and care plans were poorly completed and provided insufficient guidance to care workers about the needs of the people who used the service. Important information from referrers was not always taken into account. Quality monitoring systems had not picked up some issues or resulted in prompt action to address shortcomings until very recently. The service's ability to monitor missed calls was improving, but more work was needed before we could be confident that the provider had effective systems in place to deal with this issue.

Despite the breaches in regulations, when we spoke with most people who used the service they were positive about the care they received, describing good relationships with their regular care workers. However, safeguarding minutes indicated that there were times when some staff members were uncaring. We observed that improvements to make the delivery of care more robust and, therefore, safer were just starting to have an impact. However, it was too early to judge if they would be sustained.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report. Where we have identified more serious breaches of regulation we will make sure action is taken. We will report on this when it is complete.

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?

Inadequate

The service was not safe. There were insufficient care workers to cover all the visits scheduled. As a result, many staff worked excessively long hours without breaks to ensure that every call was covered.

There was no consistent way of checking that everyone was receiving their medicines appropriately, as there were unexplained gaps in the medicines administration records. The needs of one person at high risk of deterioration if their medicines were not taken regularly had been overlooked.

There was a contingency plan in place in case internet, telephone or other services were interrupted. This ensured the service could continue with minimal disruption, despite its reliance on computers and phones.

Is the service effective?

Requires Improvement

The service was not effective in all areas. The service had not taken steps to meet its new responsibilities in relation to the Mental Capacity Act 2005.

There were inconsistencies in record keeping. Important information was not always completed to a sufficiently high standard to ensure that there was a clear record of people's needs.

Care workers were positive about the training provided and said it equipped them for their role.

Is the service caring?

Requires Improvement

The service was not caring in all instances. When we reviewed safeguarding meeting minutes we saw, on occasion, care workers had a poor attitude towards the people they were meant to care for.

Out of hours arrangements were in place to support the delivery of care around the clock.

When we spoke with people who used the service all but one described good care. Staff we spoke with talked in a caring way about the people they supported.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive. Assessments and care plans were not always completed to a good standard. Some important information was missed and some of the care plans contained insufficient guidance to enable care workers to meet people's individual needs.

Most people who used the service knew how to raise a complaint, but those we spoke with said they did not need to. We saw that the service logged and responded to complaints and some of the lessons learned had been incorporated into the provider's transformation plan.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led. Although the provider had strengthened the management team and some improvements had started to make systems safer, it was too early to know if these would be sustained. Some significant risks were unaddressed at the time of inspection, such as care workers being infrequently supervised or monitored. Ensuring cover for visits was prioritised over everything else.

Quality monitoring had taken place, but there were gaps. Identified shortcomings had only recently started to be addressed.

Allied Healthcare London

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 checked 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 took place over three weeks. On October 28th and 30th we conducted a site visit to the office. This was followed up by phone calls to care workers and people who used the service. The provider was given two working days' notice of the inspection because the location provides a domiciliary care service and we needed to ensure managers were on site.

In total six inspectors and an expert by experience participated in this inspection. Three inspectors were involved in the site visit. Phone calls to care workers were made by two different inspectors and phone calls to people who used the service were made by another 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 services, in this case services for older people.

As this inspection was carried out in response to concerns raised about the service, questionnaires and a provider information form (PIR) were not sent out in advance. 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 spoke with 17 office based staff, 53 care workers, 50 people who used the service and eight of their relatives. We observed office staff arranging cover for shifts and monitoring the electronic clocking in and out system and we reviewed seven care files in depth, electronic records, four staff files, three weekly staff rotas and many of the provider's policies and procedures. We reviewed an action plan which was in place in relation to one contract held by the provider and we were given a presentation on the provider's transformation plan for this service.

We spoke with a range of staff who were predominantly office based, including four with regional or national responsibilities, two senior managers, the safeguarding lead, two field care supervisors, four care co-ordinators and two administration staff. Three members of staff we spoke with were part of the transformation team.

We spoke with and received information from two local authorities which had commissioned care from this service. We also reviewed the concerns that had been reported to us by people who used the service, their friends and relatives.

Inadequate

Is the service safe?

Our findings

One person who used the service said, "Frequently, [there are] late arrivals [by staff], incorrect medication, three or four times in the last year no one has turned up." Another person told us they had fallen out of their wheelchair as a staff member failed to strap them in. One person told us, "I'm thinking of changing to another company, they're not reliable enough at weekends." Several people mentioned that staff availability on Sunday mornings was often a problem. Many of these comments were corroborated by evidence supplied to safeguarding investigations by the provider and by people's social workers or family members.

