Nestor Primecare Services Limited

Allied Healthcare Maldon

Inspection report

Alpi House
Miles Gray Road
Basildon
Essex
SS14 3HJ

Tel: 08081882218

Date of inspection visit:
20 September 2017
21 September 2017
25 September 2017
04 October 2017

Date of publication:
06 November 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 20 and 21 September 2017 and was announced. This was to ensure that someone would be at the office to meet with us.

Allied Healthcare Maldon provides two distinct services. One is a domiciliary care service providing long term personal care to people living in their own homes. The other is a short term reablement service providing care and support for up to six weeks of rehabilitation after being in hospital. The domiciliary care service covers the areas of Maldon and Basildon, whilst the reablement service covers the whole of Essex except for Southend on sea. At the time of our inspection there were approximately 470 people using the service, the majority of which used the reablement service.

The service had a registered manager in place. 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.

People were kept safe by staff who had the skills and knowledge about safeguarding and protecting them from harm. Staff knew what they would do if they had any concerns about a person's health, safety or wellbeing. We saw that comprehensive risk assessments and care plans were in place to ensure that staff were aware of how to support people to remain safe in their homes and to be as independent as possible.

There were sufficient staff to meet people's needs and to manage risk safely. The recruitment process for all new staff was robust and all the required checks had been completed.

The registered manager and staff had taken steps to ensure that accurate medicine records were in place and maintained. People received their medicines as prescribed. We made a recommendation that the provider ensures that the medicine policy and procedure reflect current working practice guidelines.

Staff had access to relevant training and regular supervision to equip them with the knowledge and skills to care and support people effectively. They were aware of the principles of the Mental Capacity Act (MCA) 2005 when people did not have capacity to make their own choices and decisions. People or their legal representatives signed their consent to their care arrangements.

The service was meeting the Accessible Information Standard by ensuring people's sensory and communication needs were met.

Support with food and drink of people's choice was provided and records of people's food and fluid intake were kept if staff had concerns. Staff worked in cooperation and liaison with health and social care professionals to ensure that people received appropriate healthcare and treatment in a timely way.

Staff were kind and caring and treated people with dignity and respect. People and their families were involved in their care arrangements and on-going support plans.

Robust systems to monitor the quality of the service were in place. These included processes to support people if they wished to complain or raise concerns about the service. Complaints were taken seriously and were responded to in an appropriate and timely way. The provider had appropriately notified the Care Quality Commission of any significant events as required by law.

Effective management systems were in place which included a solid infrastructure, strong leadership and a staff team with the skills and knowledge to manage the service into the future.

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.

Risks to people's health and wellbeing were managed to ensure they maintained their independence.

Sufficient numbers of staff were in place who were recruited safely.

People were provided with their medicines in a safe way and as prescribed.

Is the service effective?

Good

The service was effective.

Staff received on-going training and supervision in order to effectively carry out their role.

Staff understood their responsibilities in relation to meeting the requirements of the Mental Capacity Act 2005 and the Accessible Information Standards.

People's nutritional needs were met and healthcare referrals were made in a timely way to keep them well.

Is the service caring?

Good

The service was caring.

Staff had were friendly and kind and had developed positive caring relationships with people.

People's independence was encouraged and their privacy, dignity and wishes were respected.

People were involved in making decisions about their care arrangements.

Is the service responsive?

Good

The service was responsive.

The service assessed people's diverse and different needs and provided their care in a person centred way.

Reviews of people's care needs were completed and care plans updated to meet their changing needs.

Information on how to make a complaint was available to people and complaints were responded to appropriately.

Is the service well-led?

Good

The service was well-led.

There was visible and effective leadership and management of the service in place. Staff were supported and motivated in carrying out their role and responsibilities.

Robust systems were in place to monitor the quality of the service. People who used the service and staff were involved in its development.

The provider notified CQC without delay about any incidents they were legally required to do so.

Allied Healthcare Maldon

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.

We reviewed all the information we had available about the service including notifications sent to us by the registered manager. Notifications are information about important events which the provider is required to send us by law. We also looked at information sent to us from others, including the local authority. 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. This information helped us to plan what areas to focus our attention on for the inspection.

