Nestor Primecare Services Limited

Allied Healthcare Greater Manchester

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

This inspection took place over several days in October 2015. The initial unannounced visit to the branch office took place on 12 October, and was followed by a second visit on 16 October. We made phone calls to people using the service, on 21 October. On 22 October we visited one of the homes of people with learning disabilities supported by Allied Healthcare Greater Manchester. And on 23 October three inspectors visited people receiving care from Allied Healthcare in their own homes in areas of Manchester and Tameside. Finally on 6 November we visited the office again, by arrangement, to give verbal and written feedback on the inspection.

At a previous inspection in January 2014 we had found that the service was not meeting three of the regulations

Summary of findings

we looked at. Those three regulations concerned care and welfare, quality monitoring and record keeping. We made a follow up visit in April 2014 and found that these three regulations were now being met.

The main service being provided by Allied Healthcare Greater Manchester was domiciliary care, which means care for people in their own homes. Allied Healthcare had contracts with local authorities in four areas: Manchester, Trafford, Stockport and Tameside. At the time of this inspection Allied Healthcare provided care to a total of around 330 people across all these areas. 126 staff were employed as homecare assistants (or 'carers'). In addition, at the start of this inspection Allied Healthcare Greater Manchester was managing two homes in Cheshire for six people with learning disabilities.

The former registered manager had left in May 2015. 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.

Allied Healthcare had appointed a replacement manager in or around July 2015 but this person had left after 10 weeks without becoming registered manager. At the start of our inspection a care delivery director from Allied Healthcare was acting as manager, but we did not meet this person during our visits. The acting manager was being assisted by an operational support manager, whom we did meet.

We found that people were happy with their regular carers but had problems at weekends or when their regular carers were on holiday. Times of visits could be erratic and people were not always told when carers would be late. Electronic call monitoring was not being used effectively. Agency staff were frequently used due to staff shortages.

There had been a high number of missed calls which were attributed to a shortage of office staff. At the bank holiday weekend at the end of August calls were prioritised and some people had not received care. This was a breach of the regulation relating to deploying sufficient numbers of staff.

Safeguarding incidents had not been reported to CQC over the last six months. This was a breach of the regulation relating to reporting such incidents.

When carers administered medicines they often had no Medicine Administration Record (MAR) to record on. This was a breach of the regulation relating to ensuring the proper recording of medicines.

We saw staff using personal protective equipment (eg aprons and gloves).

Staff had received appropriate induction training but during 2015 attendance at training courses had decreased. Staff in the supported living service had received role specific training.

Spot checks and supervisions to support carers in their work had not been carried out during most of 2015. The lack of supervisions and reduction in training for staff was a breach of the regulation relating to supporting staff.

People using the service and their relatives told us the carers were kind and sometimes went the extra mile. Some had experienced problems when the office staff had sent the wrong carers. In the supported living home we visited there was a well-established team who cared well for the people living there.

However, we also found examples of very poor care. In one case this had been allowed to continue over a period of months due to a lack of management control and supervision. This was a breach of the regulation requiring people using the service to be protected from abuse and improper treatment.

Care planning varied. Some people had new care plans which were well designed and comprehensive. Other care plans were less thorough. We found that care plans had not been reviewed for many months, and in some cases this meant that significant changes in a person's condition had not been recorded. We found that the failure to update care plans was a breach of the relevant regulation.

We found there was a mixed reaction regarding how well the service managed complaints. Some people told us that their complaints often went ignored, although some told us that their concerns had resulted in changes. There was a system for recording complaints in the office.

Summary of findings

There had been a succession of short term managers since the registered manager left in May 2015. People told us they were dissatisfied with the management. We saw an internal audit from March 2015 had identified problems in the branch but action was not taken until later.

There had been a severe shortage of office staff, which had led to many of the problems. Those staff who were there had needed to take on other roles and were unable to fulfil their own.

Staff in the two supported living homes had received little support or input from the branch office. We learnt that one of the homes was being transferred to a different branch office, and families of residents of the other home had requested transfer to a new provider.

Allied Healthcare had conducted an investigation into allegations of abuse against one person and had identified failings in the management of the branch. They had devised an action plan and appointed a new manager.

Despite this, we considered the recent failings in management had had a significant impact on people who used the service and were a breach of the regulation relating to good governance.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?
The service was not safe.

People were not always told when carers would be late. There had been a high rate of missed calls. On one bank holiday weekend many calls were cancelled by the service.

Some safeguarding incidents had not been reported. The administration of medicines was not properly recorded.

