Nestor Primecare Services Limited

Allied Healthcare Beccles

Inspection report

Hipperson Mews
53a Station Road
Beccles
Suffolk
NR34 9QH

Tel: 01502714405

Date of inspection visit:
19 January 2017
26 January 2017
08 February 2017

Date of publication:
12 April 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was announced and took place on 19 January, 26 January and 8 February 2017. We gave 48 hours notice of the inspection as we needed to ensure that the appropriate people would be available to speak with us. The service provides personal care and support to people who live in their own homes. At the time of our inspection the service was providing personal care and support to 350 people in their homes.

A registered manager was in post at the time of the inspection. 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.
At the last inspection in January 2016 we asked the provider to take action to make improvements in the supervision and appraisal of staff and their quality monitoring. At this inspection we found that improvements had not been made.

After our previous inspection the service had also put in place actions to ensure their quality monitoring was effective. However at this inspection we found that these actions had not achieved the required improvement. Audits had not always been effective in identifying problems, for example the length of time carers were spending with people to provide their support.

Staff did not receive regular supervision and appraisal. The service had put actions in place to address the supervision of staff after our previous inspection, however, these had not been sustained. The service had identified that there was an issue prior to this inspection and had put actions in place to address this.

Our previous report had also identified that the service was not complying with NICE [National Institute for Health and Care Excellence] guidelines on the scheduling of travel time between visits for carers. At this inspection we found that the service was still not compliant with the NICE guidelines.

Care records detailed the care and support people needed to remain safe whilst having control and making choices about how they lived their life. Each person had a care file which also included guidelines to make sure staff supported people in a way they preferred. Risk assessments were completed, reviewed and up to date.

People told us that staff were caring. During home visits we observed positive interactions between staff and people. People said they felt comfortable with staff supporting them. Staff treated people in a dignified manner. Staff had a good understanding of people's likes, dislikes, interests and communication needs. This meant that people were supported by staff who knew them well.

People's medicines were managed effectively and safely.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The service did not ensure that there were sufficient staff to meet people's care needs.

There were safe medication administration systems in place and people received their medicines when required.

Risk assessments had been carried out to ensure that any risks to people were identified and actions taken to mitigate these.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive regular support and supervision to ensure good practice.

People were supported to maintain a healthy diet by staff in accordance with their wishes.

Staff supported people to access healthcare services as required.

Is the service caring?

Good

The service was caring.

People felt their care staff knew them and their likes and dislikes.

People were involved in planning their care and support.

Care was provided to people in a dignified and respectful manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care was not always provided for the required amount of time or at the required time.

Care plans provided staff with clear guidance on how to meet people's individual needs??

The service had a complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

Audits were not effective and did not identify shortfalls in the quality of service.

Improvements in the quality monitoring of the quality of the service were not sustained.

Allied Healthcare Beccles

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.

This inspection took place on 19 January, 26 January and 8 February 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to speak with us.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had experience of supporting an older person.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service including previous inspection reports and notifications sent to us by the service. Notifications are information about important events which the provider is required to send us by law. We also collected feedback from commissioners and other health care professionals.

As part of the inspection we spoke with 12 people receiving care and support and four relatives. We visited three people in their homes where we were accompanied by care staff. We looked at 11 people's care plans. We spoke with the registered manager, the branch manager and eight care and support staff. We looked at records relating to the management of the service and systems for monitoring the quality of the service. We looked at 10 staff files which included recruitment processes, supervision and training records.

Requires Improvement

Is the service safe?

Our findings

Our inspection of January 2016 found that the service was not managing medicines safely and that people were not always receiving their medicines as prescribed. At this inspection we found that the service had improved their process for administering medicines with improved supervision of staff and medicine recording. Where audits of medicine records identified issues, action had been taken to address this. For example where a member of care staff had not signed a medicines record, they were spoken with about this so their practice could improve. People told us they were happy with the way staff administered their medicines. One person said, "I feel very confident they know what they're doing." A relative told us that they thought that medicines administration to their relative was "Well managed." Records and policies we looked at as part of our inspection showed that medicines were appropriately managed.

A small number of people told us that they had had visits missed by the service. One person said, I was sitting in and thought a carer hasn't called today." She continued, "I did tell the [person] who came to my review [person] said [person] would look into it but I haven't heard anything." The registered manager and branch manager told us staff rotas were planned so that the majority of staff visited the same people on a regular basis, a process the service called 'templating'. They told us that this enabled them to plan rotas effectively. However, figures supplied to us by the service showed that between July and December 2016 the service had recorded 17 visits on their monitoring system where their carer had 'failed to attend', three visits as 'no carer' and one visit as 'unable to cover'. In January 2017 four visits had been re-scheduled by the branch, three visits had been recorded as 'no carer' and one visit recorded as 'unable to cover'. Healthcare professionals gave us three examples of where visits had been missed since December 2016. This did not demonstrate that the service ensured that there were sufficient staff working in the right place, at the right time.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were robust and only suitable staff were allowed to work with people. Staff records showed the provider interviewed applicants for jobs and took up references and criminal record checks before they were allowed to work with people. This ensured that people received care and support from staff that were suitable to work in this type of occupation.

