Alina Homecare Specialist Care Limited

Alina Homecare Specialist Care - Poole

Inspection report

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20 October 2017
24 October 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place between 17 and 24 October 2017, in response to information of concern. CQC was aware there had been a recent large-scale safeguarding enquiry overseen by a local authority. There had been a number of allegations relating to short staffing and people not receiving the care they needed. The bulk of these concerns were not substantiated.

We gave notice a day ahead of the inspection to ensure the people we needed to speak with would be available. When we last inspected the service in September 2016, it was Good overall and in all domains except Caring, which was Requires Improvement. There were no breaches of the Regulations.

Alina Homecare Specialist Care was previously known as The Care Division – Poole. This service provides care and support to people living in a number of 'supported living' settings, so they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. The service is also a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. Its supported living and domiciliary care services are provided to people with a learning disability, across Poole, Bournemouth, Eastern Dorset and South West Hampshire.

Not everyone using Alina Homecare Specialist Care receives regulated activity. CQC only inspects the service being received by people provided with 'personal care': help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Under its conditions of registration the service is required to have a registered manager. The registered manager had left the service in September 2017. Their replacement was already in post and had applied to register as manager, as had their line 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.

There had been changes in the management team over the past year. Staff said the new manager seemed experienced, knowledgeable and supportive, and were hopeful that things would change for the better. However, the new manager had only very recently joined the service; hence the improved confidence in management was not embedded or sustained. We will review the positive impact of the manager at our next inspection.

Staffing levels had presented a challenge over the summer, as staff had left and there had been issues with the approval of annual leave that meant more staff were off work than should have been. Some staff reported that they or colleagues worked long hours. The managers had recognised staffing pressures and had a plan in place to address recruitment and retention.

Staff morale had been low in recent months. Staff were fearful that colleagues would leave. Some staff told us that recently there had been a better atmosphere at the office and that communication with the office-based staff and management team had improved. However, the improved morale and communication was a recent development and it was too early to say whether it was embedded and sustained. We will review this at our next inspection.

Staff were supposed to have regular supervision meetings to discuss their work and any issues it presented. The managers were aware these had fallen behind owing to staffing pressures and supervisory staff having to cover gaps in rotas. However, a strategy was in place to address this.

Checks were made to ensure new staff were of good character and suitable for their role. Staff had core training at induction in topics such as safeguarding, moving and handling and health and safety. This was updated at regular intervals. They had opportunities to undertake additional training that was relevant to their work, and were supported to obtain diploma qualifications in health and social care.

People were kept informed about which staff would be working with them.

People were treated with kindness and compassion. Staff understood their responsibilities in relation to safeguarding and knew how to report concerns about possible abuse.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005 and wherever possible sought people's consent to their care.

People were supported to follow their interests, develop independent living skills and take part in social activities, education and work opportunities.

Care plans were personalised to the individual and clearly explained how people would like to receive their care and support. Risk assessments and management plans were in place, as were arrangements to keep people safe in an emergency. Staff told us the information they required was all available in people's homes and that they generally found care plans clear. They had a good understanding of people as individuals and were familiar with people's care and support needs.

Where their care packages included support with preparing and eating meals, people were supported to have a meal of their choice. People's dietary needs and preferences were clearly recorded in their care plans.

Peoples' medicines were managed and administered safely.

When people had accidents, incidents or near misses staff recorded these. Field care supervisors and managers reviewed these records to ensure any necessary action had been taken to keep people safe. The management team monitored accident and incident forms for developing trends.

Complaints and concerns were taken seriously and used as an opportunity for learning or improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had an awareness and understanding of potential abuse. They understood how to report concerns about abuse.

Senior managers were taking action to ensure there were enough staff on duty to provide the care people needed.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff were supported through training and supervision to develop and maintain the skills they needed to provide people's care and support.

Staff obtained people's consent to their care. Where people were unable to give consent, the requirements of the Mental Capacity Act 2005 were followed.

Relevant health and social care professionals were involved with people's care, and care plans addressed people's health needs.

Is the service caring?

Good

The service was caring.

People received care and support from staff who knew and understood them, including the way they communicated.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Their independence was promoted as far as possible.

People were supported to follow hobbies and interests and to take part in community-based activities.

