Alina Homecare Barnet Limited

Alina Homecare North London

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 5, 6, 7 and 8 June 2017 and was announced. At our last inspection on 1 March 2016 we found a breach in regulation around safe care and treatment. At this inspection we found improvements had been made and there was no longer a breach in this area.

Alina Homecare North London provides domiciliary care to people in their homes and in the wider community. At the time of this inspection there were 312 people receiving support from this service. The service requires that it employs a registered manager. 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 time of our inspection there was a registered manager in post.

People said they felt safe. Safeguarding concerns were well managed, with staff having knowledge of how and who to report any concerns to.

Risk assessments were in place but needed further development to ensure they contained consistent information and captured all risks.

People reported an improvement in staff attendance to care visits but staff were sometimes still late. The electronic systems the service was using were not suited to the service and there were gaps in recording when staff attended care visits. The service was taking remedial action and implementing a new system.

The service followed the principles of the Mental Capacity Act 2005 (MCA), consent documents were thorough.

Care and office staff said they felt supported by supervision. The induction was thorough and the training provided them with the skills they needed to do their jobs effectively.

People told us most staff were caring and kind, but a small number of staff used their phones during care. The service involved people in their care planning and reviews.

Care files and care was person centred and personalised. People told us they felt listened to, and despite the office not always returning calls felt the service was responsive.

Complaints were managed effectively and in keeping with the provider's policy.

There was a registered manager in post and they were supported by senior managers. Audits were taking place with some minor gaps in recording and other quality issues not being picked up. The focus of the service was to improve care and build trust with care staff.

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 always safe. Risk assessments had some inconsistencies in them and some needed reviewing.

People reported staff were sometimes late for care visits and this was not always communicated to them.

People told us they felt safe and safeguarding procedures were followed and concerns recorded, reported and followed up.

Recruitment processes were robust and safety checks were completed to ensure staff were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective. Staff were supervised and offered appropriate training and new staff were inducted with a thorough induction.

The principles of the MCA were followed and consent was sought for care.

The management team were aware of how the service could be improved to make it more effective and efficient and had introduced new ways of working and a site move to effect these changes.

Is the service caring?

Good

The service was caring. People told us staff were kind and caring.

People and relatives said they were treated with dignity and respect.

People receiving care were involved in the care planning process and most people had seen and taken part in their initial assessment and subsequent reviews.

Is the service responsive?

Good

The service was responsive. People said they were listened to but

hoped for better communication from the office about changes to their carer or lateness.

Care files were person centred and gave clear personalised instructions so that care staff knew people's preferences.

Complaints were recorded and followed up in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well led. Staff felt supported and the registered manager had introduced change to the service to improve standards.

There was a culture of openness in the service and staff were encouraged to report any issues.

Audits were taking place but poor practise such as staff lateness, using phones during care calls and gaps in care files were not always being picked up. The service was working closely with the provider's quality manager to identify gaps and shortfalls.

Alina Homecare North London

Detailed findings

Background to this inspection

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

This inspection took place on 5, 6, 7 and 8 June 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 in.

The inspection team consisted of four inspectors and three experts 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.

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 gathered further information about the service from notifications sent to us telling us about important events that happen in the service. We also had feedback from key stakeholders such as the local authority commissioning team, relatives and people using the service.

During the inspection we spoke with 22 people and eight relatives, interviewed nine care and office staff and the registered manager, quality manager, regional manager and chief executive. We observed interactions of staff with people when they came to the office.

We also tracked the care pathways of 18 people by looking at their care files in detail and asking them if they were happy with their care. We looked at records for complaints, safeguarding and incidents, training, supervision, quality audits and six staff files.

Requires Improvement

Is the service safe?

Our findings

People said "I just feel safe', "I do feel safe and cared for quite well" and "I always feel they do their best and yes I do feel safe." A relative said "I have never doubted the care and his safety."

