Nestor Primecare Services Limited

Allied Healthcare London North

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10, 11 and 12 January 2017. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that the registered manager would be present. The inspection was carried out by two inspectors, a pharmacist inspector and three experts by experience.

Allied Healthcare London North is a large domiciliary care agency in North London providing personal care and support to people in their own homes in the London Boroughs of Barnet and Islington. At the time of the inspection there were 443 people using the service, of which 394 were receiving personal care. The service employed 190 care staff.

At our last inspection on 18, 19 and 23 May 2016, we found significant shortfalls in the care provided to people. We identified breaches of regulations 9, 11, 12, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to inadequate risk assessments and medicines management, inadequate care planning, inadequate provision of staff training, supervisions and appraisals, poor staff understanding of the Mental Capacity Act (MCA) and a lack of auditing processes to ensure good governance and overall management of the service provided. We were not satisfied that care and treatment was being provided safely.

We took action to impose a condition to restrict the provider in providing personal care to new people without the prior agreement of the Care Quality Commission (CQC). We imposed a condition that the provider must submit an updated policy to CQC that outlined the quality assurance systems in place at Allied Healthcare London North. We also imposed a condition which required the provider to undertake a monthly audit of care plans, risk assessments, medicines management, staff supervisions and appraisals and submit a monthly report to CQC outlining their findings.

The provider was also placed into special measures. Special measures are designed to ensure a timely and coordinated response where we judge the standard of care to be inadequate. Its purpose is to ensure that inadequate care significantly improves and provides a clear timeframe within which the provider must improve the quality of care they provide. When a provider is placed into special measures, the CQC will re-inspect within six months.

This inspection was carried out within the six-month time frame to check if improvements to the quality of care had been implemented. At this comprehensive inspection we found the registered provider had taken action to achieve compliance with all of the regulations previously identified as non-compliant during the comprehensive inspection in May 2016. However, we identified further areas for improvement regarding medicines management and monitoring out of hours cover to ensure that people received consistent care at all times.

At this inspection, we found that staff competencies around medicines management were assessed. All staff

training in medicines management was now up to date. Audits of medicines records were identifying areas for concern and this was addressed with the staff member involved. Healthcare professionals were consulted when concerns had been identified regarding peoples medicines. However, we found errors in the transcribing of Medicine Administration Records (MAR) charts and a lack of quality monitoring in this area.

We received positive feedback from most people and relatives regarding the support they received from care staff. However, we were consistently told that the quality of care people received altered at weekends as a result of carer changes and late calls which was not always communicated to people or their relatives. Gaps were identified in how missed call alerts were monitored at weekends.

At this inspection, we found detailed current risk assessments were in place for people using the service. Risk assessments explained the signs to look for when assessing the situation and the least restrictive ways of mitigating the risk based on the individual needs of the person.

We found that care plans were person centred and reflected what was important to the person. Care plans provided appropriate guidance to enable staff to deliver person centred care in line with people's preferences.

Significant improvements had been made to ensure that consent to care was obtained from the appropriate person. However, we found some instances where relatives had signed consent forms without the appropriate documented legal authority to do so. Care plan specifying best interests needs were in place. Most staff had received training on Mental Capacity Act 2005 (MCA) and staff understood the importance of obtaining consent from people.

We found that staff training, supervisions and appraisals were monitored and updated regularly. Systems had been implemented to ensure a better oversight of when staff training, supervisions and appraisals were due.

Staff were safely recruited with necessary pre-employment checks carried out.

We found that improved systems were in place to monitor and check the quality of care provided. We received consistently positive feedback from staff regarding the management structure in place and the support they received. Managerial oversight of the service had improved since the last inspection. Good practice had been developed, but further time was needed to address outstanding issues and for the service to demonstrate that the improvements that had already been made had been fully embedded and could be sustained.