The inspection visit to the offices was announced and the provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to respond to our queries. This took place on 20 and 21 September. Follow up telephone calls to people who used the service were completed on 25 September and staff calls and emails completed on 4 October 2017.

The inspection team consisted of two inspectors on both days of the visit and three experts by experience who contacted people and relatives by telephone on our behalf to seek their views on the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. All of our experts by experience had experience of domiciliary care services.

We visited the offices and spoke with a range of office staff including the operations support manager, three delivery manager's and the customer service manager for the reablement service, two coordinators and the branch manager for the domiciliary care service. We also spoke with the registered manager responsible for the whole service.

The service arranged for us to meet with ten staff including a physiotherapist from the therapy team and a hospital based facilitator. We also got the opportunity to meet with four people who used the service at the office in Basildon. We spoke on the telephone with 52 people who used the service and 12 relatives. We had

contact with a further eleven care staff by email and telephone. We also had email contact with two professionals to gather their views about the service being provided.

We looked at 30 people's care records and 19 staff files. We examined information relating to the management of the service such as personnel and recruitment records, quality monitoring audits and complaints.

Good

Is the service safe?

Our findings

People told us that they felt safe with the staff who supported them. One person told us, "Having the staff come four times a day has meant that I feel safe here on my own." Another said, "Yes, I do feel safe. They [staff] make sure I have a shower safely and they give me more confidence." A third said, 'I feel very safe with them, they let themselves in, and they know exactly how to look after me." A family member told us, "I would trust them all to care for my [relative] well, and also to care for their home and possessions." Another said, "The staff take my [relative] shopping, they feel safe with them. I have every confidence that they will take great care of them." People described the staff as, "trustworthy", "reliable", and, "able to cope with anything."

The service had a system in place to safeguard and protect people from harm. The service had a safeguarding policy and procedure as well as the whistleblowing process in place and this was issued and communicated to staff when new to the service and during any refresher training.

Staff demonstrated an understanding of keeping people safe and protecting them from abuse or harm. One staff member said, "I had observed something in the hospital and felt that I needed to raise it as a safeguarding so I told them so." Another said, "I feel able to raise any concerns I have at any time." A third said, "If I have any concerns, I just come straight into the office." A fourth said, "We had a number given to us for whistleblowing. It's all there who you can go to and the telephone numbers."

The registered manager and senior staff knew how to raise safeguarding concerns. We looked at some concerns which had been raised by the service when care staff had reported being worried about a person they were supporting. The service was proactive in making the safeguarding team aware of their suspicions or concerns in order to prevent abuse from taking place. They liaised closely with the local authority on an individual's behalf. There was evidence that when poor practice by a staff member had had been identified that investigations had been carried out and disciplinary action taken. For example, one member of staff had administered medicine incorrectly, so additional training had been given and a written warning issued.

People were supported to understand what keeping safe meant and were encouraged to raise any worries with the service. They told us, "If I didn't feel safe, I'd talk to someone in the office, probably the person who visited me when I first came home," and, "I would ring up the office and talk to someone there if I felt unsafe," and, "They [staff] always say to me, if you don't feel safe or feel funny about something, ring up the office."

The provider had adequate systems to assess and manage risks safely. We saw that people and their families had been involved in discussions about risk and that these were balanced with people's freedom and choice. All of the care plans we saw had comprehensive assessments in place which were personalised and covered a wide range of topics including mobility and use of equipment, health issues, moving and positioning, personal care, skin care and environmental factors. Risks to people's mental health were also documented in relation to anxiety and stress and how to reduce this. One example of a personalised approach we saw documented for one person was that seeing a person in a uniform made them stressed

and anxious. It had been agreed that the staff would visit them without wearing their uniform and this was helping to build up trust and reassurance.

Information relating to people's finances and medicines was recorded and the potential risks considered, such as who had responsibility for managing people's finances and where medicines might be stored at the person's house for safekeeping.

Staff would clearly know from the assessments and information recorded how to support people safely and what action they should take to minimise risks to people or themselves. Risks to staff health were also noted, such as working in a smoking environment and being allergic to animals. One person had said in their care plan, "I will refrain from smoking whilst staff are on the premises," In another care plan it said, "[Name] has two cats. Inform staff in case of phobias or allergies." Information was also shared with professionals in an appropriate way when there was need to. For example, risks to a person's mobility had to be changed when their raised toilet seat had been broken. We saw that the service was liaising with the family and the occupational therapist for another to be delivered.