Staff availability was insufficient to keep people safe, especially at weekends and when the support of two people was required, for example, to meet manual handling requirements. One care worker told us, "I hear [staff] complaining all the time about double ups and the other person not turning up." Another said, "There are not enough staff [available] at weekends." We noted that the provider had briefly rejected new referrals to ensure that the service could meet the needs of those it was already caring for, but this was not acceptable to its referrers to whom the provider had contractual obligations. At the time of inspection, the provider had just embarked on an extensive recruitment campaign as they were understaffed. We saw that they were engaged in negotiations with at least one local authority to improve the terms and conditions for staff to aid retention. They had also started to offer guaranteed hours to care workers who had passed their probationary period and had been working on zero hours contracts.

We noted that a significant number of staff were working extremely long days without any days off, for example, from 7:00am until 10:30pm. We were provided with information that 22 care workers had each worked for an average of eight hours each day for 70 consecutive days (three care workers had averaged over 80 hours per week over 10 weeks). One care worker we spoke with told us they had not had a full day off for over two years; another said they had not had a day off for one year. Whilst some staff told us they were happy to work these hours, others said they felt guilty if they said no because they worried about the people who used the service. Either way, it was unlikely that even the best care worker would provide a consistently good standard of care without adequate rest. Therefore there were insufficient numbers of care workers in post to meet the needs of all the people who used the service. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that there was no emphasis on matching people with staff with the appropriate skills and knowledge in some parts of the service, especially during periods of staff absence. The priority was finding any care worker to cover the shift. There was better practice in relation to children and young people and those receiving specialist packages of care, for example, we heard that a person had been matched with a care worker who spoke their first language.

We received information from one of the local authorities which was contracting care from this service about a high number of missed calls. The provider told us there had been some poor scheduling practice for a short period in August when care workers were double booked. They said that this had been resolved and missed calls were now down to occasional human error.

We spoke with members of the provider's transformation team who had been brought in to re-structure the service and improve all the required processes and we saw that they were working on implementing changes to make the service safer and more reliable. However, at the time of the inspection, the processes in place to ensure the right care worker was visiting the right person at the right time were not sufficiently robust. For example, on occasion staff had to cut visits short (mainly when covering absence) as insufficient travel time was incorporated into their rotas. We were told that the service was "two weeks away" from resolving this as they were linking care workers to a specific geographical area to minimise travel time. There were particular problems with coordinating care workers' schedules if two people had to be present at the same time. We were present when office staff were alerted to a missed call to a person who used the service. The care worker concerned said the visit was not listed on their rota. It was later confirmed that someone in the office had made an error and managers addressed this with them.

We looked through a large stack of medicines administration record (MAR) charts which were awaiting an audit in the office. We found that many contained gaps without an explanation being provided. In some cases this may have been because the key to describe the reason for omission was missing from the chart.

Inadequate

Is the service safe?

We brought one concerning example of lack of support to take medicines to the attention of senior management so they could follow it up immediately. The person who received the service had said they did not need help with taking their medicines and their care plan and risk assessment reflected this. However, the information supplied by the local authority indicated that the person was unreliable in relation to self-administering medicines and needed prompting. The medicines concerned had to be taken regularly to prevent deterioration of their health or even death.

Staff said they took their responsibilities for supporting people with their medicines seriously. One staff member said, "I get there on time to give medication, [it is] my priority." One staff member told us how they ensured medicines were safely administered if they arrived late for a visit. This was appropriate in the situation they described, but it may not be safe for all medicines. We saw that staff received medicines training and were tested for competency, but we were told that some care workers, especially those who were new to the administration of medicines, struggled to pass and needed individual support which was not always available. Therefore people who used the service were not fully protected from the risk of unsafe administration of their medicines.

These factors amounted to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we spoke with people who used the service, they all told us they felt safe, even those who were not happy with aspects of their care. We looked at the provider's policies and procedures for bullying and harassment, protecting adults at risk and whistleblowing. The issue of psychological and other harm was addressed in each of them. There was additional written guidance for managers in respect of most policies.