Concerns and complaints were taken seriously.

Is the service well-led?

Requires Improvement

The service was not always well led.

Staff morale had been low, but was just beginning to improve. Staff had not always felt confident to raise concerns with the service's managers, although they were hopeful that the new manager would be responsive.

Quality assurance systems were in operation.

Alina Homecare Specialist Care - Poole

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 comprehensive inspection took place on 17, 18, 20 and 24 October 2017, in response to information of concern. CQC was aware there had been a recent large-scale safeguarding enquiry overseen by a local authority. There had been a number of allegations relating to short staffing and people not receiving the care they needed. These concerns were largely unsubstantiated.

The inspection was undertaken by one adult social care inspector. We gave notice a day ahead of the inspection to ensure the people we needed to speak with would be available. Inspection site visit activity started on 17 October 2017 and ended on 24 October 2017. It included visits to people who use the service and interviewing staff. We also reviewed four people's care records, five staff records and records relating to how the service was managed. We visited the office location on 17, 18, 20 and 24 October 2017 to see the manager and office staff; and to review care records and policies and procedures.

Before the inspection we reviewed the information we held about the service, from notifications the provider had made about significant events such as safeguarding concerns, and information from stakeholders such as local authority staff. We also requested feedback from health and social care professionals who have contact with the service.

As this inspection was brought forward due to information of concern, we did not request a Provider Information Return (PIR) or ask for questionnaires to be sent out to people who receive a service. A PIR 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. The most recent PIR for the service was returned prior to the last

inspection.

Good

Is the service safe?

Our findings

People told us they felt safe with the staff who provided their care and support.

People were protected against abuse. Staff understood their responsibilities in relation to safeguarding and knew how to report concerns. A member of staff said safeguarding was "the most important part of my job". The service's safeguarding policy made reference to current legislation concerned with safeguarding people and gave contact details for the relevant local agencies concerned with this.

Risk assessments and management plans were in place. These protected people and supported them to maintain their freedom. Examples of risk assessments and management plans, which were individual to each person, included: night time care, home alone time, travelling in staff cars, behaviour that challenged, risks presented by medical conditions, going out, and pets. Risks presented to staff by people's home environments were also assessed, such as whether people smoked. People also had personal emergency evacuation plans for if emergency services such as the fire brigade needed to attend.

There were arrangements in place to keep people safe in an emergency. Someone who used the service said they could call the emergency on call number if they needed to and had the number on their phone. Staff told us they had telephone numbers for the office or on call in event of an emergency, and that they got help if they rang in. A member of staff commented, "They are very good when it comes to emergencies." Another member of staff told us they were encouraged to ring in if necessary and that office staff were "very good" at passing on messages, for example, letting people know if they were running late. A further member of staff said it had recently become easier to get hold of office staff and that communication had improved somewhat. However, another member of staff said office-based staff did not always return telephone calls, or called back too late.

When people had accidents, incidents or near misses staff recorded these. Field care supervisors and managers reviewed these records to ensure any necessary action had been taken to keep people safe. The management team monitored accident and incident forms for developing trends.

People were mostly supported by sufficient staff with the skills and knowledge to meet their individual needs. They told us they got the support they should have. However, in some parts of the service shifts were often covered by relief workers, including managerial and supervisory staff, who were filling gaps in rotas. Rotas in one of the settings we visited reflected relief cover most days for the following week. Even so, a member of staff who worked there explained that the people who lived there were taking part in a lot of activities away from the house. Senior managers said they had enough staff to meet people's needs, when annual leave was well managed and there was no sickness. They told us no one had been left at risk as a result of missed visits or visits that had been moved, as a lot of people's support was provided continuously over 24 hours and visits that were not time critical could be moved if necessary.

Across the service there had been shortages of staff over the summer, with staff leaving and others taking annual leave. Two professionals advised us some staff had been working long hours in order to cover

shortages. Senior managers acknowledged that annual leave over the summer had not been well managed and that procedures for approving leave had been changed to avoid similar difficulties in future. Staff confirmed there had been pressures on staffing levels over the summer, although most said the situation was improving. One member of staff told us their service was still understaffed, and that they worked 55 to 70 hours a week including sleep-in shifts. They told us, "They massively overwork staff, chop and change rotas at the last minute". Another member of staff said rotas often changed but that staff where they worked were not always told of the changes: "Everything seems to be lastminute.com – there's a lot of that." The staff rotas we saw reflected reasonable shift patterns and the staff we spoke with said their rotas were acceptable, even if they worked long hours.