At this inspection, we identified a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, as the provider has demonstrated significant improvements and the service is no longer rated as inadequate for any of the five questions, it is no longer in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. There were sufficient staff to ensure that people's needs were met. However, not all people received consistent care at weekends as staff were not effectively deployed to ensure continuity of care.

We saw improvements had been made in this area; however, certain aspects of medicines management regarding transcribing MAR charts which require further improvement.

Risks to people who used the service were identified and managed effectively.

Staff were aware of different types of abuse, how to identify abuse and what steps they would take if they had safeguarding concerns.

Is the service effective?

Good

The service was now effective. Staff had access to regular training, supervisions and appraisals which supported them to carry out their role effectively.

People were given the assistance they required to access healthcare services and maintain good health.

Appropriate consent was mostly gained before care and support was delivered. The principles of the Mental Capacity Act 2005 were followed.

Is the service caring?

Good

The service was now caring. People and relatives spoke positively about staff. People were treated with dignity and respect.

Care plans were detailed and provided information about

people's needs, likes and dislikes.

Is the service responsive?

Good

The service was now responsive. Care plans were person centred and had recently been reviewed.

People's needs and wishes from the service were assessed and support was planned in line with their needs.

People using the service told us they would speak to staff if they were not happy with any aspect of the care and support they received. Complaints had been investigated and appropriately responded to.

Is the service well-led?

Requires Improvement

This service was not always well led. Systems were in place to ensure the quality of the service people received was assessed and monitored. We saw improvements had been made in this area. However, medicines management remains a concern in addition to continuity of care at weekends and out of hours. We could not rate the service higher than requires improvement for 'well-led' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

Staff spoke positively of the registered manager and the support they received.

The provider had shared the outcome of the last inspection with people and relatives and was working with health and social care professionals to address the findings of the last inspection.

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Allied Healthcare London North

Detailed findings

Background to this inspection

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

This inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure staff we needed to speak with would be available. This inspection was completed by two inspectors and a pharmacist inspector. The inspection team was assisted by three experts by experiences who made telephone calls to people and relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service such as statutory notifications and safeguarding alerts. We also looked at the action plan that the service had provided to the CQC following the last inspection and the monthly updates received.

During the inspection we spoke with 27 people who used the service and 18 relatives. With permission, we also visited the home of two people who used the service. We spoke with the registered manager, area manager, two field care supervisors, a care coordinator, a trainer, the health and social care manager and eleven care staff. We obtained feedback from two local authorities who currently use the service.

Requires Improvement

Is the service safe?

Our findings

We received mixed feedback from people and relatives regarding staffing levels and how this impacted on their care and support. Many people we spoke with told us that they had a good relationship with their regular carers who generally arrived on time. People and relatives told us that if their regular carers were running late, they would call. The feedback we received from people, relatives and some staff was related to the provision of care at weekends with late and missed calls and poor communication a common theme. One person told us, "Oh yes, I feel safe with the one I've been allocated, but when she's away, you don't know who you're going to get." Another person told us, "Sundays is a problem day for them. On a Sunday, I have to ring them, they don't ring me and the office doesn't say the same thing as the carer will say." A third person told us, "I've had no problems recently with missed or late calls but it's different at weekends. The time, it's just random, I think." A relative told us, "No problems with late or missed appointments during weekdays but weekends can be difficult. I checked the book and could see her medication hadn't been given and there was nothing in the book, so I rang and reported it. They said they had a number of people ring in sick but couldn't get the rota covered. They said they didn't know that no-one had turned up until I phoned. It wasn't flagged up to them until I rang."