People told us they felt safe when receiving support from the service. One person said, "It's their manner, they're very friendly, do their job, very professional." Staff knew their responsibility in keeping people safe from harm. They could describe signs of potential abuse and understood how to protect people if they had safeguarding concerns. They told us they could to raise concerns with their managers and were also confident that their managers would investigate it accordingly and take necessary actions to protect people. One member of staff gave us an example of a safeguarding incident they had reported which demonstrated their awareness of the process.

Care records contained a guidance sheet on 'Early Warning Signs'. This guidance alerted care staff to signs

which may indicate a person was becoming unwell, and who they should raise it to. People's daily log of notes made reference to checking this, demonstrating that care staff had considered the person's well-being during their visit.

People's care records included risk assessments and guidance for staff on the actions that they should take to minimise risk. These had been reviewed to ensure any needs which had changed were updated. These included risks such as those which may occur in a person's home environment, skin integrity, falls, nutrition, and moving and handling. Additional information was also available to guide staff, such as what causes pressure ulcers to develop, and how to prevent them occurring. Making this information available meant that care workers could understand how to support people more effectively.

Risks to people injuring themselves or others were limited because equipment, including hoists and electric beds, had been serviced and checked so they were fit for purpose and safe to use.

Requires Improvement

Is the service effective?

Our findings

Our inspection of January 2016 found that the service was not providing adequate supervision of staff and the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had provided us with an action plan as to how this was going to be addressed. This included actions to ensure all care staff received at least two field supervisions each year, and a Personal Development Review (PDR) at six and 12 months. Field supervisions and PDR's are methods to monitor and develop staff practice. These actions were to be monitored by the management team and implemented by a designated member of staff.

In their PIR the service acknowledge the importance of regular and effective supervision of staff. At this inspection we found that the action plan had not been effectively implemented. Care staff had not had the required number of supervisions and PDR's. The registered manager told us that this had been recognised as a problem in November 2016 and the designated person with responsibility for monitoring supervisions and PDR's had left the organisation. They went on to say that all care staff files had been checked and there was an action plan in place which was currently being worked through to address the identified deficiencies.

Care staff we spoke with had mixed views on the quality of the supervision and support they received to deliver good quality care. One member of care staff said, "Supervisions, they are non-existent." Another person said they received regular supervisions and they were, "Mostly" constructive.

This did not demonstrate that the service could sustain improvements and represented a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On joining the organisation, staff completed an induction training programme which included a period of work shadowing experienced staff. Staff we spoke with said they were provided with appropriate training to carry out their role effectively. There was a programme of core training, including safeguarding, fire safety, moving and handling, health and safety, medicines awareness and a system in place to make sure staff were kept up to date with refresher training.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. People told us that their consent was sought before care and support was provided. One person said "It's all in my plan so they know what to do; they do check it's alright to do things first." Another person said, "They always ask me first, for

example when they dress me they always check if they can go through my wardrobe."

People's care records made reference to their mental capacity, and choices that staff should encourage people to make for themselves. These included every day decisions such as choice of clothing and preferences on what to eat. There was also a 'best Interests screening tool', which was used to record decisions that were made in a person's best interests. It also acted as a guidance tool for staff by describing what constitutes day to day decisions, more complex decisions, and who should be involved in these situations. Records also included documents which had been signed by people to consent to the care provided as identified in their care plans.

The support people received with their meals varied depending on their individual circumstances. Where required, people were supported to prepare food and maintain a balanced diet. For example one person said care staff helped them with their breakfast. They said, "They say what do you want, I say cornflakes with a banana usually." They went on to say they had a specific medical condition and were, "Confident they [care staff] know what they are doing." Records showed that people's dietary needs were recorded, for example, those on a diabetic diet, or on food supplements.

People were supported with their health care needs. Referrals were made to other healthcare professionals such as the dietician and occupational health when appropriate. One person said, "Carers phone up for me to get a doctor if I need an appointment. If I need to talk about something I don't mind speaking to my carers."

Good

Is the service caring?

Our findings

People told us that they were able to develop good relationships with their carers. One person said, "[Carer] knows me well enough by now, yes they know my likes by now." Another person said that when she feels, "A little down," carers sit and talk and say, "Come on you've come this far. It keeps me going, they keep me together." Care staff told us that their rotas were planned and that they usually supported a regular group of people. This was confirmed by the manager who told us that calls were templated to ensure people received support from a regular team of carers.

