Nestor Primecare Services Limited

Allied Healthcare Milton Keynes

Inspection report

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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?	Good

Summary of findings

Overall summary

The inspection took place over three days and was announced. The service provides personal care and support in people's homes. At the time of the inspection there were 31 people who used the service.

There was a registered manager in post. 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.

People and their relatives had been involved in deciding what support they needed and how this was to be delivered. A new format for care plans had recently been introduced. People and their relatives were involved in the regular review of their support needs and relatives were kept informed of any changes to a person's health or well-being

People's consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 (MCA) were met. Staff were kind, caring and treated people with dignity and respect. People were encouraged to maintain their independence and were enabled to make choices whenever possible.

People were protected from the risk of harm by effective assessment and management plans to reduce the risks to them. These covered both personal risks to people and environmental risks. There were plans in place for emergencies that might occur and the service operated an 'on call' system that meant that people could contact them on a 24 hour basis. The service had up to date policies and procedures which included ones on safeguarding and whistleblowing.

Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who used the service. Staff were trained and supported by way of supervisions, appraisals and regular checks of the way in which they delivered care in people's homes. Staff were able to access specialist training when this was needed to provide appropriate care to people.

There was an up to date complaints policy in place and a copy of the complaints system was included in the folder kept at people's home, which also included other information about the service.

There was an open culture and staff were supported by the registered manager. Regular quality audits were completed by the care quality staff and any areas for improvement were addressed with individual members of staff by the registered manager.

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.

Personalised risk assessments and risk management plans were in place, and updated on a regular basis, to reduce the risk of harm to people.

Staff were aware of the safeguarding process.

There were enough skilled and experienced staff to provide the care people needed

Is the service effective?

Good

The service was effective.

The requirements of the Mental Capacity Act 2005 were met.

Staff were trained and supported by way of supervisions and appraisals.

People's consent was gained for the support provided to them.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity, treated them with respect and maintained their confidentiality.

People were encouraged to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People had been involved in developing their person-centred care plans

There was a personalised plan of scheduled visits which detailed

what care workers would do at each visit.

There was an effective complaints system in place.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post.

There was an open culture at the service and people and staff found the management to be approachable and supportive.

The provider had effective systems to assess and monitor the quality of the service.

Allied Healthcare Milton Keynes

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.

The inspection took place at the offices of the service on 28 February 2017. The inspection was announced. We gave the provider 48 hours notice to enable them to arrange for staff to be available to speak with us and to contact people who used the service to tell them about the inspection. The inspection team was made up of one inspector, who visited the offices of the service, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspector and the expert by experience carried out telephone interviews with people who used the service, relatives of people who used the service and care staff following the inspector's visit to the offices.

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 also sent 23 questionnaires to people who used the service, 23 to relatives of people who used the service and three to members of staff to inform us of any areas that we needed to specifically look at when carrying out the inspection. We received four responses from people who used the service. We also reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with 11 people and nine relatives of people who used the service. We spoke with three care staff, a care quality manager and the registered manager. We looked at the care and visits records for four people and the recruitment records for two members of staff. We reviewed records of visits made to people and staffing rotas. We also reviewed information on how the quality of the service was

monitored and managed, including the management of complaints and the emergency plans.

Good

Is the service safe?

Our findings

People who used the service and relatives of people who used the service we spoke with told us that they or their relative felt safe with the staff who visited them. One person said, "Yes I am safe, I feel fine with them." Another person told us, "I feel safe because I have the same team."

The service had up to date policies which included ones on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. One member of staff told us that they had recently reported a safeguarding incident to the branch and to the local safeguarding team. They said, "If it was a member of staff I would use the whistleblowing process." People were given information on safeguarding and who to contact in the service folders kept in their homes. One person told us, "If there was anything untoward I would ring the manager. She is very responsive."

Care records we looked at contained a summary of the risk assessments associated with people's care and support as well as more detailed assessments and management plans. These identified actions staff should take to minimise the risks to people. Assessments had included risks associated with people's medical conditions as well those associated with their mobility, their risk of falling or poor nutrition. People and relatives told us that they had been involved in discussions about these risks. One risk assessment identified that the person was at risk of dehydration and care workers were to encourage the person to drink throughout the duration of the daily calls. People were protected from the risk of harm by effective assessment of the risks and management plans to minimise these.