Inadequate

Is the service effective?
The service was not consistently effective.

Training for some staff had not been kept up to date. Due to staff shortages supervision and spot checks had not taken place.

Staff had not been supported in their work.

Requires improvement

Is the service caring?
The service was not consistently caring.

Some people spoke highly of their carers. Others did not.

There was a good team of carers in the supported living home we visited.

Allegations about one person receiving very poor care were substantiated.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

Care plans were of variable quality. Reviews had not been done for many months.

There was a system for recording and responding to complaints, but many people and their relatives told us their complaints had been ignored.

Requires improvement

Is the service well-led?
The service was not well led.

There was no registered manager and the service had been managed by a series of short term managers.

An internal audit in March 2015 had identified problems but the response by the provider had been too slow. The office had been seriously understaffed for at least six months.

The supported living services had been left without oversight.

Inadequate

Allied Healthcare Greater Manchester

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over several days in October 2015. The initial visit to the branch office on 12 October was unannounced. We then arranged a second visit on 16 October. We made phone calls to people using the service on 21 October. On 22 October we visited one of the two homes for people with learning disabilities supported by Allied Healthcare Greater Manchester in Cheshire. On 23 October three inspectors visited people receiving domiciliary care from Allied Healthcare in their own homes in areas of Manchester and Tameside. The visits were all made by prior arrangement so that people living in their own homes knew we were coming in advance. On 6 November 2015 we gave feedback on the inspection.

One adult social care inspector led the inspection and conducted the visits to the branch office, and to the supported living service in Cheshire. Three more inspectors carried out the visits to people in their own homes. An expert by experience made the phone calls to people using 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. This expert had experience of using care services to provide care for relatives.

Before the inspection we reviewed all the information we held about the service. This included a Provider Information Return (PIR) which the service had returned in June 2015. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We also reviewed notifications submitted by the home, and by the local authorities, and questionnaires and information we had received from members of the public and relatives of people using the service.

We contacted the commissioning officers in the three largest local authorities which commissioned domiciliary care from Allied Healthcare Greater Manchester.

During the inspection we talked with 18 people over the telephone and eight people and/or their relatives face to face in their homes. We looked at five care plans in detail both in people's homes and in the office. In the supported living home in Cheshire we examined two care plans and interviewed four staff.

We talked with office staff in the branch office, including the operational support manager, a care delivery manager, a scheduler, and the regional managing director. During our visits to people's homes we talked with three carers.

In the office we discussed rotas and records of calls. We looked at four staff files which included information about recruitment and ongoing support. We reviewed records about training, and complaints, and we looked at policies on safeguarding, whistleblowing, and complaints.

Inadequate

Is the service safe?

Our findings

We asked people using the service both over the phone and in person whether they felt safe when the carers were visiting. Most people told us they felt safe in the presence of their regular carers. One person said "Yes I feel safe. The staff are so lovely." People told us that their regular carers usually turned up on time, and knew what they were doing.

However, people also told us it was different at weekends or when their regular carer was away. They said they never knew who was going to arrive, and this made them feel unsettled. One relative said: "I dread [the regular carer] going on holiday because everything goes wrong then." They said that on one occasion they had seen seven different carers in one week. Another person told us, in relation to the number of different carers they had seen, and the irregular timings: "I totally truly hate it – inconsistency and timing." They added that their bedtime visit was supposed to be 8.30 to 9pm, but that the carer sometimes arrived at 6pm.

One relative told us they were sometimes informed if the carer was going to be late, but not always. The office staff told us that the carers were instructed to phone the office if they were running 30 minutes or more behind schedule. We spoke with carers who said that they usually informed the office if they were running late, but in their experience the office did not always contact the customers. One carer said "It happens a lot of times." People told us that this undermined their confidence as they could not rely on the carers coming on time or being notified if they were late. One person told us this made it very difficult for them to make appointments with the dentist as they could not be sure what time the carer would come.

One person told us: "Everything is fine as long as my regular carer is on duty. She calls and gets me up by seven which suits me but, when she is off, her stand-ins can arrive as late as lunchtime to get me out of bed."

In one person's house we saw a list of times that the carer had arrived. Over a two week period the morning carer had arrived only once within the time set out in the care plan (namely 9.15 to 9.30am). They had, however, arrived consistently between 10 and 10.15am. Similarly in the evening the calls were all (except one) earlier than the time agreed in the care plan. This meant that the person receiving the service and their family could not rely on care being delivered at the agreed time.