Up to date information about any new risks to people's health and wellbeing was transferred to the work mobile phone handset used by staff so that they were aware of any new or potential risk. This information could be updated remotely and quickly by office staff which promoted the safety of people and staff. Staff said it was a very good system as it kept people's information safe but they were able to access important information such as the code for the key safe and any medicine updates.

The registered manager told us that they had sufficient staff to provide for the needs of people using the service. The reablement service deployed staff across a wide geographical area to meet the needs of people across Essex. Two separate rota systems were in place for the assignment of staff to the reablement and the domiciliary care service.

Rota arrangements for people using the domiciliary care service were organised on a monthly basis and provided people with consistent staff who knew them well. Staff were happy with the rota arrangements as they usually had regular shift patterns but flexibility within the rota enabled them to cover for staff who were off sick or on holiday. They told us that they usually saw the same people. One staff member said, "Seeing the same people provides continuity and reassurance for them." Another staff member told us, "I had extra training days so that I could support someone with complex needs with more confidence." People who use the service told us, "[Name] usually arrives within a few minutes of the time I need them," and, "They always stay and do everything I need help with. They always make time for a chat as well, which is nice because it gets very lonely when you're housebound and on your own."

The rota arrangement for the reablement service was more complex as people who used this service changed daily with people coming to the end of their reablement and those just starting with the service. The service employed a team of planners who worked to prepare and manage a system of rotas to enable people to receive their service within a set timescale.

People were given information at the start of the service about the timescales in which their visit would take place. This was usually between a three hour time slot in the morning and evenings with a two hour slot during the day. The service was also not able to guarantee a preferred specific time, unless the person needed their medicine or food/drinks at particular times. These visits were recorded and allocated as 'time critical' calls.

People had mixed views about the times of the visits. Some people told us that visits were often later than

they preferred but that the staff would arrive within the three hour time slot. One person said, "I was told straightaway that I wouldn't be able to have specific times for the calls, but they do vary drastically. Last week, my night call didn't happen until 11pm. By then, my [relative] had helped me to bed." Another person told us," When I met with the manager, they told me that they don't have set times for calls. I was given four slots at different times of the day. It took a bit of getting used to, I must say, but now it's settled down and I just wait until they arrive." A third person said, "Well they should be here at 8am and it was 11.15am this morning and they didn't let me know they would be later."

Some people told us that the times of having help with their medicines varied depending on when the staff arrived. We saw records which showed that people had missed their medicines and the reasons for these late calls. These had been picked up as complaints and dealt with appropriately. One person said, "I have help with my tablets. One day I'll take them at 8am and another day it will be 9am, but I can only take them when the staff arrive." A family member said, "[Relatives] tablets are not always given at exactly the same time in the morning because of never knowing when they are coming but they always get them so it's not a problem."

However, the majority of people did tell us that whilst they had to wait for care staff to arrive, they had not been let down by the service or were left unsafe because of the late call. They said it was more an inconvenience to their daily life and only for a short period. One person said, "They have been late a couple of times, but they never let me down completely." Another told us, "They have never let me down but it can be anytime between 7am and 11am." A family member said, "We can expect them anytime. We just wait for them to get here. I can't remember them ever letting us down

Other people told us that staff did all that was expected of them, arrived on time and left on time and they understood how busy they were. One person said, "Sometimes, they are clock-watching but they take their time with me. It never makes them unkind or irritable." Another person told us, "I've never noticed them leaving really early. We usually get everything done in about 20 minutes but they never mind helping me with extra jobs most days." Most people told us that they had care and support from a range of staff who were regular. They said, "I have my usual ones unless someone is off sick or on holiday," and, "I have one or two different people and this is my third week and they are getting better at sending the same people," and, "I have one or two different ones but they are all nice," and, "There is a lot of chopping and changing as some staff left who have all been fantastic, can't fault any of them."