In addition to the personalised risk assessments, environmental assessments had been completed to identify any possible areas of risk to people and to staff accessing people's homes. The care records we looked at showed that the environmental risk assessments were reviewed on a regular basis. We saw that there were systems in place to monitor that the cars staff used for their work, including when taking people out, had current roadworthiness certificates and insurance. Staff's driving licences were also checked regularly to ensure that they continued to be legally entitled to drive.

Accidents and incidents were recorded within a centralised data base. The registered manager was alerted about incidents recorded and the causes were analysed regularly to identify any improvements that could be made to prevent the occurrence of similar incidents in the future.

There were enough staff to provide care for people and staff usually arrived when they were due. One person told us, "They are on time mainly but they do notify me if they are late." Another person said, "They are not always on time but the office always phones if carers are going to be late. They are very, very good at letting me know." Nobody could remember any of their calls being missed. Wherever possible the care schedulers tried to ensure that the same staff carried out the calls to people as much as. One person told us, "I am used to my carers now. It's the same girls, the same faces." However, another person said, "I have had six different carers this week." A relative told us, "My relative has the start of dementia and they are trying to get a more regular core team."

We checked the call records of four people for the week prior to our inspection. These confirmed that calls had usually been made within a few minutes of the planned time and no call had been missed. Call rotas were sent to staff on Wednesday each week for the calls they were to make the following week. This gave time for any identified problems to be resolved before the calls were due. The registered manager told us that there was an 'on call' system in place. There was an emergency central number for people to contact and the call was transferred to the 'on call' duty officer who would either arrange for calls to be completed by another member of staff or would complete the calls themselves. This enabled the service to fulfil its commitment to people to provide the care and support that they needed. One member of staff told us of an emergency that occurred when they were with someone. They described the procedures that were followed to ensure that the rest of their calls were completed whilst they stayed with the person and supported them through the emergency.

We found that robust recruitment procedures were in place. Relevant checks had been completed to ensure that the applicant was suitable for the role to which they had been appointed before they were allowed to start work with the service. These included checking evidence of their identity, checking their right to work in the United Kingdom and checking with the Disclosure and Barring service that there was no known reason why they would not be suitable to work with people who used the service. This showed that the provider had taken every care to check that people were cared for and supported by staff that were of good character and had the necessary skills and experience to provide the care and support they needed.

Some people required staff to provide assistance to them when taking their medicines. For some people this was just a prompt by staff to take their medicine but for other people, staff administered the medicines to them. Medicines risk assessments and care plans contained information about the medicines people were prescribed and how these were to be administered. People we spoke with who told us that they had assistance with taking their medicines said that this was recorded in their care records each time.

We saw that medicines administration records (MAR) were completed and were subject to regular audits by a care quality supervisor. We looked at the MAR sheets for four people. We found that they had not always been completed fully but staff had recorded in the daily notes that the medicines had been given. We discussed this with the registered manager who told us that this had been identified during the auditing process and the staff involved had received further training. They showed us evidence of this. Where people had been prescribed creams and lotions, there were body maps accompanying the MAR to advise staff where the medicines needed to be applied. A care quality supervisor told us that staff had to complete training in medicines administration and had their competency assessed before they were able to administer medicines to people. Staff induction records confirmed this. People therefore only had their medicines administered by staff that were trained and competent.

Good

Is the service effective?

Our findings

People told us that staff had the skills needed to provide the care they required. One person told us, "They are amazing, a helpful approach and professional. The best I have ever had." Another person said, "The [staff] are really good. I can't find fault with them."

Staff told us of the induction training and regular refresher training that they received. This included medicine administration, food and hygiene and moving and handling. The service had introduced care coaches who initially showed a new member of staff how a specific care task should be completed. They then completed the task with the new member of staff, followed by them being observed by their care coach completing the task unaided. It was at this point that they were validated as having achieved competence in the task. We saw that one member of staff had worked with an experienced member of staff on 60 calls before they were able to make calls to people on their own. One member of staff told us, "I did four days of training in the office then I did six or seven days of shadowing [working with experienced staff] which built up my confidence."