There were policies and procedures in place to safeguard children and adults. A safeguarding lead was employed by the service to investigate concerns and liaise with local authorities. Safeguarding was covered in staff induction and refreshers were provided at regular intervals. When we spoke with staff we found that most were able to tell us what signs of abuse they looked out for and confirmed they would report any concerns they had for people's well-being to the office. One care worker said, "I look out for signs of abuse in so many ways, for example, changes to [people's] personalities. I check them over when washing them. If I notice anything, I write it down and inform my line manager immediately." Another said, "If I noticed a colleague being rough, I would not hesitate to inform the office." However, we saw evidence from meeting minutes that some internal safeguarding investigations were not always robust. This had the potential to impact on both people who used the service and any care workers wrongly accused.

When we looked at people's care files we saw that there were risk assessments in place. However, some of them were unhelpful as staff had not completed them in a way which provided any guidance to their colleagues. In the examples we looked at we saw that the risk assessments had been compiled in consultation with people who used the service and/or their families. Whilst this was commendable, we did not always find evidence of any cross-referencing with information from referrers and other professionals. Therefore some important issues were not reflected in risk assessments which could impact on people's care or staff safety.

Safe delivery of the service relied heavily on the provider's telephone system and IT. Senior management told us that there was a robust contingency plan in place to divert calls to another Allied Healthcare service in the event of a failure of the telephone system. They also had arrangements to access their electronic records in the event of a server failure. Mobile phones and secure laptop connections were available to enable key staff members to work from any location. The company reviewed the contingency plan every six months.

Staff files showed that the safe recruitment practices outlined in the provider's policy and procedures were followed. There was one exception where we found that, although two references had been supplied, one of them was from a different organisation to the one listed on the staff member's application form and there was no explanation recorded for this.

We found that, under its new management, the service was establishing a robust approach to disciplinary matters. Two members of staff separately told us that, previously, managers and office staff had been "scared" of tackling care workers about poor practice as they knew it would be difficult to cover their visits if they were suspended.

Requires Improvement

Is the service effective?

Our findings

Many of the people who used the service told us the care workers they felt most comfortable with asked them informally for permission before carrying out tasks, using phrases such as, "shall I do it in this way?" or "is it alright if I do this?"

The provider had a policy in respect of the Mental Capacity Act 2005 (MCA). The version we were provided with pre-dated the recent Supreme Court judgement, but managers had been updated with briefings. This judgement required providers, in conjunction with relevant professionals if appropriate, to review any restrictions that may be in place to keep people safe if it was thought that the person may not have the capacity to make the decision for themselves. If an assessment for capacity was needed or restrictions could not be safely removed for a person without capacity, there were further procedures to follow. We did not find that the service was initiating any action in relation to the MCA. There was an over-reliance on local authorities leading the process, even though care workers were better placed to pick up on people's changing needs and any restrictions of liberty in place.

The provider had not started reviewing the needs of people who used the service in the light of the Supreme Court judgement which broadened the scope of the Mental Capacity Act 2005. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw evidence that the provider had taken steps to obtain people's consent to share information about them with relevant professionals on a need to know basis. There were signed forms in people's care files.

Poor completion of other records meant it was impossible, at present, for staff to easily identify who had capacity to make which decisions for themselves and whether there was a Court of Protection order or Lasting Power of Attorney in place. Care workers were clear, they "cannot force a person to do anything". Most of them described how they would try to persuade the person to comply with their care plan, for example, to have a shower. If the person was still resistant and they had time, they would get on with other work before raising the matter again. Then, if all their attempts were unsuccessful they would log it in the written record and phone the office. This showed that they were mindful of people's rights.

Part of the recruitment process required potential staff members to undertake a written English test. However, we found very few documents which were completed to a good standard, except those related to the specialist contracts. In some cases the forms were complex and time consuming to complete, in other cases lack of in-depth training, or poor application of training, for example, in assessment skills or report writing, impacted on the staff member's ability to complete documentation in a clear, unambiguous way. This affected people who used the service because their needs were not accurately recorded and there was little guidance for staff to follow when meeting those needs. The Director of Nursing advised us that many of the forms had been designed to fit in with an electronic database which would be introduced in the future.

We looked at how visits were covered in the event of staff absence and noted that the database showed care coordinators which staff members had previously worked with the person concerned. The care coordinators, who were responsible for scheduling visits, used this list to determine who would be appropriate to cover the visit, only moving on to staff who would be new to the person if there was no other option. This ensured continuity of care, but we did not see any evidence of account being taken of the location of the adjacent visits or the number of hours already worked by the care worker when last-minute cover was being arranged. A person who used the service who was a dog owner told us they had been sent a care worker who was terrified of dogs so the call had to be cut short. All these factors impacted on the time available to carry out the required tasks and the quality of care.

