Allied Healthcare Group Limited

Allied Healthcare London

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out an announced comprehensive inspection of this service on 28 and 30 October 2014. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to people's care and welfare, assessing and monitoring the quality of service provision, staffing, medicines administration and ensuring consent for care was obtained from people who use the service in line with the principles of the Mental Capacity Act 2005.

We undertook a focused inspection to check that the provider had followed their plan to remedy the more serious breaches that related to care and welfare, assessing and monitoring the quality of service provision and staffing and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Allied Healthcare London on our website at www.cqc.org.uk

Allied Healthcare London was established in April 2014 following the merger of three Allied Healthcare services. It provides domiciliary care services to approximately 900 people, of whom approximately 600 receive their service under the contract we had concerns about. The majority of those who receive the service are older people, some of whom are living with dementia or mental ill-health. The service provides care workers to visit people in their own homes at agreed times in order to carry out personal care and other tasks.

The focused inspection took place over two days. On 17 February 2015 our arrival was unannounced. On the second day of the inspection, 19 February 2015, the provider was expecting us. There was no registered

Summary of findings

manager in place, but an application was in progress. 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.

We found that the provider had completely reorganised the team structure within their office base and the systems used to run the service. The changes they had made had the potential to impact in a very positive way on service delivery, but the benefits were only just starting to filter through to people who used the service and the care staff who supported them. However, the changes were sufficient for the service to meet the regulations, although improvements were still required.

Office based staff who organised the delivery of care had received intensive training and competency checks to ensure they knew how to operate the safer working systems that the provider was in the process of introducing. They spoke highly of the support they had received and told us that now systems were more streamlined, they had time to visit people who used the service to check that the service met their needs and to resolve any problems.

When we looked at the new processes that had been introduced or were going to be introduced within the next month we saw that, if applied properly, there was less margin for error. For example, care workers' schedules would be more rational with sufficient travel time allotted, therefore their arrival time at people's homes should be more reliable.

At the time of the inspection, people who used the service and their relatives had mixed views on the quality of the care provided, but it was clear that whilst most valued their regular care workers, the same standard was less often achieved by those who covered the regular care workers' absence. Care workers also had mixed views on the support and information they received from the provider. Some described a strong relationship with office based colleagues; others felt they were kept in the dark. One area for improvement was telephone access, both people who used the service and care staff complained about how hard it could be to get through to the office.

The standard and timeliness of internal safeguarding investigations had improved. Reassessments of need had been carried out for all people who used the service with complex needs and new care plans had been set up to ensure those needs were met. Reassessments of people with less complex needs were now taking place.

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?

Requires Improvement

We found that action had been taken to improve safety. New processes were being introduced to ensure the right care worker visited the right person at the right time.

Improvements had been made to the arrangements for double-handed visits. This resulted in less waiting around for the second care worker to turn up.

Recruitment of new care workers exceeded resignations and an incentive for weekend working had been introduced.

We have changed the rating for safe from inadequate to acknowledge the work the provider had put in to improve safety, although there was still more to do. We will check the provider's progress in this area during our next planned comprehensive inspection

Is the service responsive?

Requires Improvement

We found that action had been taken to improve responsiveness. Extra staff had been taken on and trained to ensure that all people who used the service had their needs reassessed and new care plans had been set up to meet those needs.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection

Is the service well-led?

Requires Improvement

We found that action had been taken to improve management and leadership.

Audits had been carried out to establish baselines and the progress of the provider's transformation plan was measured against them. The provider knew the strengths and weaknesses of the service and had strategies in place to address the weaknesses.

We have changed the rating for well-led from inadequate to acknowledge the work the provider had put in to improve management and leadership, although there was still more to do. We will check the provider's progress in this area during our next planned comprehensive inspection

Allied Healthcare 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Allied Healthcare London on 17 and 19 February 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider had been made following our comprehensive inspection in October 2014.

The team inspected the service against three of the five questions we ask about services: Is the service safe? Is the service responsive to people's needs? Is the service well-led? This was because the service was not meeting some legal requirements in these areas.

The focus of this inspection was on the breaches which had most impact on people who used the service, for which warning notices had been issued: care and welfare, assessing and monitoring the quality of the service and staffing.

The inspection site visit to the office base was undertaken by two inspectors. Two other inspectors conducted telephone interviews with care staff, another inspector carried out telephone interviews with care staff and people who used the service and an expert by experience also made calls to people who used 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, in this case older people's services.

During our inspection we spoke with 75 people who used the service, 22 of their relatives, 51 care workers and 14 office based staff. We checked four staff files and six care files as well as a wide range of management records and procedures.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service in October 2014 we found that the service was not safe. It was in breach of the regulation for staffing. This had particularly affected the reliability of the service and impacted on people who used the service as there were insufficient staff to cover all the required visits at the agreed times. We had concerns about care worker availability, particularly at weekends, poor scheduling of visits which required two care workers to be present (double-handed visits) and some staff working exceptionally long hours without sufficient rest days.

In addition, staff skills and experience were not always being matched with the needs of people who used the service and insufficient time was scheduled for care workers to travel between visits.