Staff told us that they were able to request additional training to improve their performance or as needed to provide effective support for people with specific medical conditions. One member of staff told us, "I have had specialised training on clear way to support one person and am now doing [percutaneous endoscopic gastrostomy] PEG feed training. They are not using the PEG yet but I am doing the training for when they do need to use it." PEG feeding is a procedure in which a flexible feeding tube is surgically implanted in a person's stomach to feed them when they are unable to take food by mouth. We observed a member of staff discussing access to training for MAKATON with the registered manager to enable them to communicate better with a person who had learning difficulties.

The registered manager showed us the compliance regulation tool that had been introduced by the provider. This detailed the training that individual members of staff had completed and showed that staff were compliant with the training requirements. This showed that people were cared for and supported by staff who were continuously encouraged to develop their knowledge and skills.

Staff told us that they received supervision every three to six months. One member of staff said, "We fill in a form beforehand and go through it at the meeting. We also discuss our development. I want to do National Vocational Qualification (NVQ) level 2." Another member of staff told us, "During supervision we talk about what we want to do in the next three months. I have done NVQ2 and now want to go on to NVQ level 3. I am waiting to start it. [The provider] will support us." In addition there was an annual appraisal system at staff development needs were discussed.

Records showed that staff had received training on the requirements of the Mental Capacity Act 2005 (MCA). 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. Applications for people who live in their own homes must be made to the Court of Protection. There had been no applications made at the time of our inspection. We saw evidence that some people had advocates who had legal authority to make decisions on their behalf.

Staff understood the requirements of MCA, although they had not been involved in the assessment of people's capacity to make and understand decisions about their care. They were aware of when a relative had Power of Attorney for someone and that they would make decisions on the person's behalf. One member of staff told us, "A few people I care for have dementia but they are still able to make their choices clear with a bit of encouragement." Another member of staff told us, "They usually tell me what they want done. In asking me to do it they give their consent." One member of staff told us, "If they refuse care I would try to encourage them but if they kept refusing it I would change the subject but document their refusal and report it to the branch. Hopefully the next time they would agree. If their refusal would cause them harm though I would carry on trying to persuade them until they agreed. It once took me 90 minutes to get someone who was covered in urine to let me help them."

People we spoke with confirmed that staff always asked for their permission before providing care to them. Staff told us that they always asked people whether they were happy to have their care and provided choices. The care records confirmed, that people had given their consent for the care planned and they, or advocates on their behalf, had signed a document, which was held in the care record, to agree the care.

Staff told us that they encouraged people to eat and sufficient amounts to maintain their well-being. One person told us, "The girls always ask if there is anything else I want such as a cup of tea and they make a bottle of orange juice up for me which I keep by my chair." Another person said, "They ask if I would like a drink. I only have to ask if I need anything." A member of staff told us that if they worked with dietitians when required. They said, "I try to come up with different ways to get people to eat. I work with them. One person will only eat cake. As long as they eat something I am happy. If I cook their meal sometimes the smell of the food encourages them to eat. If I am concerned I get the GP to get the dietitian's involvement."

This also showed that people were supported to maintain their health and well-being. One member of staff told us, "One person had to have physio but would only do it if I did it too. So I do the exercises with them. I encourage them to move, even if it is just when they are in the bath." The provider had introduced a process to improve communication between the service and hospital to prevent missed care visits. Staff told the office if someone went into hospital or if they heard that they were due to be discharged.

Good

Is the service caring?

Our findings

People told us that staff were friendly, kind, caring and treated them with respect. One person told us, "The carers are very very nice. I am very pleased. They are very polite. They speak nicely and I have a nice chat." Another person said, "They are very nice girls. They are very respectful, kind and helpful. I am very grateful for all they do." A third person said, "They treat me well and talk to me very nicely." A relative told us, "My relative likes the care workers so much. They chat with [them] and have time for [them]. "A member of staff told us, "I always treat them with respect. It is their own home and I want them to feel as comfortable as they do when I am not there."