The provider was stronger in the area of induction and training. Care workers praised the quality of the training received and said there was plenty of it and it equipped them for their role, although some said they needed more dementia training. A few staff were confused about the impact of dementia on the lives of the people they supported. They confirmed to us that if they were not up to date with their mandatory training they did not get any more work from the provider. Some office staff told us they

Requires Improvement

Is the service effective?

had not been trained for the role they were occupying. This had an impact on the way they carried out their duties as they tended to focus predominantly on the tasks they were confident in.

Earlier this year the provider introduced an "on boarding" programme to ensure care workers had sufficient support during their first 12 weeks of work. Some existing care workers had received additional training to become "care coaches", new starters were assigned to shadow them for at least 12 hours and could contact them for advice. At the end of this period, the new staff member's performance was appraised. If satisfactory they passed their probationary period.

We read the provider's policies and procedures in relation to supervision and appraisal. When we looked at the appraisal form templates we saw there was a subsection called "control", which was not well understood by staff. The policy did not give guidance about how sections of the form were to be used for their largest group of staff - care workers. Therefore, there was a risk of parts of the appraisal being misunderstood. During phone calls to care workers, most were vague about the role of supervision and the frequency at which it was supposed to be delivered. Those who recalled having supervision did not think they had received a record of it. Only one of those we asked could remember being subject to a spot check by a Field Care Supervisor or manager. Several staff told us that the provider did not tell them when they were doing their job well, but were quick to make contact if there was a complaint.

Most people who used the service commented favourably on the support they received with eating and drinking. One person said, "I get pureed food at the moment, because that is what I need." Another person said, "I get a good breakfast every time they [care workers] visit." Two people told us that they had to teach staff how to prepare basic meals as the dishes were unfamiliar to them. Another person told us that their care worker always purchased the cheapest brands for them when shopping on their behalf, even when they had asked them to buy specified brands. The care worker thought they were being helpful, but they were not taking the person's wishes into account.

The provider employed a regional nursing team, one of whom acted as a link nurse for the service. We heard that this nurse was approached for advice and carried out assessments on people with complex care needs. We saw some evidence of those assessments on people's care files. The care workers we asked were all clear about their responsibility to call an ambulance if someone was taken seriously unwell. The amount of support people received in relation to managing their healthcare depended on their assessed need. Some care staff reported that they were actively involved, others were not as family members or friends took on this role.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us that their privacy and dignity was respected. Comments included "the staff are very respectful" and "they [care workers] make sure they take care of my feelings".

We heard many accounts of the strong trusting relationships that care workers had built up with people who used the service, sometimes over many years. All the staff we spoke with talked about the people they supported in a caring way. One care worker said, "I like to put a smile on people's faces." Another said, "I have worked with the same clients for many years and have a good relationship with them." Whilst one person was not positive about the service they received, typical comments from people who used the service were "I have two good, lovely carers", "they [care workers] know exactly what I like" and "[I am] very happy with the staff".

Relatives of people who used the service had more mixed views. We exchanged emails with one who was pursuing a complaint, but another said, "The staff are good at listening to [my family member's] needs and wishes."

Despite the positive feedback received, when we reviewed minutes from safeguarding meetings, we found that there were inconsistencies in the way some care workers carried out their duties, which in some cases was neglectful, and, therefore, the service provided was not always caring.

We found that people were asked for their views when their needs were assessed. Care workers told us that they were trained to ask people for their consent before they carried out any personal care. The provider carried out an annual survey of people's views and was in the process of sending this out at the time of our inspection. We saw some questionnaires that had been returned promptly and the feedback was positive.

People who used the service told us that they were consulted about their views. One person said, "I get to give my opinions." Another person commented, "The staff are polite and ask me about my own opinions and how I am feeling about everything. I like that because it shows they care."

From the evidence we received from staff and most people who used the service, we found that many care workers worked extra unpaid hours to complete the tasks required, for example, picking up medicines from a pharmacy when they had not been delivered to the person's home, or simply staying longer to get the work completed. Care workers said they had to work in this way as it took the provider a long time to negotiate longer visits with funding authorities.

We spoke with a member of staff with professional qualifications in mental health. They said that they found all their colleagues were sensitive to the needs of people with mental health needs.