Systems and processes were in place for the safe recruitment of suitable staff. Checks on the recruitment files for 19 members of staff showed that they had completed an application form detailing their employment history, provided photographic proof of identity, satisfactory references and their eligibility to work in the UK had been obtained. The provider had also undertaken Disclosure and Barring Service (DBS) checks on all staff before they started work to ensure they were not prohibited from working with people who used health and social care services. We saw from the records that the interview process was robust. Applicants were considered on the qualities needed to become a care worker such as caring and respect, dignity, reliability, and how they might deal with challenging situations. This process enabled managers to make safe recruitment choices.

People received their medicines safely and as prescribed. Care plans included information relating to people's medical needs, the medicines they required and any risks to their health such as any known allergies. We saw that the service had an up to date policy and procedure for the administration of medicines. We found that information in relation to the medicine Warfarin (an Anticoagulant) was not clearly documented in the policy. The registered manager told us that when people were being discharged from hospital with Warfarin tablets and their levels fluctuated, medicine support wasn't offered to these

people unless their levels were stable. The medicine policy and procedure did not reflect this way of working.

We recommend that the provider ensures that their medicine policy and procedure reflect current working practices and follows the National Institute for Health and Care Excellence (NICE) guidelines.

Most people took responsibility for their own medicines. Those who needed support with this told us that staff were efficient and confident in dealing with their medicines, creams and eye drops which were administered when needed. One family member said, "There was a query once about my [relatives] tablets. They [staff] didn't just keep going with it; they rang me and suggested I check it out with a doctor. They're on the ball with stuff like that." One person said, "I have help with my morning tablets. They hand them to me with a drink and when they've seen me take them, it gets written down in the book."

Staff had received training in the safe administration of medicines. Competency checks were conducted by senior staff during spot checks at the person's home. We saw from information recorded on these checks that any issues identified were then used as part of the individual staff member's supervision or they were required to attend further training. The medicine administration records were audited when they were returned to the office to make sure that they were being completed correctly and people were receiving their medicines as prescribed.

Good

Is the service effective?

Our findings

People were supported by knowledgeable and skilled staff who effectively met their needs. Training records showed that staff had completed a range of training in topics relevant to caring for people such as moving and repositioning, safeguarding people from harm, mental capacity, first aid, medicine administration, food safety and fire awareness. This was up to date with dates included when refresher training was required. Staff told us that they had also received training to meet people's specific health needs such as dementia care and catheter care. Staff were supported to complete vocational qualifications in social care to enhance their learning and knowledge. One person told us, "[Name of staff] was worried about my leg which seemed very red. They rang 111 but were not very happy with their advice, so they rang 999. I ended up in hospital with cellulitis. I was so grateful to them. That's how good they are, very well-trained, and they know what to look for. I wouldn't have noticed."

A staff induction process was in place. It consisted of three days face to face training by in house trainers to understand the principles of working within health and social care; online topic based learning to back up what they had learnt and the completion of individual topic based workbooks covering the essential subjects needed for their role. The operations support manager told us that the completion of the workbooks was at the staff members own pace but were completed usually within the 12 week induction period. We did not see any of the completed workbooks within the staff files we looked at but staff confirmed they had completed them as well as a range of other training.

Staff undertook coaching and shadowing experienced members of staff to support them to be confident in their role. There was evidence that the manager followed up with the staff member following their first shift and at specific intervals to talk through any concerns or challenges they may have had. Staff told us that this process equipped them for their role. They were also asked to share their views and experiences about how they had found the coaching. A staff member told us about their experience. "I was invited to attend an hour long face to face interview and I started four weeks later and was given four days training followed by three days shadowing. The training consisted of a day learning about the reablement service followed by three days of training such as moving and handling and safeguarding. During the shadowing, I filled out all of the booklets to confirm that I was competent and up to scratch. I had regular meetings after one month and then at nine weeks to ensure that I was okay and gave me a chance to raise any issues."

One to one sessions also included a competency check and observation of practice. These checks looked at areas such as if the staff member was communicating effectively with the person and was treating them with dignity and respect, that good hygiene procedures were being used, use of equipment and the adequate recording in the daily notes of care given in relation to nutrition, hydration and personal care. A specific medicine competency check was also carried out. For example, if the person had the right medicine and right dose and this was given at the right time. Any issues were picked up and discussed with staff members to improve their practice.