We knew from notifications received from local authorities and from other sources that there had been a high level of missed calls in recent months, in other words occasions when the carer failed to turn up. In one instance the same person had not received the care visit on three successive days. The relatives of one person had contacted us to say they had been asked to provide the care themselves. The commissioners for Tameside Local Authority had told us that they had investigated a number of missed calls and were not happy with the reliability of the service provided by Allied Healthcare.

We asked about missed calls when we visited the office. The main reason given was that over the summer months there had been a shortage of office staff to plan rotas and co-ordinate calls. The operational support manager told us there had been a particular problem over the bank holiday weekend at the end of August 2015. Due to staff holidays and shortages, Allied Healthcare had realised they were unable to provide enough carers over that long weekend. They had adopted a "traffic light" system, identifying calls that were essential and others where they thought that family members would be able to cope. This was why they had contacted some relatives asking them to provide the care themselves.

This meant that people who went without care that weekend were put at risk. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation requires providers to ensure that sufficient numbers of staff are deployed to meet their obligations.

Allied Healthcare used electronic call monitoring in three of the four geographical areas where they provided care. This is a system whereby the carer uses the person's phone to call an automated freephone number when they arrive and when they leave. It should enable the office to identify if a carer has not arrived, and coordinate a replacement. One person told us they were happy for their phone to be used this way because they knew the call was free. However, several people told us that their carers used to make these calls, but had now stopped doing so. This suggested the system was not being utilised, or that staff were not being encouraged to use it. We also learnt that the system was

Is the service safe?

not monitored outside office hours, which meant that if a carer failed to turn up for an evening visit the out of hours team would not know about it from this system. This meant that vulnerable people were at risk of not being supported with their personal support needs for example being helped in or out of bed and with meals, and no-one knowing about it.

The evidence showed that staffing levels had been an issue especially over the last few months. The regional managing director told us there had been problems with recruitment and retention of carers. As a result Allied Healthcare employed many agency staff. Several agencies were subcontracted on a regular basis to provide carers. This partly explained why some people using the service complained of seeing so many different carers. It also created risks because, as the operational support manager told us, the agencies rather than Allied Healthcare were responsible for the training and suitability of workers.

We obtained the provider's safeguarding policy, revised in April 2015. This included responsibilities of carers and branch managers in the event of an allegation or suspicion of abuse. It set out that it was the responsibility of staff to remain up to date with training on safeguarding. Training records were kept for individual staff and there was no overall record of how many staff had received safeguarding training and whether it was up to date which means that the service would not have an overview of the skills and experience of its workforce. But those individual staff files we looked at showed that staff had received this training recently. We talked with one carer who had received training in March 2015 and they told us what signs of abuse to look out for and knew how to report it. For the Cheshire supported living service staff training records showed that four out of 17 staff were overdue for refresher training in safeguarding according to the service's own policy.

We observed that the safeguarding policy was not clear about the provider's duty to report allegations of abuse to the Care Quality Commission (CQC). The policy set out that it was the duty of the branch manager "to ensure information is recorded and reported by…contacting the Local Authority Safeguarding Team to inform of the concern or abuse." It then stated "If the customer is in immediate risk of harm the manager must contact the Police. The regulatory body must also be informed."

However, it is not only in cases of immediate risk of harm that the provider must inform the CQC. The regulations require the provider to report "any abuse or allegation of abuse in relation to a service user." The provider should report to the CQC even if they know or believe the allegation has already been reported to us by the local authority. One of the office staff told us that they regularly reported safeguarding incidents to the local authority, but not to the CQC.

Around 20 missed calls and other allegations of concern had been reported to us by local authorities in the six months prior to this inspection. These included allegations that only one carer had arrived when there were supposed to be two. This meant people who needed support to move within their home were at risk of unsafe care if there was only one staff member when two were needed, eg to use a hoist.

However, prior to this inspection, the last notification from Allied Healthcare Greater Manchester of a safeguarding incident was of a missed call, submitted on 14 April 2015. Two notifications relating to a safeguarding incident were submitted on 20 October 2015 during the course of this inspection. For six months no incidents or allegations of abuse had been reported to us. This was a breach of Regulation 18(1) and (2)(e) of the Care Quality Commission (Registration) Regulations 2009.

The safeguarding incident in October 2015 was dealt with robustly by the provider, who at the request of the local authority brought in a team from head office to investigate. This resulted in disciplinary measures against several staff and three dismissals, including of senior staff members.

We saw records of another disciplinary process on a staff file were incomplete. There was only one page of an interview with the member of staff, and no detailed account of the incident that had given rise to the disciplinary process. A letter that had been sent out at the end of the process was not on the file. We asked to see the missing paperwork, which we were told existed, but it was not provided. It would be better practice to keep all relevant records together.