We observed that many office staff worked additional hours to ensure that the needs of people who used services were met. The provider had an on-call system to support the delivery of care outside office hours. They had also worked with at least one local authority to set up a "Night Owl" service. Two care workers with access to leased cars were available overnight and at weekends to cover emergency situations, for example, if a care worker went off sick mid-shift or if a care worker had to wait with a person for an ambulance so they could not attend their next visit. We noted that the on-call office staff received and made a very high number of phone calls. We were told that the "Night Owl" service was likely to be extended which might help to reduce this.

Requires Improvement

Is the service responsive?

Our findings

People told us care workers were responsive to their needs. One said, "Whatever I ask [the care worker] to do, [they do]."

The provider carried out their own assessments for all people newly referred to the service. We looked at the provider's old-style assessments and their new-style assessments. The former mainly comprised basic personal details, their diagnosis and a breakdown of tasks. It could be read very quickly. The new-style assessment was intended to be much more detailed, but the poor standard of completion meant that it was not. It required a separate page for each area of need and was bulky and time consuming to find the relevant section. The template contained typing errors. Some assessors told us that they struggled to find out people's body mass index (a means of assessing whether or not people are a healthy weight for their height) so often left this blank, unfortunately this meant the skin integrity and the nutrition assessments were incomplete as they could not be scored. People's needs in these areas could be over or underestimated as a result.

There was limited information about people's preferences or interests, even though the assessment was carried out in conjunction with the person and their family and in their own home. The entry for "hobbies and interests" for one person read "[The person who used the service] leads a normal home life." We did not see or hear much consideration of people's communication needs. However, for the people who received specialist care from the service it was a different picture, for example, shower gel preferences were noted and pictorial guidance was available to enable staff to assist with eating and drinking.

Assessments were gradually being updated using the new style forms for all people who used the service. However, we found an example of new-style care plan being completed a month before the person was re-assessed, with no evidence that it had been reviewed in the light of the assessment information.

New-style care plans were similarly lengthy, but they contained a summary section which was meant to give care workers guidance about the tasks they needed to attend to on each visit. However, these were not prominent or easy to find within the care plan. Care workers told us that they rarely looked at people's assessments or care plans and relied on their own knowledge of the person and word of mouth from their colleagues. This could increase the risk of essential information being missed. It also required people who used the service "to re-tell their story" at frequent intervals, which may not suit some people.

We found there was a higher standard of completion and much more information about people's individual needs and preferences in the files for people receiving specialist care. However, office staff told us that the new assessment format only addressed the needs of adults, not children.

All of the above information indicated that the welfare of people was not always promoted and people's needs were not always effectively met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care workers complained that they did not always have sufficient time to carry out the required tasks. One told us they were expected to attend to a person's laundry and other needs during a half hour visit, but this involved hand washing as the person did not have a washing machine at home. They said they had reported this on numerous occasions. Office staff said they reported such issues to the funding local authority, but did not always get a quick response.

Most people who used the service told us they knew how to make a complaint, but said they had nothing to complain about. We saw minutes from staff meetings which showed that learning from concerns and complaints had been relayed to staff members. Some aspects had been incorporated into the provider's transformation plan. We looked at the electronic system in place to track complaints, response times and outcomes. This was reviewed regularly by senior management.

Inadequate

Is the service well-led?

Our findings

The provider's quality assurance systems were not used effectively, so concerns about under-performance within the service were not picked up and dealt with before they had had a negative impact on the care provided. Internal audit had identified the need to complete or review care plans in February, but it was still listed in August as an outstanding action. Senior management were open about the problems within the service, but we were concerned that some of them had not been anticipated and resolved in advance when planning took place to merge three branches into one.

We also found evidence that the introduction of an electronic call monitoring (ECM) system had not been well managed. It had been brought in during the summer to monitor staff arrival and departure at people's homes to carry out care on behalf of one local authority. If fully used, this would help to ensure that no calls were missed and, therefore, that people were not left at risk. However, only around 60 per cent of people had consented to staff using their landline for the ECM. A small number of people who were most at risk had been issued with a 'black box' which enabled care workers to log in and out without using a landline.

We heard that care workers were reluctant to use the ECM. We saw from minutes of meetings that the provider was working with the local authority to incentivise staff and we saw graphs which indicated that staff compliance with the system was increasing. We were told that ECM had been re-launched within the staff team with emphasis on the benefits of the system for all. However, uptake remained low despite its use being mandatory where consent was in place.