At our last inspection we found a breach of regulation around safe care and treatment relating to care visits being missed in some cases and where two staff were required to hoist a person, only one was doing it, putting both the person and staff member at risk. We found improvements had been made in this area. We looked at care records and the registered manager told us they did some intensive fortnightly feedback sessions with people until improvements were made. We saw that spot checks where unannounced visits were made to people's homes to check on the quality of care had increased during this period and records showed staff disciplinary action as a result of concerns. The registered manager told us the concerns we found previously were not happening anymore and staff were advised not to hoist a person alone if the other staff member had not arrived and they should call the office. The service was no longer in breach of regulations in this area.

There were robust safeguarding systems in place. Concerns were passed on to the office and reported to the local authority and investigated in line with local policies. During our inspection there was a concern raised about a vulnerable person visiting the office and suspected abuse from a member of the public. We saw that staff and managers acted promptly in ensuring the safety of the person but were also sensitive to their views and supported them through the process. Staff were aware of what abuse might look like and who to report it to.

Risk assessments for people were integrated into their assessment and support plan. Risk assessments were being completed, however many we looked at were not signed or dated making it difficult to tell if they were still relevant. This had not been picked up on audits where care files had been quality checked. For example, one person had a Waterlow assessment that scored very high for being at risk of developing pressure sores. As their risk assessment was not signed or dated it was not possible to see whether this assessment was current or had been reviewed, putting staff in a position where they might not know the current needs of this person or be able to provide appropriate care in this area.

The quality of risk assessments was variable. We saw one persons' very detailed fire risk assessment and evacuation plan in the event of fire in their home and any support need they had. In another file we saw a very detailed risk assessment in relation to moving and handling them during care. The actions were clearly broken down for the care worker so as to minimise identified risks to the person. In other instances however, risk assessments were briefly noted in the person's assessment, where the summary of risk stated the client could be confused but no actions as to how staff could keep the person safe or what to say if they were confused. Although further information about this was available elsewhere in the file this was more time-consuming and less easy to access.

For one care file we looked at there was no risk assessment in place for a risk that the service knew about. This person was at risk of exploitation from other people and there had been recent examples where care

staff had needed to intervene to keep the person safe. This information was not integrated into a risk assessment. The registered manager said this would be written by the end of the day and integrated into the care file. People and their relatives were aware of risk assessments and said "I think the risk assessment protects us all", and "There is a risk assessment in place and [the care staff member] does a verbal one with us and with my son each time they go somewhere new e.g. How to get there easily and safely, how to contact them, what to take. He is fantastic."

We had been informed through safeguarding notifications in the months leading up to the inspection of some missed care visits and lateness. When we spoke with people they said this had improved but staff were sometimes late due to traffic or public transport. They said "There are usually two of them and if they are delayed I sometimes get a call. They are often delayed or one of them is", "The carer is late often and they don't let me know. {Name of office staff member} lets me know from the office sometimes" and "They are always late or one of them is and then they have to rush care as one has finished their shift before the other. I never know if they are going to be late or not show up." Another person said "They've been late on the odd occasion but they let me know it is not a regular thing", and a relative said "They are never late but we always have the same person. He is very efficient."

We looked at how the service tracked staff who were late and found the system used for care staff to log in and out of their visits was inefficient. Some staff were unable to call in and out if the person did not have a home phone or did not consent to care staff using it. We fed back our concerns to the registered manager and they explained they had been aware of this issue for some time and were introducing a different way of calling in and out so that care staff could call in using a more reliable system and the timing of their arrival would be recorded more accurately. Therefore office staff could ensure care visits were taking place on time and staff whereabouts were known for their own safety.

People also told us when their regular carer was on holiday or unwell they had care staff arrive at their home they did not know. One relative was unhappy with this and said "There are many risks taken when they send people we don't know. This means I need to assist even more as my husband finds it really distressing and the carers are not prepared for his needs. The carers usually rely on me heavily as many times they don't turn up together. I am forever chasing them." We found for one person the care records showed they had several late visits from a care staff member who was not their regular care staff member. However, the regular care staff member was always on time and the person was very happy with the care most of the time. We asked the registered manager if people are sometimes cared for by staff they had not met before. They said it does happen sometimes and that staff are made aware of the person's needs and asked to read the care plan so they know what support should be provided.