Staff told us that they were supported and they could talk to any of the managers at any time. They said, "I feel really listened to," and, "If I ring up, the message gets relayed and they get back to me," and, "We get

heard by customer services and planning, not just the bosses so I feel really supported."

Staff received recorded supervision at regular times which included agreements and areas for development. Appraisals were held annually to discuss performance, progress and practice. When staff had not been in the role for 12 months or over, a 12 week probation review had been completed. Staff meetings were held so that staff could come together to share information and discuss their work. One staff member said, "I feel well supported and have been given the tools to do the job." Another said, "Six months down the line and not a lot throws me now." A third told us, "I got real good support especially when I was out there on my own."

Communication across the service, both internally and externally, worked well. People who used the service told us that care staff communicated well with them and office staff were always polite and would try to help them with their query or concern, although sometimes it was hard to get through on the phone to the office. A family member said, "They know [name] so well and write everything they do in the book which helps us. They also leave notes for us if they need to report anything to the family, or they'll ring us if necessary."

Staff told us of ways in which communication could be better. For example, sometimes information they received about people on the App they used on the mobile phone system was not as full or updated as quickly as needed, so they went, for example, to people whose calls had been cancelled. Also when the office staff sent messages, there was not enough space on the App to add in all the necessary information which meant that care staff had to phone up to receive the last sentence. The registered manager told us that the system was getting better all the time and these issues were being resolved as part of the improvement plan for the service.

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

Staff had received training in the MCA and understood the principles relating to people's right to consent and their capacity make decisions about their care. We saw that care plans considered people's capacity levels and that decisions taken in their best interests were made by the people who were able to make those decisions on their behalf, for example a Lasting Power of Attorney (LPA). We saw that it was recorded where people had a LPA involved in protecting their rights. People or their representatives had signed their agreement to the care and support provided in all except one of the care plans we looked at. When people had fluctuating capacity, best interest decisions around day to day tasks were kept flexible. For example, "What [name] wants may change on any given day. Also they may not realise the changes in the weather and that it is getting cold and they need to wear their cardigan."

The service was meeting people's information and communication needs. Their needs had been assessed and were reviewed and appropriate support was in place to enable them to make their needs known. For one person, whose first language was not English, a set of three cardboard cards were used by them in their bathroom to inform the staff if they wanted a 'lower body wash please,' a 'full body wash please,' or a shower,' each day. For another person, whose first language was British Sign Language, an interpreter assisted the assessment and review process so that both parties could effectively communicate with each other

Staff supported people to eat and drink in line with their preferences. We saw that information was available for staff about how to support people to eat, what they liked to drink and what sort of food they liked. Examples of people's choices and preferences included, "[Name] has a Hindu diet and they will tell you what they have," and, "[Name] likes salad with each meal," and,"[Name] used to be a chef and if they do not like the food then they will not eat it," and, "[Name] prefers cheese and pickle." One person told us, "I am only allowed certain things because of my diet but they [staff] are aware."

Where people required specialist diets because it had been identified that they were at the risk of choking, professional advice about their eating difficulties and ways to ensure they could eat and drink safely were recorded in two of the care plans we saw. However, we saw in one care plan that a person needed support to eat safely as they were at risk of choking and there was conflicting information for staff about what to do if this occurred. For example, the referral from a speech and language specialist stated that the person should have a textured diet which means that food should be mashable. The care plan stated that this person's food should be cut up into small pieces. The registered manager told us they were currently reviewing this situation with the person's relative who was very involved in the preparation of their meals.

The daily notes recorded the help that people had with the preparation of their meals and drinks and how they were managing in doing this task if this was part of their reablement. Any changes or concerns such as the person having no appetite or feeling unwell were recorded so that this could be monitored. One person told us, "A staff member comes and helps me get a meal at lunchtime and they help me make a sandwich for my tea which then sits in the fridge until I want it. My arm has got a lot stronger and I can do almost everything now for myself again." Another person said, "My staff member cooks me a ready meal for my lunch. They always ask me what I'd like and they will usually leave me some biscuits to have during the afternoon if I get hungry."

People's care records showed the involvement of health and social care professionals. We saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. We saw effective communication and liaison with people's GP's, the mental health team, social workers, speech and language, physio and occupational therapists. Records reflected the advice and guidance provided by external health and social care professionals. This meant staff had the correct information available to work with professionals to ensure the individual needs of the person were met effectively.