The senior management team recognised that staff recruitment and retention had been problematic, which they felt was at least in part due to the pay they were able to offer. They also identified that summer presented particular pressures on staffing levels. They were working on an action plan to recruit further staff and to change procedures for approving staff leave so not too many were away at the same time. This included having a full time recruitment officer. Senior managers told us no agency staff were used as this would not provide continuity for people, and that it was better to spend on recruitment efforts instead.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure they were of good character and suitable for their role. Staff files included application forms, records of interview and appropriate references. Criminal records checks had been made with the Disclosure and Barring Service. On one of the staff files, the person's employment history was stated only in years rather than months and years. We drew this to the attention of the management team; the correct information was in place by the end of the inspection.

Peoples' medicines were managed and administered safely. Someone who had support with ordering and taking medicines said they got support with this at the right time and that their medicines were always available when they needed them. Arrangements for obtaining and administering clearly reflected in people's care plans, which set out the level of support people needed. Staff who handled medicines were trained to do so and their competency was assessed at least annually. A member of staff who had responsibility for overseeing medicines commented that there had been fewer medicines errors in their services since medicines had been supplied in pharmacy-labelled boxes rather than pre-filled blister packs. In one of the houses we visited, some staff instructions for administering a person's prescribed skin creams were missing. However, the management team were already aware of and addressing this.

Good

Is the service effective?

Our findings

People were supported by staff who had access to a range of face-to-face training to develop the skills and knowledge they needed. Staff told us they had the training they needed when they started working at the service, and were supported to keep this up to date. Staff told us training was "prioritised" and also that they were offered training in topics over and above their basic training and annual updates. Staff were supported to work towards diploma qualifications in health and social care.

New staff had six days of face-to-face induction training followed by a series of shifts where they shadowed experienced staff before working in their own right. Core training at induction and with regular updates included moving and handling, health and safety, safeguarding, equality and diversity and supporting people with a learning disability.

The provider had launched a training academy that worked alongside all of its services. It had developed a training programme for the Care Certificate, which is a national qualification that staff new to health and social care are expected to undertake. It had also developed and was developing specialist training for staff in the service, based on the needs of people who used the service. This included diabetes awareness course that was due to run later in the month and a course in communication.

Staff had supervision meetings with their line manager or one of the other supervisors. Senior managers told us that every member of staff had a named supervisor. However, supervision meetings had not always happened as often as they should have done due to staff shortages and office staff needing to cover care calls. One member of staff said they had last had supervision so long ago that they could not recall when, although they did have regular contact with office staff and so did not usually have anything additional that they wished to discuss. Another member of staff described supervision as sometimes being "a bit lax" but that on the whole it happened and was useful. A third member of staff said they usually got their supervision and that if they did not, they arranged it. The staff files we viewed contained the most recent records of supervision dating from April 2017 in two cases and June 2017 in another. The management team were aware that supervision had fallen behind and a plan was under way to get it up to date.

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. The senior managers confirmed that where deprivations of liberty were identified these were always referred to people's commissioners so they could apply for the necessary authorisation from the courts.

People's rights were protected because the staff acted in accordance with the MCA and wherever possible

sought people's consent to their care. Managers and staff understood their responsibilities in relation to the MCA. For example, a member of staff who oversaw part of the service told us about how someone had capacity to manage parts of their finances and so had access to their bank accounts accordingly. The person's mental capacity had been assessed with involvement from their family and professionals because there had been grounds to doubt their mental capacity to handle their finances.

Where their care packages included support with preparing and eating meals, people were supported to have a meal of their choice. People were encouraged to be involved in shopping and cooking. For example, someone told us about how they decided on the meals they wanted: "I tell [member of staff] and she writes it down on the meal planner." They went shopping each week and also told us, "I help with cooking sometimes." People's dietary needs and preferences were clearly recorded in their care plans.

One person whose care we reviewed had swallowing difficulties and was at risk of choking. They had a safe swallow plan devised by a speech and language therapist. This information was readily available for the staff who supported the person. A member of staff was able to explain to us the person's particular dietary needs.