We discussed the out of hours cover arrangements in place at the service. Most care staff we spoke with told us that they received appropriate support from the out of hours cover. One staff member told us, "When I call a person responds. Very effective." A second staff member told us, "On call is okay. They follow up." A third staff member told us, "Yeah I call they kept putting the phone down. They kept cutting the call. Before Christmas, I was shocked, they kept cutting the call. The registered manager told us that staff work on a rota arrangement on evenings and weekends, with one staff member each covering Barnet and Islington respectively. At the time of the inspection there were 85 people using the service from Barnet and 318 people using the service from Islington. This meant that one person was responsible for answering calls from people, relatives and care staff in addition to monitoring the electronic call management system for alerts for late or missed calls. The staff member covering the out of hours service also had to arrange short notice cover and inform people when their carer was running late. We saw that on the weekend prior to the inspection, the staff member covering Islington logged 54 calls relating to issues such as carers calling in sick, carers running late, emergency situations, complaints from relatives and people refusing care. We saw a recent incident of two missed calls and the investigation found that the on-call cover was busy and did not see the missed call alerts. We discussed this with the registered manager and area manager who advised they would review the weekend and out of hours arrangements in place. However, we found that staff were not deployed effectively to ensure that people received consistent care at all times.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found medicines management was unsafe. People's medicines were not always being administered safely or recorded appropriately. At this inspection, we found that the provider had partially addressed this issue although there were still some shortfalls. We saw evidence that consent for the provider to complete medicines tasks had been obtained. The medicines care and support plans and

Medicines Administration Record (MAR charts) were written by the Field Care Supervisor (FCS) based in the office. Staff told us that the information on the MAR charts had been taken mostly from the dispensing label on the blister pack. However, this information was not checked by a second person which increased the risk of errors as there was no second checker in place to ensure that it had been transcribed correctly. The MAR chart itself did not give direction on doses but listed the medicines people were prescribed regularly and recorded the total quantity of tablets the person was taking. This potentially increased the risk of transcription error as well as the likelihood of people getting the wrong dose of their medicine. In one MAR chart we looked at the total number of tablets the person was recorded to take at night which was 14 tablets. However, this was incorrect and the person was actually taking two tablets. A carer amended the MAR chart to reflect the correct quantity of tablets.

We saw that appropriate medicines risk assessments were in people's care plans which gave clear instructions on how to manage their medicines. For when required (PRN) medicines, we saw that the dosage instructions were written on the MAR chart. However, this did not always include a maximum frequency and the circumstances in which they should be given. For example we saw the following instruction on a client's MAR chart; 'Paracetamol 500mg when required'. We did not see evidence that clear instructions were given advising care workers how to manage medicines that were taken when required. The provider told us that they would seek advice from the pharmacy or district nurse in order to manage these medicines.

Medicines reconciliation is the process of obtaining an accurate list of a person's current medicines. It was not clear whether the provider had a system for carrying out medicines reconciliation for people when they were initially referred to the service or on a regular basis. However, records showed that care staff updated the FCS when they noted that the person had been prescribed an additional medicine and the person's MAR chart was updated. The registered manager told us that when a query was raised regarding the person's prescribed medicine, their GP would be contacted for clarification. The registered manager also told us that on occasions where care staff had identified that people were not taking their medicines or refusing their medicine, the provider informed the client's GP and social services. We saw evidence in people's care plans where such communications had resulted in the GP changing a client's medicine or the local authority reviewing the care package.

Where people whose medicines were administered by care staff, their MAR charts were audited on a twice yearly basis. The providers own retrospective audit had also identified errors on MAR charts such as allergy information not recorded, incorrect instruction on how medicines should be taken and carers not signing the MAR chart after administration. Actions resulting from MAR chart audits were that that staff were generally spoken to regarding their record keeping.

Training records showed that staff received medicines training every three years. At our last inspection we found that staff competencies in medicines had not been assessed on a regular basis as Field Care Supervisors (FCS) had not been trained to assess staff competency in medicines. Training records showed that staff had now received a yearly medicines competency check. During the inspection, the provider's health and social care manager was in attendance at the office to assess and sign off FCS medicine competency.