During this inspection we found evidence that the provider had made improvements in the area of staffing and was no longer in breach of the regulation. A recruitment campaign had attracted a high number of applicants and we saw there were safer recruitment procedures in place to process their applications. A small but steady flow of new care workers were starting work for the provider each week. We saw statistics which showed the number of new recruits was greater than the number who had resigned.

We noted that the provider had introduced an incentive for staff to work at weekends. It was too soon to evaluate the impact of this.

When we compared the number of hours worked by staff to our previous findings, we found that there had been little change. However, we saw evidence that the week after our focused inspection new runs were going to be introduced. 'Runs' were the provider's way of organising the visits to people who used the service. Routes had been mapped which matched staff skills, experience and location with the needs of people who used the service. They took account of the time needed to travel between visits. This was in order to improve quality of care and, also, the reliability of staff, as they would be working within a specific geographical area.

Most of the staff we spoke with were working the hours they wished to work. Those who were most satisfied had told the provider the number of hours they wanted to work, the post codes they would work in and the days/times they were available and they said these requests were generally respected. One member of care staff said their rota was very crowded with eight morning visits, which meant that some people could not get up at the time of their choosing. Some other care staff said there was insufficient time allowed to travel between visits, but the new runs had not been implemented at the time of the interviews.

We saw that office staff were being trained to consider a number of factors when allocating care workers to runs, including how many hours they had already worked that week. Managers were confident that, so long as recruitment of care workers continued to be successful, these measures would lead to a reduction of hours for those who were working too many. Some of the staff we spoke with said this had had no impact on them yet, others had seen their hours reduced as the people they supported died or moved on.

The provider's care delivery managers (team leaders) and schedulers (the office staff responsible for scheduling visits) were pairing up care workers to deliver all the double-handed visits for a specific geographical area for a specific part of the day, for example lunch time. Once the care workers had met up they travelled together, therefore they arrived at visits at the same time. Six of the care workers we spoke with confirmed this was now happening. Previously care workers had to manage on their own or with the person's family member if the care worker partnered with them was late. The new arrangements reduced the risk of this happening. Most care staff we spoke with did not report any significant problems with visits requiring double-handed cover, which was not the case last time we interviewed them. One member of care staff said of the care workers they doubled-up with, "We swap phone numbers and it works OK, [we both turn up at the scheduled time]."

The provider had collected information about the number of missed visits and we saw that they had reduced to around three out of 45,000 visits undertaken. As soon as a missed visit was identified it was followed up. Care delivery managers described the follow up process. The response varied according to the exact circumstance, but normally involved an immediate home visit by a care quality supervisor (the staff members responsible for assessment and care planning). We saw that a full investigation followed, but minutes from safeguarding meetings showed that the quality of these had varied. In response, a senior manager had undertaken to personally review all the

Is the service safe?

safeguarding investigations which were still to be concluded. We were told the backlog which had developed due to the need for re-investigation had now been eliminated. Care delivery managers told us they had worked alongside the senior manager during investigations which had enhanced their skills in this area.

The provider advised us that they had appointed a safeguarding and complaints lead who was due to start work in the near future. This person would take on a quality assurance role to ensure care delivery managers followed issues up within agreed time frames.. The senior manager responsible for leading on safeguarding was unavailable during our inspection and we were unable to access the full records. However, there was sufficient information available, mainly in the form of safeguarding minutes, for us to evidence improvements in this area and the transformation plan addressed many of the learning points from safeguarding investigations.

We asked people who used the service if they had experienced missed visits and approximately 50 per cent said they had, usually when their regular care worker was away. As far as we could ascertain only one or two of these incidents had taken place since the last inspection. People spoke well of their regular care staff, one person said, "I've had my carers a long time so now they know me better than I know myself." A relative said, "Normal carers don't miss [a visit]." However, there were still complaints from people who used the service and their family members about gaps in cover, resulting in delayed or missed visits, and the quality of care when their regular care workers were away, one person who used the service said, "The replacement carer was slapdash."

Within the office the provider had instigated a systems based approach called 'One Best Way' which set out processes for staff to follow in order to organise the delivery of care. Office staff described how they were supported to understand and implement these procedures; it varied slightly according to the procedure, but normally they would complete a work book, then they would receive face to face training and subsequently they would receive coaching at their desk to ensure they were implementing the procedure correctly. Finally they would be tested on it, initially by their coaches, then by regular office based staff. One member of office staff told us that when they first started work last year everything was very disorganised, but there had been a "dramatic change" for the better. Another member of office staff said, "It's been amazing. Now [I have time] to go out and see my clients in their own homes [to resolve problems]."

We looked at some of the new processes, for example, one called 'optimise route planning' and another called 'resolve refusal of care issues'. Flow charts showing all the steps that office staff needed to take or consider were available on the desks of all relevant staff members.

We saw that the route planning process required office staff to consider such factors as whether the timing of the planned visit was critical, for example, to administer medicines as prescribed and whether care staff of a particular gender were required for the visit. The procedure for the refusal of care ensured that all relevant parties were informed that care had not been provided. The process also prompted a review, in conjunction with the local authority, of the person's needs if they persistently refused care for any reason.