We looked at the recruitment records of four staff. All the required checks had been made to ensure that people were suitable to work. The application form required a full work history going back 5 years and accounting for any gaps in employment. Proof of identity was on the file. A

Inadequate

Is the service safe?

record was kept of answers given at interview. These measures were intended to ensure that Allied Healthcare recruited people who were suitable to work with vulnerable adults.

We looked at how medicine was managed across the service. In many cases carers were expected either to prompt or administer medicines to people. When this is done it is vital to maintain accurate records of what medicines have been given and when. This should be done using Medicine Administration Records or MAR sheets. We saw copies of completed MAR sheets were transferred to the office and kept on the individual's care file. However, office staff admitted that, due to shortages of staff, in one area in particular MAR sheets had not been made available for staff to use for several months. We received information that this had happened in other areas too. In the absence of a MAR sheet, staff were supposed to write in the person's care diary that they had administered medicines. In some cases carers had been creating handwritten MAR sheets and then using them. However, without a proper MAR sheet medicines had not been correctly recorded. Office staff told us that in some cases there was no record for a prolonged period of what medicines a person had received. The provision of MAR sheets was now being addressed as a priority. Nevertheless, there had been a failure to provide MAR sheets, and therefore to ensure there were records showing that people had received their prescribed medicines, for a significant number of people over a prolonged period. This was a breach of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Personal Protective Equipment (PPE) was stored in the office and staff collected it from there. We saw that staff working in areas could collect stocks to distribute to colleagues. However, one member of staff had told us that there was "Insufficient PPE, no gloves being delivered and limited sizes. No hand sanitiser." We had received this information two months before the inspection and it was not confirmed by staff during the inspection. During our visits to people's homes, when the carers were present, we observed good practice in relation to the wearing of aprons and gloves, and changing gloves in between tasks. This would help protect people from the risk of infection.

Requires improvement

Is the service effective?

Our findings

We asked people using the service whether they felt that staff had the right knowledge and skills to provide the care and support they needed. All 18 of the people we spoke with by telephone confirmed that they did have such confidence in the staff. When we met people in their homes they also stated that the carers "knew what they were doing". One person said "I have no reservations about the abilities of carers. I am 80-90% happy with the care. I am unhappy with the management."

We saw from individual employees' records that they had received induction training in core subjects necessary to their role: fire prevention, food hygiene, health and safety, infection control, moving and handling, safeguarding, basic first aid and management of medication. Staff confirmed that they had received this training when they started, but stated that it was not always kept up to date. We noted that the core training did not include training on dementia or on the Mental Capacity Act 2005, which are very relevant topics for carers supporting older people in their homes.

In the most recent internal audit, dated 23 March 2015, the auditor commented that: "We are continuously struggling to release care workers to attend mandatory training as we are unable to cover their work." As a result the rates for compliance with training were variable. The overall score was 86%, which had fallen from 100% in the previous audit in August 2014. In some areas there was 100% compliance. One of the lowest scores (45%) was for manual handling training, which is an essential area. Since this audit had taken place in March 2015, the operational support manager conceded that the rates had probably fallen further since then, due to the difficulties encountered by the branch during 2015. Nevertheless, some refresher training had been maintained. One carer told us they had received training in moving and handling and food hygiene during 2015.

In the supported living service we saw records for all the staff. Many of these staff were long serving. The majority were up to date with their training, although in some cases some core subjects had 'expired' during 2015, meaning that staff had not refreshed their training in those areas. Staff told us they were invited to attend training in the Manchester office but sometimes if they were unable to attend on a particular day there was no alternative available. In addition to the core subjects they had received role specific training in learning disability awareness, epilepsy, and catheter and stoma care. This meant that staff had appropriate skills and knowledge to understand the specific needs of people they were supporting.

In the same audit in March 2015 the rate of compliance for spot checks was 33%. Spot checks are when a supervisor or manager observes a carer's performance and presentation during a home visit. Carers told us they had not received a spot check during the last six months. The operational support manager confirmed that there had been no or virtually no spot checks since the registered manager had left in May 2015, due to the shortage of office staff who could perform that role. They told us that normally spot checks would be done only annually. However a large number of staff who had been due to receive spot checks within the last six months had not received them.

We saw supervisions had not taken place within the last six months. One member of staff in the supported living home told us they could not remember the last time they had had supervision. This meant that staff had not had the opportunity to discuss their work or training and development formally with their line manager. Nor had there been any annual appraisals. One carer recalled a positive experience of appraisal in a previous year, which had included discussion of their career aspirations.