People we spoke with said for most care visits the staff stayed for the whole time, one person said "Yes they stay and help me with other things if they finish early or have a chat. Usually they are helping me the whole time though", "Some go when they finish. Most stay the whole time" and "He always stays for the whole six hours and works hard for the entire time."

Medicines were managed safely. The registered manager told us historically there were no medicine administration records and these had been introduced and were now being used. We saw these were being audited, that there were very few gaps but that some of them were untidy making it difficult to audit and see how well they were being used. We saw detailed body maps being used for some people, but for others who required topical administration of creams, the maps were not being used. We fed this back to the registered manager who told us this would be followed up and body maps used where they were needed.

Recruitment processes were robust and checks were performed to ensure staff were safe to work with

people before they started with the service. References were obtained and staff went through an application, interview and competency testing process before starting to provide care for people.

Every care file we looked at had an individual personal emergency evacuation plan in place for each person in the event of a fire or other emergency. This included what the person should do if care staff were there but also showed staff had discussed with people and their relatives what to do or where to go if care staff were not at their home and there was a fire. This showed an awareness of keeping people safe after the care staff had left and making people aware of keeping their homes safe.

Good

Is the service effective?

Our findings

People told us the service was effective and met their needs well. They said "I feel I have the support I need and staff are well trained and if they read my care plan they find it easy to meet my needs", "I think they know what they are doing. I haven't had one that doesn't yet." Another person said "They usually do everything I need well" and relative told us "His needs are met brilliantly."

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.

Consent documents in people's care files were thorough and covered a range of consent issues. We found for most files we looked at the consent information was in place but for some there were some minor gaps that needed filling in and fed this back during our inspection.

Induction records showed the induction process for new staff was thorough. They went through four days classroom based learning with the trainer covering aspects of the Care Certificate. They then completed a work book, and then starting shadowing experienced care staff on care visits. We asked the registered manager how long new staff would shadow for. They said new staff shadowed for as long as it took for a supervisor to feel they were competent and confident enough with the care package to work alone. A new staff member told us the induction was "really good and they found their initial training "really in depth and they pointed out everything we needed to know."

Staff told us they were having supervision and found it helpful. We found supervision had recently started taking place more regularly and the frequency of records of meetings matched up with what the registered manager and other members of the management team told us took place.

The service had a training manager who ensured staff were up to date with essential training such as safeguarding, moving and handling and health and safety. We saw a group training booking for moving and handling training which took place yearly and covered both theory and practise so that competency could be checked. Training records showed most staff were up to date with training and for those who were not, had been booked in for future courses. For one person who required specific support because of their complex needs, staff had been provided with training so that they could meet that person's needs.

Most people said they felt confident that staff were trained well, one person said "I think they know what they are doing" and another said "They are very good. I feel like they are trained well." However one person told us they didn't feel confident in staff knowledge about specific areas of training. For example, around diabetes care they said "Sometimes I feel that they don't know too much. I think Alina should give the staff

more training on medical issues." After the inspection we contacted the registered manager about this and asked them to look into it. They assured us diabetes care would be discussed in supervision and the next team meeting and all staff emailed diabetes guidance as a reminder. We fed back our concern about this specific issue due to the potential risk it posed to one person but people felt care staff were equipped to do the job effectively on the whole.

One person told us of a carer being thorough and spotting an error in their medicines, they said "The other week I came out of hospital. The carer check my medication and said this is not your medication and she was right." People and relatives said for the most part that staff were diligent and did their jobs well.

Some people were supported with mealtimes. People reported care staff making the meals they preferred and one person who didn't have support with meals said that care staff sometimes made them a snack and knew what they liked. People told us care staff frequently offered them cold drinks and cups of tea.

People told us they felt the office staff sometimes did not get back to them or inform them of things and the service could be more effective in this way. They said "Well I'm not very happy with the office there seems to be a lack of communication if I tell the office something they don't pass the information on." This issue was acknowledged by the registered manager and senior managers within the provider. The management team told us a current issue being the office they were located in, as it was over three floors sometimes communication could have been better. The chief executive said they had decided to move the office from its current site to an open plan office with better facilities so that best practice could be better shared, communication improved and morale boosted. They said they thought this would make the service more effective and they wanted to "introduce technology to improve consistency in care."