Staff had time to build relationships with the people they cared for. One person told us, "I am quite happy. I have a laugh and a joke with them. There is nothing they could do better." Another person said, "They are the same girls. I like this. There is continuity and safety and they get to know someone's needs better." A member of staff told us, "I have a set round every day so know my people. I enjoy talking to them; having a laugh with them and making them feel comfortable." One member of staff told us that they had received one of the provider's 'Shining Star' awards in December 2016 for tidying up the garden of a person that they cared for in their own time. They had done this as they knew the person had loved to look at the flowers in it but was no longer able to care for it.

We asked staff how they protected people's privacy and confidentiality. One member of staff told us, "When I am washing someone I cover them with a towel or blanket, whatever they want over them. Some people don't want anything covering them. I shut the windows and curtains or blinds. I also shut the doors in case anyone walks by."

People were encouraged to be as independent as possible. One member of staff told us, "I try to get them to wash themselves as much as possible. I usually only have to wash their backs for them." One member of staff told us of how they had worked with a person who had dementia. They had been unable to go out as they could not give their address when asked if they got lost. They would give an address they lived at a long time ago. With the support of the member of staff the person had now learned their current address and was able to go out unaccompanied. One care record we looked at stated that the person should be encouraged to do their own washing up.

People were able to make decisions about their care. A member of staff told us, "People tell us how they want you to do things." The care records we looked at showed that people had made their wishes as to how their care was delivered known when the initial assessment of their needs had been made. One showed that the person liked to drink coffee with milk and two sugars at breakfast time. One person told us, "They do everything they need to do and check I am okay before they leave."

There was good communication between people who used the service and the office. They were able to contact the office at any time to talk to one of the schedulers or the registered manager. One person told us, "There is two way communications with the offices. They let me know and I tell them things." Another person told us, "I have a good rapport with the offices."

People were provided with information they needed about the service in the folders that were in their homes. This included copies of the care plan consent form, an introduction to the service, a summary of the person's care plan and a personalised individual environment risk assessment. The welcome pack provided to each person with the information folder also included information about the out of hours service. People were able to request that they be sent information about the time of their visits and the staff who would support them on the Friday of the previous week.

Good

Is the service responsive?

Our findings

Records showed that people and their relatives had been involved in the initial assessment of their support needs, sometimes with the involvement of a social worker, and subsequent reviews of this. Their care and support plans were focussed on their individual identified needs. The care records we looked at showed that they had all been reviewed recently and people and their advocates had been involved in this process. Copies of the care and support plans were kept in folders in people's homes. One person told us, "I read every day what my carer writes in the book. Every two to three weeks she takes it back to the office." Another person said, "They write everything down in a big folder."

The care records identified the desired outcomes of the care that was provided. The initial assessment provided information about the individual, their support networks and other health and social care professionals involved with them. The records included information on the person's likes and dislikes, activities and hobbies and, where appropriate, their end of life care plans. The records were kept electronically as well as in hard copy. If the data system contained information that a person wanted only female staff to support them, it would not allow male staff to be scheduled for their visits. The care records included plans to address people's identified needs, such as breathing, communication, mobility, nutrition, hobbies and interests.

One care plan stated that an individual could communicate verbally but that if they were asked a question the answer would always be 'No'. Staff were advised to ask 'open' questions that required more than a yes or no answer. We noted that a new format was being introduced for the care plans. However, when we looked at plans that used the new format we found that these were not as personalised as the existing plans. They did not give staff as much information as to how to provide care that met the person's individual needs as the older format. We discussed this with the registered manager who told us that they would provide more training to staff on personalisation of care plans in the new format. They would also discuss the matter with the provider.

Each person had a personalised plan of scheduled visits. For each visit that a member of staff was to make to the individual, there was detailed information about exactly what the member of staff was expected to do and how this should be completed. For example on the first visit of the day for one person, the plan stated that the member of staff should knock on the door to be let in. Staff should use gentle persuasion to encourage the person to be assisted to have a wash. The plan went on to detail other duties staff should perform before leaving and returning keys to a key safe box.

People told us that they could request changes to the care that they wanted. One person told us, "If I need to change my call time I let the offices know and they organise it." We saw that care plans were reviewed when people's physical or mental health changed. Care plans had been developed to support people with their interests and hobbies. A member of staff told us, "I often help people to do puzzles or crosswords."