A further issue with the ECM was that the planned visit times in the system were not synchronised with the actual visit times detailed in care plans within the provider's database. This made it very difficult for the staff member who monitored the ECM to know if care workers really were late or had missed a visit. Monitoring staff told us they had identified a growing list of 70 people who used the service who were at high risk if visits did not take place and they tried to prioritise these people. However, live monitoring of the system only took place during weekday office hours. As a result of these combined factors, the service remained reliant on people phoning in to report missed calls, yet some of those most at risk were unable to use a phone.

These issues amounted to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was extensive evidence of poor management and leadership for, at least, the first six months of the operation of this service. However, once senior managers did become aware of the extent of the problem in August, the provider invested considerable time and money sending in a large transformation team. In addition, new managers had been brought in and they, together with regional and national managers, had already identified most of the issues we picked up during our inspection and their transformation plan sought to address them. It was too soon to assess the impact of the changes as it was a "work in progress", but there was an urgency to the timescales within the plan and we were assured that we would notice a big improvement if we were to return in three months time.

The plan depended heavily on the success of the current recruitment campaign and we were concerned that it did not take full account of the reading and writing skills of some employees, nor their access to technology. Most care workers we spoke with did not use smartphones and many did not have regular access to a computer, yet some of the proposed changes depended, to an extent, on the use of these items. We brought these concerns to the attention of senior management as the plan would benefit from further consultation with care workers.

We saw that two positive outcomes of the transformation plan were beginning to emerge, care workers were starting to be allocated visits which were closer to each other so travel time was reducing for their regular visits. The problem only remained significant when they had to cover absence. Furthermore, the new measures put in place to anticipate cover needs were starting to achieve this as, by the end of the second day of our inspection, all planned visits had been covered for the following four days. It was too early to assess whether or not these improvements would be sustained.

Whilst some care workers reported that office staff were responsive when they rang in with queries or concerns, it varied according to whom they spoke to. One care worker

Inadequate

Is the service well-led?

said, “My rota doesn’t work. I can’t be in two places at once.” We also found that care workers were left “holding problems”, such as too many tasks for a half hour visit, whilst the provider negotiated with the relevant local authority. Care workers told us they had frequently reported these issues to the office. There was a lack of consistency in responding and, since extra staff had been drafted in as part of the transformation plan, care workers told us they were confused about which member of office staff to contact. All staff told us that if they raised a concern, they rarely got direct feedback about how it had been resolved unless they were persistent.

Staff informed us that they were often verbally abused by people they supported or dealt with by telephone. Whilst they accepted this could be the result of people’s mental health conditions, they said their concerns were not taken seriously within the service. However, many staff spoke positively about the support received from one member of the management team and we fed this back to senior management.

From safeguarding minutes we saw that investigations into poor care practice were not always comprehensive, nor was the provider’s own policy and procedures always followed when dealing with staff subject to an allegation. On at least one occasion this had hindered the conclusion of a safeguarding investigation. However, we did find evidence that staff were normally removed from care duties if there was a concern about their practice.

Staff meeting minutes showed no evidence of staff involvement in discussions about issues affecting the service. They mainly listed shortfalls that were raised with staff. For example, staff were told they must be on time for visits, but there was no acknowledgement that scheduling made this impossible at times. We found that the supervision and monitoring of staff was inconsistent. The provider had appropriate policies and procedures in place, but these were not being followed.

We asked senior managers to check the telephone numbers that were published for the service as we had difficulty locating the number and Allied Healthcare’s website and central switchboard did not have the service listed. They assured us that people who used the service had all been given the branch’s on-call number and were not affected by this problem. Two weeks later the website was still listing three separate services, rather than Allied Healthcare London, the registered name of the service, but the central switchboard was able to supply the number.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who used the service were not protected from the risk of unsafe administration of their medicines.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person is required to have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. They need to act on the recent Supreme Court ruling.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user; and the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs, and ensure the welfare and safety of the service user. Regulation 9 (1) (a) (b) (i) (ii)

The enforcement action we took:
A warning notice has been issued. You are required to become compliant with Regulation 9(1)(a)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, by 30 January 2015.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. Regulation 10 (1) (a) (b)

The enforcement action we took:
A warning notice has been issued. You are required to become compliant with Regulation 10(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, by 30 January 2015.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22

The enforcement action we took:

A warning notice has been issued. You are required to become compliant with Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, by 30 January 2015.