People were supported to maintain good health. We saw evidence of communication with health professionals including dieticians, district nurses and GP's and where care staff were concerned about people's health they reported it to the office to be followed up.

Good

Is the service caring?

Our findings

Most people we spoke with said staff were caring, they said ""very caring as far as care working goes", "They're always smiling always happy they are always tell me things are getting better" and "Some of them have a chat with me about my family and what I've been doing. That's a nice thing and that is not on the plan."

However, one relative fed back they had met care staff who were sometimes rushed and weren't all caring. One relative said "They don't really respect me as they would turn up on time and provide an excellent service." Two relatives said that staff were sometimes on their phone, one relative said "They often have their phones in their hands checking them, even during the care." We fed this back to the registered manager so they could follow it up with care staff.

Staff spoke fondly of people they supported and were able to describe their needs and personalities and this matched with what we saw in care files. Staff spoke of people "like my own family" and were respectful in how they spoke about people and their needs. In one care file we found language used in the care notes that was not caring and fed this back to the registered manager. The registered manager said they will follow this up with the staff member and then provide some further training on what language was appropriate to use when writing about care that had been provided during a care visit.

People told us staff knew them, especially where there were regular staff. Some people were pleased they had been working with the same care staff for several years and felt comfortable with them. One relative said of their family member "If she is unwell her personality changes and the experienced one knows that" and one person said "Yes they know what I eat and drink and with clothes they know what I wear."

People told us they were involved with their care planning and remembered having an assessment of their needs before the care started. They said "They read my plans if they don't know me too well. I get adequate care and like that people can come to my home", "I have a support plan in place. It was done when I started with them. It does have a risk assessment with it and carers do stick to it." A relative said "There is a plan in place for my son. He knows about it and they involve him in the plan for the individual care we receive."

We saw evidence that field care supervisors went to people's homes to follow up on any issues and review the care plan if a person wanted a change. People told us they were involved in day to day care decisions as well as feeding in to their care plans. One person said "They give good care and I am supported in my decisions and knowing what works well for me. I have a plan and they support me with this." Another person was not as happy with how staff interacted with them and what it said on their plan and said "Most of them are lovely but some are quiet and don't talk. I feel lonely some days so it's nice to have a chat with someone."

Other people felt staff respected their dignity and privacy well and said "Staff do treat me with respect, they speak to me kindly and ask me if they can do things to help", "Yes they are respectful and courteous" and "I have my dignity always. They are kind and respectful when giving my personal care." We asked staff about

dignity and respect in care and they had good working knowledge of how to respect people during care by asking permission and listening to people and covering people up when they were receiving personal care. The registered manager told us about certain care staff being dignity champions, where they raised awareness of the different ways to respect people whilst caring for them and promoted good practise amongst the staff team. We saw that in the office this role was promoted with a list of 'dignity do's' in visible places. Files containing personal information were locked away so people's confidentiality could be maintained.

Care files recorded people's religious beliefs and cultural heritage and any specific needs that arose out of these. The registered manager told us they tried to match people up who spoke the same language to aid communication between care staff and the person receiving care but this was not always possible. People told us their lifestyle and religion was respected. They said "They do respect me as a female and they are gentle. They acknowledge my Christian beliefs and respect my home" and "They respect our culture definitely."

Good

Is the service responsive?

Our findings

Most people we spoke with said the service was responsive and person focussed around their care. People told us they were not always happy with the way the office communicated and things got missed or not followed up. People told us sometimes they didn't get a call back and they had to chase things themselves if care staff did not turn up or were late. They said "I don't have any complaint about the service. Only if the carer is not coming they don't ring you, you have to ring them" and "it's all about the money. The carers listen more than the office." The registered manager acknowledged that sometimes office staff forgot to call people back but was confident that introduction of their new more integrated systems and office move would smooth out these communication errors.