The provider had employed a number of health care professionals such as occupational and physiotherapists as part of the care team to work with people using the reablement service. Allied Healthcare facilitators worked directly with the hospital discharge teams and took referrals from wards and therapy staff at Broomfield, Colchester and Basildon hospitals. One facilitator told us that they can also refer to other specialists if the person was not appropriate for the reablement service at that time. They said "There are some pressures to get people out of hospital but good liaison, communication and the right support were the key ingredients of a successful hospital discharge." They also said, "It can be pretty full on some days. I enjoy it. It is a really good service for some people who are in hospital. We can then signpost for further support or on-going care if, at the end of the six weeks, they still need support."

People who used the longer term domiciliary care service had the input of nurses to advise and support staff in working with people with more complex health conditions. Staff commented that more liaison and sharing of knowledge about working with people with long term and life limiting conditions would be worthwhile and valuable. We shared this information with the registered manager.

Good

Is the service caring?

Our findings

People were very complimentary about the staff who supported them and told us they were, "Kind and professional, friendly and helpful." One person said, "I was concerned at the prospect of having strangers in my home. We've been very impressed and pleasantly surprised by the quality of the people who come. The staff are bright and cheerful, chatty and friendly, and will do anything I ask of them." Another told us, "They [staff] are absolutely wonderful. I would be lost without them." A third said, "My six weeks care had just finished. The staff were very pleasant and friendly, and really cared for me well. They've got me back on my feet again." Family members also praised the service. "The staff are all lovely, always happy and cheerful which makes such a difference," and, "They [staff] have really helped my [relative] improve and now, six weeks later, they are able to look after themselves. The encouragement and support have really spurred them on."

Good relationships had developed between people, their relatives and staff who visited them. A family member said, "The staff are all lovely, always happy and cheerful which makes such a difference." One person said, "They all find time to have a chat with me." Another told us, "The six weeks has just gone so quickly, that I don't think that really anybody has had a chance to really get to know me properly, and I certainly haven't got to know many of the staff very well. I can't fault them however, because now going forward I will be back to looking after myself, which, when I first came home I thought would probably be impossible. I will always be grateful to all of the staff for their help and care to get me to this point." Staff told us that despite only knowing some people for a short period of time, they got to know them very quickly. They told us they had a sense of pride too when people didn't need them anymore. One staff member said, "It's great on one hand and sad on another when we say our goodbyes." Another said, "I love the people I go to, it's never a chore or a task, I never think of my work like that."

People told us they were listened to and involved in their care arrangements. One person said, "When I first came out of hospital they listened to me. I still felt I was in control of things in my own home. I appreciate all their kindness and thoughtfulness to me. I've improved in the last few weeks. We're going to discuss soon about them coming just once in the evening." One family member told us how flexible the service was around her need for respite care. "I am grateful that the agency understands my [relative's] needs so well as they won't have anyone else other than [staff member's name]. Allied understand that and won't send anyone else, only them. If they are not available, they'll change the day or time for me. I know that I can safely go out and not worry for a few hours. It's such a relief." Another family member said, "The service was efficient and reliable when my [relative] needed an early visit because of a hospital appointment. I specifically asked for an early visit that day, and they came at 7am, which was plenty of time. It meant that [relative] didn't have to rush around, which was great."

People told us they were encouraged and supported to be as independent as possible. One person told us, "I have been really pleased with the help that I've been given by the staff and it is lovely to be back to my old ways not having to rely on anybody else to help me. Another said, "I'm improving, and they've helped me enormously. They're lovely, well-trained, capable people. I know they would do anything to help me." A third said, "They look after me very well. They always make sure I am wearing my pendant." A family member said,

"They [staff] don't take over, they encourage my [relative] to do as much as they can."

Staff knew the importance of respecting and promoting people's privacy and dignity and gave examples of how they did this. For example, "Making sure I find out how people like things done," and "You need to introduce yourself and show your badge, and if you are doing anything personal for someone you need to gain their consent." A family member told us, "The staff are really good. They will notice things like, if the bed sheets are dirty and they will strip the bed and make sure [name] is comfortable. Little things like that make a big difference to be honest." One person said, "They are very good when helping me shower, very respectful and let me do as much as I can for myself." Another person told us, "They always are very respectful and treat me well."