People told us how they were involved in decisions about their care. One person said, "Someone comes out and we write the care plan together." Another person said, "When changes are needed we talk about it. [Service senior] comes out and just talks to you." We accompanied a member of staff on visits to review people's care plans and saw this was discussed thoroughly with the person covering all aspects of the support they received.

People's privacy and dignity was promoted and respected. One person said, "Yes they I think so, for example I have to have a bed wash, they make sure the door is shut, they close the curtains so it's all private." Care records made reference to the importance of ensuring people's care was individualised and their privacy maintained. Daily care plan summary sheets were included in care plans, and were written in a way that demonstrated that people had been involved. Statements were constructed by people, for example, "I would like you to assist me to undress" and, "Maintain my dignity at all times by placing towels across me". In another care plan we saw that one person had said they were sensitive about a medical procedure they had, which altered the appearance of their body. The care plan documented the language care staff should use to ensure the person was made to feel comfortable when they were assisting them with personal care. This demonstrated that people's individual views were considered and incorporated into their care plan.

Where people were being transferred using a hoist, guidance showed that their dignity was considered, for example, one record said, "One carer to take the lead, and explain to me what is happening. Reassure me and communicate with me throughout the transfer".

People were supported to be as independent as possible. One person said, "I can potter around and do my own pot of tea, they always encourage that." Another person said, "I do as much as I can, they help me to keep doing that."

When speaking with people and staff and visiting people in their home we found that, despite organisational failings, staff were caring in their approach to supporting people. Staff demonstrated this when speaking with us about how they managed their visits to ensure that people received the care and support they needed despite not being allocated time between calls.

Requires Improvement

Is the service responsive?

Our findings

During our inspection of January 2016 people had expressed concerns regarding the punctuality of care staff. We found that care staff were not being given sufficient time between visits to ensure they arrived punctually. We pointed out in our report that this was contrary to NICE guidelines. At this inspection we found that people were still not receiving their visits punctually and visits were not being planned for the times people requested and care staff were not always staying the required amount of time.

People told us that care staff not visiting at the required time could impact on their health and well-being. One person described how, "If I have meds, I have to eat, so if I have to wait until the afternoon to eat, I have to wait until the afternoon to have my meds." Another person said, "When the carers are late, I can't take my pills as they need to help me." Another person said, "Sometimes they come in and get out as quick as possible. Some only stay five or 10 minutes [instead of half an hour]. For example just this morning [carer] was here for 10 minutes." Another person told us they had requested their visit times to be changed at their review just before Christmas but had heard nothing.

Care staff we spoke with told us that their rotas did not allow time to travel between visits. They described various ways that they compensated for this to try and ensure that people received the care and support they required. These varied, but included starting visits earlier, not taking breaks and "Pinching a couple of minutes here and there." When asked what effect this had on the people they supported one carer said, "It happens so often they are just accepting." They also told us that this could cause them problems when attending a visit which required two carers as one would often be late.

Care staff rota's we looked at demonstrated that care staff were regularly scheduled to attend visits with no travel time in between to allow them to get from one location to another making it impossible for them to meet the schedule. Daily record entries made by care staff demonstrated that care staff did not always stay the required amount of time. For example one person had been assessed as needing one hour of support each morning. However, the daily record showed that for one week in September 2016 they had received between 36 minutes and 45 minutes of care each day. The service was not meeting this person's assessed care needs.

Care was also not provided at the time people required it. For example one person's care plan stated that they required support from 6.45am to 7.30am. We checked the recorded start times for one week in January. These varied between 7.35am and 8.30am. Their evening visit was required at 4pm, and the times for this visit varied between 3.40pm and 4.55pm. A health care professional told us about a person who required a visit at 6am as this was the time they usually got up. However the carer had not arrived until 10.30am which had caused the person to become agitated.

The manager told us that the daily record was audited when it was returned to the office. We asked to see what the audit checked. We found that it did not address if the person was receiving their allotted time at the time they required.

This continues to be against the NICE guidelines and is a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views as to whether the service listened to their concerns and complaints. One person said they had a care review every six months and was able to give feedback but said, "It doesn't really change anything though." Another person said that their care plan was reviewed, "by the one who comes out and just talks to you. You have to tell them that they [carers] are paid to stay for half an hour, but nothing has changed." However another person told us about a formal complaint they had made and that, "Allied seemed to listen and things got better."

The service had a complaints procedure where each formal complaint was recorded on the computer system which was monitored by Allied head office to ensure it was dealt with appropriately and within timescales. However, not everybody felt able to, or knew how to make a complaint. One person said, "I don't want to get into trouble." However after some discussion they said they "Might ring and get it sorted." The complaint was that their carer's only stay for five or 10 minutes instead of 30. However, another person said they had rung and asked for "a more personable carer and they [the service] have responded very well."