Those office staff who were in post were obliged to perform tasks such as 'scheduling' (arranging rotas) which meant they could not carry out spot checks and supervisions. We spoke with two office staff who stated their concern that because of the lack of time to conduct supervisions they did not know how staff were performing. One said that because supervisions and spot checks were not being done they did not know whether or not staff were following procedures. They gave an example of a new member of staff who had not received a supervision since starting. They added "I do speak with them, and they have been working alongside an experienced member of staff."

The operational support manager told us that recently staff from other branches had been brought in to provide support in the office, and one person would be arranging and conducting supervisions with staff as a priority.

The effect of incomplete training for all staff, combined with the absence of spot checks and supervisions during a

Requires improvement

Is the service effective?

period of six months, meant that staff had not been properly supported to fulfil their roles. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providing food was a part of some people's care package. Only a small minority of people whom we met or spoke with had meals cooked or provided by their carers. Those who did were satisfied with the food they were given. We observed good practice when one person was offered a choice of hot or cold meal. They chose soup which was offered in a beaker and then transferred to a bowl, enabling them to eat it more easily. This showed that the carer was aware of the importance of providing nutrition effectively.

Requires improvement

Is the service caring?

Our findings

We asked all the people we met and spoke with about the care they received from Allied Healthcare. The caring approach of the staff was highly rated by all. Comments ranged from "good" to "very good" and "Angels". All the people thought that staff gave them enough time but one person commented that the staff were often obviously under pressure. One relative said: "Some just want to come in and get out."

One person gave an example of the caring approach staff had: they told us, "Last winter I had been a bit unwell and was feeling very low so she came back after her shift and took me out for the rest of the day, refusing my offer of payment. She then arranged to do her shopping at the same time as me so we could meet for a coffee in the café on Wednesday mornings."

People told us that their regular carers respected their dignity when they were supporting their personal care needs. For example, the carer would cover them with a towel. We saw one carer being respectful by knocking on the person's bedroom door and waiting for a reply before entering.

One relative told us that the carer who was present during our visit "would do anything." However, they added this contrasted with another carer recently, who had refused to assist their relative to have a shower because they "had a bad arm." This did not represent an example of good care matching the person's needs.

The same relative said "I just want [my relative] to have proper care. They shouldn't be scruffy and shouldn't smell. There's deodorant in their bedroom - I don't know what the carers think it is for". The relative showed us a photograph taken two months ago which showed a pile of dirty clothing on a bath chair in their bathroom, and there was a used incontinence pad on the floor next to the bath. The relative said they were very upset that this was how their bathroom had been left by one carer.

One relative explained a particular problem they had experienced. The person using the service (a lady) needed two carers to use the hoist and did not want male carers to support her. The relative had told the office numerous times, but repeatedly the office had sent a male carer along with a female carer. This had meant that the relative had to act as the second carer. The person using the service received four calls a day and this had happened on each call over a weekend recently. This meant the service did not respect the choices of people who used the service or maintain their dignity.

We found evidence that some carers actively encouraged people to maintain their independence. Twelve out of eighteen people we spoke to by telephone said that they were supported to be as independent as possible. One person said that their carer was constantly reminding them to do things for themselves. Another said that the carer would ignore their requests when they thought it was better for the customer to do something. A third person told us that their carer had convinced them that they would be much better off with an electric mobility scooter and that they would soon get the hang of it. This person said that the outdoor mobility had transformed their life.

In the supported living home we observed a well-established and dedicated staff team who were committed to providing a caring environment for the people they were supporting. This was facilitated by the staffing arrangements which were flexible to meet people's needs, for example by taking them out shopping. We observed genuine affection between staff and residents.

We did, by contrast, come across evidence of poor domiciliary care. We had received information about two carers working in one of the local authority areas, suggesting that they did not carry out their duties, with the result that one person had been left unsupported with their personal care needs for 14 hours. Another allegation was that these carers had neglected and bullied the people they were supporting. Although we were not given details of the individuals involved, we looked at the personnel files of the two carers which lent credibility to the allegations in that they had been found to have committed similar acts in the past.

We found more definitive evidence of poor care in a series of allegations which were made while the inspection was in progress. These included the person using the service being left in bed all day on one date, verbal abuse and poor manual handling, and medicines being given incorrectly or not at all. There was strong evidence that these acts had been committed. At the request of the local authority Allied Healthcare conducted an investigation into these allegations and found they were all substantiated, and took

Requires improvement

Is the service caring?

firm disciplinary action against a number of staff, including several dismissals. Staff from another branch visited all the people who had received care from the carers involved. We were told that no similar examples of poor care were found.