People said they were always spoken to in a friendly, polite and respectful way. One person said, "I had a new staff member this morning, who I had not met before. They introduced themselves and showed me their ID badge. I really appreciated this as it gave me peace of mind." One family member said, "I hear them chatting away to my [relative] and it's so nice. They are lovely people, very respectful, and friendly and cheery. They are gradually giving him his confidence back in a gentle, sensitive way." Staff said that the best thing about their jobs was the people they were supporting. Staff commented on the diversity of the people they worked with and how they enjoyed supporting people with different needs. A member of staff said "It is really good because it keeps your knowledge up to date and it varies the care you are giving." Another said, "I don't know any staff member that is not caring and kind, that's why I work for Allied."

People's records and documents were kept securely in the service's office as well as on the computer system. Paper copies were available in people's homes and available in case there was a problem with the electronic system.

Good

Is the service responsive?

Our findings

People contributed and were involved in the assessment of their needs and support arrangements. Their long and short terms care needs had been assessed before receiving either the reablement or the domiciliary care service which helped to ensure the service was the right one to meet their needs.

We looked at 30 care plans. Each file contained assessments that had been carried out to identify people's individual support needs and the care plans contained appropriate information detailing how these needs should be met. Documentation included information about the person's background, any cultural needs, sensory needs, medical conditions and capacity and decision making. Risks to people's health such as nutrition, skin integrity and slips, trips and falls were clearly identified. We also saw in the care plans that people's sensory needs were recorded. This included any hearing loss and use of hearing aids, if they wore glasses or their vision was impaired. Advice to staff in one care plan stated," Staff must speak slowly face to face and do not stand in front of [name] with the sun behind you." This showed that the service took into account people's different ways of communicating and were considerate in meeting them.

The care plans were written in a person centred way with people's likes, dislikes and preferences recorded, for example, "[Name] likes their hair platted," and, "I want to be clean and presentable daily". Also recorded were the outcomes people wished to have after their reablement, for example "I want to be able to live safely in the home I share," and, "To be able to manage on my own." People said, "I have a care plan and they do stick to it. They come from the office to look at it," and, "I think it is in the folder, someone from the office came to do an assessment, and, "Yes there is one but when they only have 15 minutes there is no way they can read it all, but they know what to do anyway."

The registered manager told us that people could have a choice about the gender of the staff that provided their care. This question was asked as part of the initial assessment. In some people's files we saw that people had expressed a choice of having a male or female staff member to assist them. In other files, this was not recorded; however, we were shown on the computer system that this preference had been noted.

We saw in the files that for one person only female staff should assist them due to cultural reasons. A family member told us that their [relative] was initially very concerned when a male staff arrived, saying, "When they first walked through the door [relative] was startled and worried. However, [name of staff member] is so nice and polite that they soon got on well and they looked forward to seeing them." However, some people could not remember being asked their preference and it was important to them that they did not have a male staff assist them. We raised this with the registered manager who assured us that within the daily and weekly checks with people, there was an opportunity for people to raise any issues they had and their wishes would be respected. They said they would pick this issue up and discuss with their managers.

Care plans were reviewed regularly and updated if a person's needs changed. We saw questions which promoted the reviewer to check if the batteries were working correctly on people's hearing aids and if their clothing or their jewellery was becoming too big for them as an indication that they were losing weight and action could be taken. One person said, "They do check on me from time to time, and update my care plan

occasionally. I'm not going to get any better, but they don't just leave me, they like to know I'm getting the right care."

The daily records about the tasks undertaken for people were written in a respectful and sensitive way and in handwriting which was legible. Any change to people's mood, emotional state, health or behaviour was noted so that this could be monitored if required.

We saw that a system of dealing with complaints was in place and they were thoroughly investigated, recorded and clear actions taken. Communication with people who used the service and their relatives was recorded and people received formal written outcomes from their complaints. The service listened to the complaints and used the learning to make improvements to the service.