Relevant health and social care professionals were involved with people's care, such as doctors, dentists, community nurses, specialist nurses and occupational therapists. Care plans addressed people's health needs. One person's health and social care professionals had met with service managers just before the inspection to discuss improvements that were required to the management of the person's diabetes, including providing diabetes training for staff beyond the aspects covered during basic first aid training. The managers had a plan in place to make the required changes.

Good

Is the service caring?

Our findings

People we spoke with usually received care and support from staff who had got to know them well. They talked about staff by name and told us they liked their regular staff. One person said they sometimes had relief staff who filled gaps on their rota and that on occasion they did not like some of these staff as much, although they felt safe with them.

At the last inspection people fed back that they were not kept informed of changes to their rota, and some people were supported by a changing staff team. One of the people, who had then given negative feedback, this time talked about a regular staff team and mostly receiving support when they expected it. We received no feedback about people not being kept informed.

Staff and managers had a good understanding of people as individuals, including how they communicated and their preferences regarding their care and support. People's records included information about their personal circumstances and how they wished to be supported. This included details of their communication style, such as one person's unique sign language. There was a process for matching people with staff who had compatible attributes and interests. For example, people who liked going swimming were matched where possible with staff who were comfortable with swimming, and the rostering system flagged where people required support from staff of a particular gender. One of the office-based staff who coordinated rotas had previously been a support worker and knew a number of people who received a service. They regularly spoke with people on the telephone, and also worked with field care supervisors to ensure suitable staff were rostered with people they did not know as well.

People were treated with kindness and compassion. This was evident in the way staff interacted with people. Staff described people in a respectful way with a degree of affection. They had mostly known people for several years.

Good

Is the service responsive?

Our findings

People were supported to follow their interests and take part in social activities, education and work opportunities. People told us how they received support to manage personal and household tasks and to take part in community activities. For example, someone told us how staff took them to college courses and regular social groups, and also supported them to have a friend over regularly for a roast dinner. They talked about their goal of finding a new voluntary job, which staff were encouraging them with. Someone else told us how they went out independently most days and now had paid employment. They told us how their staff rota had been worked out to accommodate their various activities. A further person discussed with staff their plan to play pool at the pub later. The member of staff explained that both people who lived at the service went to the pub regularly and were welcomed there.

People were supported to develop independent living skills. Staff told us how "getting the guys more involved in things" was an important part of their role. Care plans reflected what people could do independently and what they needed staff to support them with, identifying the loss of independence as a risk. Senior managers recounted how they had been able to hand back parts of some people's support contracts because these people had become more independent.

Care plans clearly explained how people would like to receive their care and support. They were personalised to the individual and contained information about their preferences, needs, aspirations and people important to them. Care plans addressed topics such as physical and mental health, medicines, health and fitness, mobility, personal care, nutrition, behaviour, communication, hobbies and interests, finance and keeping safe. Staff told us the information they required was all available in people's homes and that they generally found care plans clear. They were familiar with people's care and support needs.

People and their circles of support, key relatives and health and social care professionals, were involved in developing and reviewing care plans. All but one care plans we saw had been reviewed very recently and the other had last been reviewed in early 2017, although a member of staff confirmed it remained up to date.

Complaints and concerns were taken seriously and used as an opportunity for learning or improvement. People told us there were staff at the office they could contact if they were concerned with something about their care. For example, someone told us they had texted one of the office-based staff about something and she had come and talked with them about it. There were three compliments and six complaints on file from 2017, including aspects of safeguarding concerns the service was also treating as complaints. These had been investigated and responded to in good time. Complainants had been offered opportunities to meet and discuss their concerns.

Requires Improvement

Is the service well-led?

Our findings

There was a lack of consistency in how well the service was managed and led. There had been a very recent change in manager and staff reported that morale and communication had started to improve. However, it was too early for these changes to have become embedded and sustained.

Staff morale in various parts of the service had been low over the summer. This had recently started to improve, although these improvements had not been embedded and it was too early to say whether they had been sustained. A number of staff had left and staff were worried that further valued colleagues might resign. A member of staff commented, "It feels like we're all muddling on and that puts a downer on everything." Other staff described improving morale and were positive about their experience of working for the service. Comments included: "Morale is better than it was" and, "I'm pleased and I'm really content." We will review staff morale at our next inspection.