There was an up to date complaints policy in place and was included in the information folders in people's homes, although people we spoke with told us that they had not used it. One person told us, "I would ring

the offices if I had any concerns." A relative said, "The offices responded when one of the carers spoke to my relative like a child and we weren't happy with this." We looked at the computerised system that covered incidents, accidents and complaints. We noted that a complaint had been made that the service had cancelled the provision of care unfairly. We saw that the registered manager had carried out an investigation into the complaint and had sent a response to the complainant within a week of the complaint being received. The registered manager told us that complaints could be assigned to members of staff records and brought up in their supervision or appraisal. This allowed for the monitoring of complaints about individual staff and also enabled them to identify any trends. Staff told us that learning from complaints was shared at staff meetings in order to prevent similar complaints from occurring. This showed that the provider listened to people's concerns and took action to address them.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was seen as supportive and approachable by people who used the service, their relatives and the staff. One person told us, "In two months the manager has visited me four times to chat and check everything is okay." A member of staff told us, "Although I don't see anybody in the office I am always on the phone to [registered manager.] I would email [registered manager] if I had a problem and she would help me."

We saw that people and their relatives were regularly asked to provide their feedback on the service that they had received and any changes they would like to be made to it. One person told us, "The manager rings and checks things." People told us, and records confirmed, that quality checks were made by both telephone and visit on a regular basis. One person told us, "The manager does spot checks, by phone and a visit. I have had both." People and their relatives were unanimously positive about the service. One relative had responded about the quality of the service in a recent telephone check saying, "Excellent. I couldn't ask for anything more."

Staff told us that they had regular staff meetings. One member of staff told us, "We had a team meeting just before Christmas. We are told what is going on, any known changes that are coming, such as changes to the induction training, any complaints or concerns that have arisen and discuss areas for improvement, such as writing in logs." We saw that at the winter branch meeting in 2016, held in conjunction with the Ampthill service, topics they had discussed included the on-line learning centre, mandatory training, IT system, pay and rewards. In addition they had discussed specific risks to people caused by the time of year, such as hypothermia and carbon monoxide poisoning. They also discussed forthcoming events such as 'National Heart Month' in February 2017. This had enabled staff to have input into the way the service delivered care and support.

An information booklet given to staff gave details of ways in which the service had changed following their input. These had included the introduction of guaranteed hours, care coaches and changes to uniforms worn by care staff. This information booklet also reminded staff of the values of the service which were stated as 'the foundation stones of our culture and signify what we stand for.' It also reminded staff that the vision of the service was, 'to be the choice for Care that gives people the freedom to stay in their own home'.

Care quality supervisors carried out regular audits of care records and medicines administration charts. The registered manager told us that any discrepancies were brought to their attention. They would either then speak with the member of staff immediately or they could include information about the discrepancy in the member of staff's electronic file and discuss it at their next supervision.

In addition to the internal audits, the provider carried out a regular independent audit of the service and an action plan was developed from this to address identified areas for improvement. This action plan was monitored by the registered manager, as well as the provider's centralised quality team.

There was an incentive scheme in place across the provider's services with various awards for innovation

and good service, both locally and nationally. Staff were able to nominate their colleagues for the awards. We saw that some members of staff had been presented with 'Shining Star' award certificates for good service. We were told that these were accompanied by monetary awards, such as shop vouchers. There was also a 'carer of the month' award, which carried rewards such as weekend breaks, spa treatments and even a car. This scheme gave staff additional incentives to provide the best possible service to people. Staff were also encouraged to recommend the service as an employer to their friends and family, as staff recruitment was one of the biggest challenges that faced the service.

We found the provider had effective data systems for the storage of information about people who used the service and the visits made to them. This data was protected by passwords and was only available to people authorised to access it. Hard copies of people's records were stored securely within the office. We saw that these were accurate and up to date. Hard copies of the files of people who no longer used the service, log books and medicines administration records were kept for six months on site before being archived by a professional confidential storage service. The papers were kept in accordance with regulatory requirements before being destroyed confidentially.