The poor care, substantiated in this case, meant that the person using the service had not been protected from abuse. This was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found many examples of good care, which were a credit to the carers especially given the lack of management during the past months, these examples of bad care have adversely affected our rating of Allied Healthcare in this section. There was some good care, but it was not consistent across all the areas where Allied Healthcare was providing care.

Requires improvement

Is the service responsive?

Our findings

We looked at care files both in people's homes and within the office, in order to see how well they described people's needs and whether they were regularly updated. In theory the care file in the office was intended to be a duplicate copy of the file kept in the person's home, but this was not always the case. Daily notes were supposed to be transferred into the office, before being archived, but on one file in the office there were no daily notes at all.

We saw a wide variety of care files in people's homes. The operational support manager explained to us that a new more detailed care plan and associated documents had been introduced in January 2015. This included an assessment of needs with multiple sections, with mandatory assessments and questions to be completed with the person or their representative.

The questions covered, amongst other areas, nutrition, emotional wellbeing, skin integrity, allergies, slips trips and falls, moving and handling, medication, environment and health and safety. Based on the information gained in this assessment, a personalised care plan was written, covering all the above areas. At the end of the document was a "Summary of individual's needs and care plan".

We saw one of the new-style care plans in a customer's home, and found it very thorough, detailed and person-centred.

However, the operational support manager told us that due to the shortage of senior carers who could be trained in completing the new care plans, the rollout had been slow, and the older care plans were still in use for most people. We saw that these were much briefer. They included risk assessments, and descriptions of the care to be provided at each call. They did not include any history of the person using the service or personalised information about them.

This meant that only some people had person-centred care plans. We also learnt that reviews of care plans had not been conducted recently. For example, one person we met with had been unable to get out of bed for about a year. This was not reflected in their care plan, which had been written at a time when they were able to get up. This meant that the changes in their needs had not been reflected in their plan. Although the current carers were aware of the person's situation, this created risks if, for example, a new carer or agency carer was assigned. Some of the risk assessments for this person had not been updated since 29 January 2014, 21 months earlier.

On another person's file, dates for review had been missed. For example the medication risk assessment was due to be reviewed on 19 June 2015. The plan as whole had last been reviewed on 20 June 2014. Another care file identified on 29 January 2014 that the person was at high risk of pressure sores, but there was no mention of this in their care plan even though this person was now cared for in bed.

In the supported living home, where there were three people living at the time of the inspection, the care files were very detailed. However, some of the documents were obsolete and had not been replaced. On one file the care plan dated from 2007. We met a service development manager who told us their first priority was to write new care plans.

The failure to update care plans was a breach of Regulation 9(1) and 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each file in the supported living home included a 'patient passport' which was intended to be a page of essential information in case the person needed to be transferred to hospital. It included information about medical needs, communication, and support needs. This was handwritten and difficult to read. We asked why it had not been typed up. The carer told us it was because staff did not have access to the computer in the home.

Two people receiving the domiciliary care service told us that in the past, within the last year, they had complained about a particular carer and that carer had been replaced. This showed a willingness on the part of Allied Healthcare to respond to people's preferences. However, one person said that the out of hours team had subsequently asked them if they were willing to receive care from a carer they had previously requested should not attend. This was evidence of people's preferences not being supported and/or a lack of communication.

One relative stated that when they had complained to office staff they were told to "take it or leave it." A relative commented in a questionnaire we had sent out: "Various issues that are raised, we receive assurance that they will be looked at, but the same issues occur time and time again." Nine of the 18 people we spoke to by telephone,

Requires improvement

Is the service responsive?

said they had made a complaint. Six said their complaints had been ignored or badly handled. The other three said that as a result things had changed for the better. One person had stated in a questionnaire: "I have very little contact with the agency. I have found them to be responsive any time I had reason to speak to them." A relative told us that their complaints had always been resolved, and there was now more continuity of staff. Another person said: "All in all I am fairly happy and I have nothing important to complain about."

Another person said: "Weekends are the big problem with this company, that and lack of organisation. I told them clearly I did not want a male carer so they sent one anyway. Luckily there were two carers so one saw to me while the man sat outside in the car. I have complained about things but they handle complaints very badly in my opinion." One relative said they had not made a formal complaint in writing. They had wanted to, but could not work out who to complain to. There was no introductory letter on the person's care file as there was on other people's files to inform them how to make a complaint.