There had been changes within the management team. The registered manager at the time of the last inspection in September 2016 had left, as had their replacement. A new service manager had recently started in post and had applied to register as manager. A member of staff told us this manager had a lot of experience and seemed to be supportive. They commented, "It would be nice if things could be sorted out properly". Another member of staff said the new manager "really seems to know her stuff" and had acted on all the issues they had raised; they were hopeful things would change for the better. A further member of staff said they had been impressed with an email from the new manager, reminding them of who to go to if they had concerns. It was too soon to say whether these positive developments in management had been embedded and sustained. We will review this at our next inspection.

Staff told us that recently there had been a better atmosphere at the office and that communication with the office-based staff and management team was improving. Comments included: "You know who you can go to. I think it works much better... More so lately, it's been easier to get hold of people" and, "The atmosphere in the office is so different this week. I felt welcomed; I felt part of the organisation, whereas before I didn't feel I had the connection." However, a member of staff from a different part of the service said the service had to them felt less personal and more corporate since a change of company ownership in 2016. It was too soon to say whether the improved communication and atmosphere at the office had been embedded and sustained. We will review this at our next inspection.

The service's whistleblowing policy had been reviewed within the past year. This reflected the requirements of legislation regarding whistleblowing and gave details of organisations that could support whistleblowers. However, a member of staff told us they had not felt confident to raise concerns as they felt they might be victimised for doing so.

Management and supervisory roles had been restructured with a view to improving the oversight of the service and strengthen support to the office-based field care supervisors. Field care supervisors oversaw the work of the team leaders and care staff who provided care and support to people. Posts had been created for an additional deputy manager and an additional coordinator. The service had introduced a competency

framework to incentivise and provide a career structure for staff, and had over the year promoted staff within this. This was part of the provider's strategy for encouraging recruitment and retention.

Whilst staff meetings happened from time to time in some parts of the service, managers gathered staff views and shared news and learning with staff predominantly by email, telephone and notes on the computerised care records system. The provider also sent out a staff newsletter every couple of months. The summer 2017 newsletter included updates about new branches, an article about quality, changes to the medicines policy and procedures, and a staff ambassador scheme to promote recruitment. The new manager had started visiting staff where they worked. Senior managers told us the six-monthly staff survey was due and would be sent out shortly. The previous survey had taken place in April and May 2017 with a 54 per cent response rate. Actions had been undertaken to address areas of concern, including the promotion of the staff competency framework.

People and those important to them had opportunities to feed back their views about the quality of the service they received. An annual forum for people who used the service was due to be held close to Christmas. Every so often there were social events for people who used the service, such as a recent charity coffee morning.

The service had worked in partnership with commissioners to resolve difficulties at one its projects. This part of the service had become more settled after issues about the compatibility of people living there had been addressed. A person who lived there told us it had become quieter and calmer since certain people had moved out, and that they liked living there. The service had also worked in partnership with commissioners to establish a 'crisis flat' in another setting. Senior managers said this had been a "massive success" and that they had had positive feedback from some commissioners.

The provider's senior management team reviewed monthly vital signs reports from its services. These were based on returns from service managers and focused on key performance indicators including safeguarding, health and safety, recruitment, supervision and training. Service managers attended monthly business meetings to discuss matters including vital signs reports, recruitment and retention, and quality and risk. There were also clinical governance meetings where good practice and learning from incidents, complaints, safeguarding concerns was shared. A manager of one of the provider's other services told us the company's chief executive regularly attended and participated in management meetings.

Quality assurance systems were in place to monitor the quality of service being delivered. The provider had a quality charter that had been reviewed in 2017. This set out what the service was committed to, including ensuring that all involved in delivering people's services understood those people's specific needs, and striving to turn people's aspirations into reality. There were monthly audits of people's medicines and financial records where the service supported people with medicines and money.

Managers had notified CQC about significant events. CQC uses this information to monitor the service and ensure they respond appropriately to keep people safe.

Prior to the inspection, the provider's website did not direct viewers to the correct CQC report and rating. We drew this to the attention of the nominated individual at the inspection and immediate action was taken to correct the link.