People's care records included care plans which guided care workers in the care that people required and preferred to meet their needs. These included people's diverse needs, such as how they communicated and mobilised. Care plans explained what people were able to do for themselves and provided instructions for staff on what support people required to meet their needs. We found that there was opportunity to develop some care plans further to increase the amount of information relating to people's life history, hobbies and interests. Having this information could support staff to have meaningful conversations with people about their lives and what was important to them.

Each care plan held a 'visit summary', which described clearly what the purpose of each care visit was, and gave clear guidance for staff to follow. The detail recorded within these reflected people's personal preferences, and important information such as leaving the remote control to hand, making sure they could reach the telephone, and leaving certain lights on.

People's records contained a 'Grab file' which contained important information about a person that others may not know [For example, if going into hospital]. Information included things such as their mobility, medical history and food and drink preferences. These enabled other professionals to understand the most effective ways to support people when they were in an unfamiliar setting.

Inadequate

Is the service well-led?

Our findings

Our inspection of January 2016 found that the service was not well-led and there was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not have effective quality assurance processes. Subsequent to the January 2016 inspection, the service had provided us with an action plan setting out how they would address the issues. At this inspection we found that quality assurance processes were still not effective.

The service quality assurance processes had not identified that people were not receiving care and support for the amount of time they had been assessed as needing it. People told us that their carers did not arrive on time. One person told us that their carer was supposed to arrive between 3pm and 4pm, ".. but I've had carers turning up at 10 o'clock at night before. That was after I rang up to complain as well." We spoke with the manager about this who told us that audits were carried out on carer daily record logs which recorded when the carer arrived and when they left. However the audit did not check that the carer had been at the visit for the required amount of time. In our report of January 2016 we had identified that the scheduling of visits without travel time between was causing problems with the amount of time care was provided for and the punctuality of visits. We directed the services' attention to the NICE guidelines on scheduling travel time between visits. At this inspection we found that the problem had not been fully addressed and resolved. The service told us in their PIR that they were introducing an electronic call monitoring system in January / February 2017. This will enable carers to log in and out of a person's property electronically thereby enabling visit times to be monitored more effectively. The manager told us during this inspection that the system was still planned but had not yet been implemented.

Our inspection of January 2016 had identified that staff were not receiving effective supervision and appraisal. The service provided an action plan to address this. At this inspection we found that carers were still not receiving spot checks and appraisals in accordance with the service policy. The manager and registered manager told us that a person had been employed to ensure that supervisions had taken place but that it had been identified in October 2016 that they were not performing effectively and they had subsequently left the service.

A full audit of carer supervisions had been carried out and an action plan put in place to address the shortfalls. We discussed with the manager why this had taken place as part of the service action plan in response to our January 2016 report had stated that PDR's and supervisions would be audited by management on a monthly basis. The manager told us that the management audit had not taken a large enough sample to enable effective monitoring.

The service computer programme and regular liaison between the registered manager and the provider allowed the provider to monitor the quality of the service provided by Allied Beccles. However, this monitoring can only be as effective as the information which is put into the system. As demonstrated above if the audits do not monitor the appropriate issue or take a large enough sample they will not be effective.

The registered manager told us that improvements had been made to the service following our previous

inspection with the implementation of the action plan and the recruitment of new staff. However, these improvements had not continued and were not in place when we carried out this inspection. The service was still breaching regulations. The service has not demonstrated that it could sustain improvements over time.

This was a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that the service carried out regular quality assurance surveys of people using the service the most recent being in November 2016. The survey had been analysed and identified a number of issues. Actions had been put in place to address these, for example, where people had not known how to complain a meeting had been held with staff to remind them to discuss this with people when they carried out a review.

The service provides a service across a wide geographical area with staff living a distance from the offices. The registered manager had recognised this and arranged regular meetings at venues accessible to staff. This allowed staff to access meetings to share views, information and gain support.

The Beccles branch had merged with the Norwich branch during the months prior to our inspection. This had caused disruption to the staffing of the office with a number of staff leaving and being replaced with new staff that needed to learn the organisational systems and processes. We saw that this training had begun and further training was planned. Commissioners were complimentary, describing the transition as a best practice example of a transfer of service.

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 RA Regulations 2014 Person-centred care People did not always receive visits at the required time or for the required duration.

The enforcement action we took:
Impose conditions.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits did not always identify issues. Improvements were not sustained.

The enforcement action we took:
Impose conditions

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient staff resulted in missed visits. Staff did not receive adequate supervision.

The enforcement action we took:
Impose conditions