Allied Healthcare used a computer based system called CIAMS to record and monitor complaints. This stood for "complaints, incidents and accidents management system". We asked to see how it worked. Full access to the system was restricted to the care delivery director who was not available during our inspection. We were able to see an example of a concluded complaint on CIAMS. This was a complaint about lack of consistency of carers. The outcome was recorded, and it was stated that the customer was happy with an alternative carer. Another event, a missed call on a Saturday evening, had been recorded as an incident. Since it had been reported by the person using the service, it ought to have been recorded as a complaint.

At the time the Provider Information Return (PIR) was submitted in June 2015 there had been 89 formal complaints within the previous 12 months. The common causes identified were "lack of communication, rota issues and missed episodes of care." The former registered manager who had completed the PIR, stated: "We then have a process to go through where we have to discover the root cause and what we have learnt from this, once all evidence is present …, then the care delivery director can then and only then close the case." We asked at the inspection whether there had been any recent analysis of complaints to identify trends or causes. In the absence of the care delivery director we were not able to verify whether this procedure had been followed recently.

One member of staff had told us in answer to a questionnaire before the inspection: "There are times in which I have raised concerns with my office staff about other members of staff that have never been dealt with. And also complaints I have received off customers about other members of staff that have also never been dealt with, leaving customers feeling upset and angry with the company and also then being forced to have carers they do not wish to have in their property caring for them because the complaints raised have been ignored."

We considered that the provider did have a system for dealing with complaints, but not all the people using the service considered their complaints had been dealt with effectively.

People using the service and relatives told us they had not recently received a survey from Allied Healthcare to enable them to give feedback about the service received. Staff told us there had been an anonymous survey the previous month, and they had been able to complete it honestly.

Inadequate

Is the service well-led?

Our findings

One person using the service told us: "The carers are ace, the company is rubbish. Things have got worse since last year and the good staff are always leaving but it is a waste of time talking to the office."

Another person said: "I have been with them for two months so far and the individual carers are okay but I have only had a regular one for the past week. The company is poorly organised and no good."

A third person said: "Allied are far less organised and the carers are not as happy as they were. They are causing the staff turnover. My main carer, who is brilliant, was on holiday recently and the office still put her on the rota to turn up. I have spent a fortune phoning that office."

Another person said: "Things just don't run as well as they used to do. There used to be a list of who would be coming and how long they would stay but now the office frequently can't tell you who will be with you tomorrow even if you phone at four in the afternoon. Sundays are just not good."

We asked to see the latest internal audits of the branch, and received two electronic reports dated 11 August 2014 and 23 March 2015 respectively. The audit was in a standard format and was detailed, and all questions had been answered. A number of issues were identified, and the report stated: "Actions from the last audit would seem not to have been completed as some of the issues are the same." A date was set for completion of an action plan. The overall audit score for the branch decreased by 18% from 90% to 72% between August 2014 and March 2015. The regional managing director conceded that this was a significant drop. No further audit had taken place since March 2015. The registered manager had left at the end of May 2015. Although resources and personnel were being drafted into the office at the time of the inspection, including a new branch manager, there had earlier been insufficient response to the problems identified in the audit report and to the lack of management and administrative staff in subsequent months.

After the departure of the registered manager a replacement had been appointed but had worked for only ten weeks. We were told that this person had not worked in the care industry previously. Allied Healthcare had then appointed internally a care delivery director to manage the branch, but this was not their only role. As mentioned, this person was not at work during our inspection, and shortly afterwards left their post. The branch was effectively being managed by an operational support manager. A new branch manager was appointed as the inspection ended. This lack of continuity and organisational support and leadership contributed to all the problems identified in this report.

The office staff were also depleted. One carer described the office as "vastly understaffed." The planned resource was to have one care delivery manager (CDM), one care quality supervisor and one scheduler covering each of three areas: Trafford, Manchester and Stockport and Tameside (which were treated as one area for this purpose). That would make a total of nine staff. At the start of this inspection there were only three of these staff in post. This meant that resources were stretched thinly, and staff were not able to carry out their duties. At the March audit it was noted that "The CDM for Stockport and Tameside is currently scheduling the weekly rotas and is not carrying out her roles as a CDM." The shortage of staff explained, for example, the lack of supervisions and spot checks in recent months. Care plan reviews had not been done, and MAR sheets had not been distributed.

The CDM told us there had been weekly drop in meetings for staff in their area until June 2015, but they had not had time to organise them since then. A carer in another area told us there had been no team meetings since that time. One carer told us they received more praise and thanks from customers than from management.