People told us that they knew who to contact if they had any concerns or complaints. We saw that information about the service including the complaints process was clear and easy to read. People said, "I'm sure I remember seeing a leaflet in the folder where the care plan is and where the staff write the records every day," and, "We were given a leaflet about how to make complaints which I think, set's out everything so that you know how many days everyone has to respond by and what you should do if you're not happy with the outcome," and, "I have spoken to them about the quality of some of the staff and I have asked for one or two not to be sent back to me, which they have noted. They have always apologised and I've never been made to feel guilty for mentioning it."

People told us that if they needed to contact the office, they would be confident that they would be listened to and their concerns or requests dealt with. One person said, "Because of my health needs, I have to have my calls at a certain time. They kept coming at four pm to do my dinner which is far too early. Since ringing up to complain they've been very reliable." A family member told us, "We were unhappy about a particular member of staff. We asked for them not to come back, and they haven't been. The office have been very good about it. The manager even rang my [relative] to say they were investigating. My [relative] was grateful that the incident was clearly being taken seriously." Another family member said, "I was very impressed by the response I received to my complaint. I was sent a letter telling me that it was being investigated. I find the office staff very approachable whenever I need to ring them. They are helpful, take me seriously, and do what they promise."

Compliments about the service had been sent in by people and their families and were recorded. "Staff go way above and beyond to help us," and, "The tips on how to do things was a great help."

Good

Is the service well-led?

Our findings

People told us that they thought the service was well led from their experiences of the care provided, contacting the office and how their complaints had been dealt with. As the majority of people using the service were only receiving a short-term package of reablement towards independence, they were often not able to comment in any great depth on the management of the service. People's comments included, "I don't know the manager but everyone in the office is helpful when I call them," and, "A manager came to do an assessment and they were very helpful. They all are if I have to ring for anything," and, "Whoever makes decisions should be congratulated. They employ exactly the right people in my opinion. I feel safe and relaxed with them all."

Regular feedback on the quality of the care people received had been gained from those using the service, their relatives and staff. This had been achieved in a variety of ways and included telephone calls, surveys, reviews and supervision. The last survey of the reablement service was undertaken in April to July 2017. It showed that people were satisfied with the service and they provided some very positive and useful comments for the service to learn from. Any negative comments were dealt with directly with the person. The response to the staff survey for the quarter June to September 2017 had also been positive. For example, over 80% of care staff said their manager/branch team regularly engaged with and provide information in a timely and positive way and it was good place to work.

There was a registered manager in post. They provided good visible leadership for the management team. They understood their role and responsibilities and were supported themselves to manage the service well. Resources had been made available to drive improvement during 2017 when the service had moved offices and the on-going improvement plan was used to monitor progress and achievements. The registered manager told us that now the systems had been in place for a while and people were feeding back their views, they could see the improvements which were needed, for example, looking to reduce the three hour time slot for calls in the reablement service.

The staff told us that they had seen improvements with the service which they had been part of. Staff said they were supported by their managers and the office staff who were available and accessible to them. The staff across all departments praised their colleagues for working so well together and for wanting to make the service as good as it could be. Staff told us they had been kept informed of planned changes through meetings and newsletters and had seen that things that were talked about during the year had happened. One staff member said, "It is almost as if Allied has been reabled."

The registered manager and the management team were open and transparent with the staff and welcomed the sharing of information and promoted dialogue and communication across the service. Staff comments included, "The registered manager is really receptive to meetings if you want to see them," and, "My manager is approachable and supportive. We wouldn't get the support we do if it wasn't for [name] as they push for everything," and, "My manager is really good and on the ball."

There was a robust quality assurance process in place. The managers and teams worked together to assess

and monitor the quality of the service. There was a comprehensive data management system which recorded, actioned and processed all complaints, concerns, accidents, incidents, missed and late calls, rota arrangements and planning and costumer services information. This system provided the registered manager with an understanding of quality, people's views and experiences and improvements required to the service.

Internal audits were carried out on the recruitment files, the care plans, the medicine administration records, supervision and competency of the staff which ensured the correct records, information and checks were being carried out. One professional told us, "The structure, systems and processes in place are much clearer and appear to be working well." Another said, "I would say they are a safe and trustworthy provider that understands the importance of delivering the best outcomes for people."

The registered manager was continuing to learn from the investigations, governance and management arrangements and processes in place. They were also proactive in developing quality tools such as the efficiencies of technology in enhancing and driving up the delivery of good quality care.