We also viewed the checklist used to monitor whether or not each member of office staff had embedded the new process into their everyday work; the checklists we looked at showed all staff had received at least three follow up checks. A member of staff who had been subject to these checks told us that the new ways of working had "really sunk in". We were told that as the provider was rolling out 'One Best Way' across all its locations, full training and support would be available to any new office staff for the foreseeable future. We also saw evidence from the provider's training department which confirmed that any changes to office processes which impacted on care workers were leading to changes in the training care workers received.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in October 2014 we found that the service was not responsive to people's needs. It was in breach of the regulation for care and welfare. This impacted on people who used the service as staff members had little reliable written information to refer to if they needed to check how best to meet the person's needs. We had concerns about the quality of assessments carried out by the service, the accuracy of some of the information in the care files, the lack of guidance available to care staff about how to meet people's needs and the limited information about the preferences and interests of people who used the service.

During this inspection we found evidence that the provider had made improvements in the area of care and welfare and was no longer in breach of the regulation. The provider's care quality supervisors, the team members responsible for assessment and care planning, had temporarily increased in number and had been provided with two days training and two days shadowing a more experienced member of staff in order to carry out their role. This was enabling reassessments to take place and new care plans to be developed for everyone who used the service. If people had complex needs a member of the provider's nursing team could be called upon to assist.

We compared some old-style assessments and care plans and some new-style ones and found the information about how to meet people's needs was much more detailed within the latter than within the former. However some inconsistencies persisted between different parts of the care plan; for example, in one part of one file it stated "my carer helps to prepare my meals" but the daily care plan only mentioned assistance with breakfast. Elsewhere it was clear that care staff were in fact assisting the person at other meals too.

Each new care plan now included a summary sheet which could be referred to quickly by a care worker visiting the person for the first time. It outlined the person's main needs and how to meet them. A person who used the service told us, "New carers look at the care plan so they know what to do."

New-style care files contained some more information about people's personal history, their likes and dislikes, but there was room for further development in this area, particularly for those people who were living with dementia or had communication needs. It would enable care staff to better understand what is important to people.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service in October 2014 we found that the service was not well-led. It was in breach of the regulation for assessing and monitoring the quality of service provision. This impacted on people who used the service as managers had not put measures in place to deal with under-performance by staff members or systems, nor could they keep track of the care provided and identify missed visits promptly. We had concerns about the provider's audit systems failing to pick up under-performance, particularly in relation to completing and reviewing care plans and poor introduction of, and staff compliance with, an electronic call monitoring system to track the care provided.

During this inspection we found evidence that the provider had made improvements in the area of assessing and monitoring the quality of service provision. They were no longer in breach of the regulation. Senior management were very open about past mistakes, lessons learned and current progress. The provider had installed an in-house transformation team for six months in order to improve the service and new processes had been introduced, although they had not had much time to make an impact at the time of this inspection.

Extensive audits of the service had been carried out in order to establish baselines before the provider's transformation team began its work. Progress was frequently monitored against these and used to assess whether or not milestones within the transformation plan had been met. Members of the transformation team and other senior staff could instantly supply us with facts and figures to demonstrate progress. We found that in areas where progress had not been as good as expected, analysis of the issues had occurred and new strategies were in place to try to address the issues. Electronic call monitoring (ECM) compliance was a case in point.

Slow progress was being made with getting staff to use ECM on arrival and departure from people's homes. We saw that the provider had held at least two meetings to reinforce the need for this and they were now approaching non-users to discuss the issue on an individual basis in order to identify solutions.

The provider had a good understanding of the homes in which it was not possible to use ECM, either because the person who used the service did not want staff to use their phone for the free calls or because there was no landline or poor reception. However, even taking these factors into account, there was room for improvement. Care staff gave us various reasons for their non-compliance with ECM, including "Logging into ECM doesn't match what we end up getting paid", "If there is an emergency after we have logged out or the client just wants to talk we will not be paid for staying to deal with it" and "Sometimes the client is on the phone and they will not stop the conversation for us to clock out".

We saw that short reviews to discuss the quality of care with people who used the service had been scheduled in the provider's electronic calendar, but they had not yet commenced. In the meantime we saw records which demonstrated that care coordinators (team leaders) were visiting people at home to address problems. They or a care quality supervisor made a point of visiting people who used the service when care workers reported that insufficient time had been allocated for tasks. We saw that, when necessary, they used the information from these visits to discuss the situation with local authority colleagues.

A member of the provider's transformation team was line managing the care quality supervisors and maintained a list of people who were a priority for reassessment. We saw evidence that nearly everyone who was rated 'high priority' had had their needs reassessed and a new care plan set up. The care quality supervisors were now starting to visit those with less complex needs.

A consistent concern that people who used the service, their relatives and care workers raised with us was the difficulty in getting through to the provider's office. They said that, sometimes, the phone was not answered or their message never seemed to reach the intended recipient if they were out at the time of the phone call.