The CDM told us that the past few months had been very stressful, but help was now coming in. The scheduler told us they had been working four nights a week on call, and receiving up to 20 telephone calls a night, often from staff who had not received their rota for the next day.

During the inspection Allied Healthcare took steps bring in new staff, arrange supervisions and improve the arrangements for rotas, so that staff would receive a whole week's rota in advance. MAR sheets were now being distributed for people who had not had them for months. These measures demonstrated that the management of the provider were now acting to remedy the problems experienced by the branch. But the regional managing director conceded that this was a very late response.

These issues had impacted on service delivery. One relative had contacted us in the months before the inspection. First

Inadequate

Is the service well-led?

they had been expecting a visit from the interim manager, who never came, and then from the care delivery director who also never came. The relative expressed frustration that their concerns about carers not arriving at the right time were not being addressed.

Staff in the supported living service told us they had recently received very little support from the Manchester office. Previously there had been a dedicated team within the office who were knowledgeable about learning disability and provided practical advice. That team had disbanded and not been replaced. The previous registered manager had visited them once a week. These visits had virtually stopped. We saw minutes of a staff meeting held on 28 August 2015. The care delivery director who was acting manager at the time had sent apologies. One member of staff was recorded as saying: "When we call the office the staff who answer just want to get rid of you."

When we visited one of the supported living homes we met a service development manager who told us they had not been aware of the existence of this home until the week before our visit. They were now arranging for management of this home to be transferred to a different branch of Allied Healthcare. There was a second supported living home in Cheshire. We were told shortly afterwards that the families of the three people living in that home had requested that a new provider take over the management of the home.

In relation to domiciliary care, an investigation was requested by Trafford Social Services in October 2015 into serious allegations of abuse against one person using the service. The investigation was conducted by senior management of Allied Healthcare. The conclusions included: "Lack of local management control which resulted in severe staffing issues both in branch and in the community and the impact was an over-reliance on sub-contracted [Agency] staff.

Lack of local management control with incidents and concerns not consistently identified and logged on CIAMS. Significant issues in the branch not escalated despite frequent opportunities to do so."

The report also set out details of an action plan to improve performance. The first step was the appointment of a member of Allied Healthcare's clinical governance team as branch manager. They commenced work on 9 November 2015. There was a focus on recruitment of both office staff and carers. A mentoring programme would encourage staff skills development. All care plans and MAR charts would be updated.

We acknowledged that action was now being taken to remedy the deficiencies in management of the branch and the shortage of office staff. Nevertheless, these failures had impacted on many people. We found that the earlier failure to mitigate risks relating to the health, safety and welfare of people using the service constituted a breach of Regulation 17(1) and 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure that sufficient numbers of staff were deployed.** Regulation 18(1)

The enforcement action we took:
In relation to all the breaches identified, at our request the provider made a voluntary undertaking not to take on any new packages of care without the express written permission of the Care Quality Commission.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider did not notify the Commission of allegations of abuse during a six month period.** Regulation 18(1) and 18(2)(e)

The enforcement action we took:
In relation to all the breaches identified, at our request the provider made a voluntary undertaking not to take on any new packages of care without the express written permission of the Care Quality Commission.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider failed to ensure the proper recording of medicines.** Regulation 12(1) and 12(2)(g)

The enforcement action we took:
In relation to all the breaches identified, at our request the provider made a voluntary undertaking not to take on any new packages of care without the express written permission of the Care Quality Commission.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Staff had not received appropriate support, training, professional development, supervision and appraisal to enable them to carry out their duties:

Regulation 18(2)(a)

The enforcement action we took:
In relation to all the breaches identified, at our request the provider made a voluntary undertaking not to take on any new packages of care without the express written permission of the Care Quality Commission.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users had not been protected from abuse and improper treatment: Regulation 13(1)

The enforcement action we took:
In relation to all the breaches identified, at our request the provider made a voluntary undertaking not to take on any new packages of care without the express written permission of the Care Quality Commission.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not meeting their needs because timely reviews had not been carried out. Regulation 9(1) and 9(3)(b)

The enforcement action we took:
In relation to all the breaches identified, at our request the provider made a voluntary undertaking not to take on any new packages of care without the express written permission of the Care Quality Commission.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not mitigated the risks relating to the health, safety and welfare of service users.

This section is primarily information for the provider

Enforcement actions

Regulation 17(1) and 17(2)(b)

The enforcement action we took:
In relation to all the breaches identified, at our request the provider made a voluntary undertaking not to take on any new packages of care without the express written permission of the Care Quality Commission.