Despite the office sometimes forgetting to call them back, people and relatives said the service was person centred and focussed on them as individuals. One person said "They treat me like a person and have a chat about my day or how I am." We saw that care files were person centred and positive in their design and the language used. For example, care plans centred around what a person could do rather than what they were unable to do. We saw detailed descriptions of how people liked things and individual wording for how people liked care. For example one person's care file said "Please make me a cup of raspberry tea and leave the teabag in." Another we looked at described how a person likes to sit down to brush their teeth in front of the sink and needs support to put toothpaste on a toothbrush. It was clear from care files what care staff needed to do and what the preferences and past histories of people were.

We asked the registered manager how people's needs were assessed and reviewed. They told us when a referral is received the care manager checks availability of staff. If the referral is accepted a field care supervisor assesses the person's needs during a practical session where they provide care and ask the person how they like to be cared for. The registered manager explained that they weren't currently accepting any further referrals for people who required two care staff members to mobilise until their new system was up and running as they wanted to avoid any mistakes in scheduling being made and not picked up due to inefficiencies in their systems. We saw that care needs were reviewed for care files we looked at. People told us they had their needs reviewed when they were visited by a field care supervisor and asked how they found the care and if there was anything they would like changed.

Complaints were recorded and followed up in the complaints file we looked at. People and relatives said they would speak to the office or a field care supervisor with a complaint. They said
'Well if I wanted to complain firstly I would complain to the office, if I did not get anything back from them I would complain to social services get them to do something about it', "I have no complaints" and "It's taken a while for them to kind of settle down I send an email If I am not happy with something. Now you get a phone call back more quickly." One relative said "When I had an issue it was resolved within a few days."

People told us they felt listened to and care staff responded to what they were told or asked to do. They said "Carers listen to me. I tell them the easiest way to do things for me", "They are usually very patient and good at listening, I feel supported", and a relative said "The carer is super with my son and listens to everything he says. He is fair and understanding of his needs and the office have done a great job matching him to our

needs."

Requires Improvement

Is the service well-led?

Our findings

Alina Homecare North London had a registered manager in post as required by its conditions of registration with the Care Quality Commission. The registered manager was being supported by a deputy manager who was based in the office, and an operations manager. The service had recently had support from the local authority quality team. We saw evidence and were told by external professionals how the management team had worked to overcome failings in systems and issues with some care staff that had affected the overall quality of the service.

We met with the chief executive who showed us that the leadership was visible at all levels for Alina Homecare North London and were told by staff the approach of senior managers was one of "what can we do to help." The operations manager said "this company is really open and honest and encourages us to be the same" and care staff told us they were encouraged to report issues to the office as soon as was possible. People told us they knew of the deputy manager and field care supervisors but did not know the name of the registered manager. One person said "As I said a named port of call would be reassuring."

We looked at audit processes to check the quality of care and found managers completing audits were picking up on some issues but not all, such as a risk assessment missing or a risk assessment containing inconsistent information on needs. We saw care files were regularly reviewed, that MAR charts were checked and care notes checked. Where actions were required these were recorded and followed up.

We discussed with the registered manager how care notes were checked as we found an issue that had not been picked up on an audit. The quality manager who was visiting on the day of the inspection showed us how they tracked key indicators to see if any trends were appearing that needed addressing. We saw that the registered manager was able to identify an issue before it arose, for example, they told us of some care staff who mentioned they felt uncomfortable working with some people. The registered manager identified the staff needed more training in advancing dementia so they could better understand those people's needs and it was arranged.

The registered manager was aware of the areas in which the service needed to improve as identified in the last CQC report. There were plans in place to address these shortfalls and a focus on improving and providing high quality care. However, we did find examples of poor practise that we weren't confident were being addressed, with staff turning up late for visits, and undated documents. These were issues that could have been picked up through quality control systems but were not.

Care staff and office staff told us they felt supported, some said they had found changes hard to adjust to but were getting used to a slightly different way of doing things and were looking forward to the introduction of mobile phones to log in and out.

People told us they were informed by letter of any changes but often the only correspondence they received from the service was about money. We saw that questionnaires were sent out to people on a yearly basis and suggestions acted on. We saw evidence of regular spot checking on the quality of care by unannounced

home visits and phone calls to people. Findings from these spot checks were often followed up with a discussion with staff so that any issues could be addressed.