Care workers received in-house training to enable them to carry out medicines related tasks. During the inspection, we observed some of the medicines training delivered as part of new staff induction. We found the training to be detailed and informative. We observed staff in attendance at the training engage and raise questions with the trainer. Following medicines training staff were required to have a yearly medicines competency assessment, which was confirmed by records seen.

At our last inspection, we found that risk assessments were inadequate and did not provide staff with enough guidance on how to mitigate risk. Risk assessments were a tick box format which addressed generic areas of risk such as slips, trips and falls, skin integrity and environmental risks. Individual risks posed to people such as health conditions were not risk assessed. Risk assessments did not provide information on what signs staff should look out for, what staff should do if the risk occurred and how to mitigate the risk.

At this inspection we found that the provider had addressed this issue. Risk assessments were no longer in a tick box format but in a narrative format which contained guidance for staff to understand the risks posed to people and the actions staff should take to mitigate the risk. Risk assessments were person centred and completed in collaboration with the person or their relative. Where people had a diagnosed health condition such as diabetes, chronic obstructive pulmonary disease (COPD), heart disease, Multiple Sclerosis (MS) and hypertension (high blood pressure) a risk assessment had been completed to provide staff with guidance on how to understand the persons condition and associated risks. Risk assessments also contained clear guidance on actions staff should take if the person experienced ill-health.

At our last inspection, we found that the risks associated with the use of oxygen had not been assessed. During this inspection, we looked at a care plan and risk assessment for a person who had been prescribed oxygen. The risk assessment detailed the risks staff should be aware of when supporting this person. Where people had a mental health condition, their risk assessments included comprehensive information regarding the symptoms of their condition and how staff should safely support the person when they experienced mental ill health. For example, one person's risk assessment advised staff to take the person for a walk to buy them a newspaper or a cup of coffee when they became anxious. In another person's risk assessment, care staff were instructed to call for an ambulance should the person who used the service injure themselves, as the person's risk assessment explained that the person was prescribed a blood thinning medication which increased the risk of serious injury to the person should they start to bleed. In an environmental risk assessment for a person who lived with dementia, guidance was available to care staff on how to minimise disruption to the lay out of the person's home in order not to add to the person's confusion.

At our last inspection, we found that appropriate staff recruitment checks were not carried out or documented for all staff employed. We found that the interview and referencing process was not robust and staff eligibility to work in the UK was not always evident in staff files. At this inspection we found that the provider had addressed this issue.

We looked at 10 staff records and saw there was a safe and robust recruitment process in place. We saw completed application forms which included references from their previous health and social care experience, their qualifications, their employment history and explanations for any breaks in employment.

Staff employment records had two employment references and where a person had not had extensive experience of employment, two personal references were submitted. References were also verified. This meant that staff were considered safe to work with people who used the service. Where there had been a delay in references being returned, we saw evidence of this being pursued by office staff. There was a Disclosure and Barring Service certificate (DBS) on each record we looked at, in addition to copies of employee's identification documents and visa status, if applicable.

All people we spoke with told us they felt safe and were happy with their regular carers. Comments from people included, "They are very good people", "Yeah, I feel safe. Well, she just takes care of me" and "The carers are very good." A relative told us, "Yes, she's not under any threat. I've met quite a number of them." A second relative told us, "Yeah, because my husband's got Parkinson's, they help him in the shower and stop

him falling." A third relative told us, "Yes. They do what they've got to do and on the whole they are alright."

Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. All staff had received training in safeguarding adults from abuse. They were able to describe the types of abuse to look out for and the steps they would take if they had concerns. Staff identified that they could report abuse and concerns outside of the organisation to the local safeguarding authority and the CQC. One care worker told us how they recognised possible signs of abuse, for example, if the mood of the person was different, "If they were withdrawn." Another staff member told us, "I am constantly aware of how vulnerable my clients are so I always pay particular attention to any new marks or bruises on their body." All those with whom we spoke said they reported all matters of concern to the office and they received a supportive response.

The service had a whistleblowing policy which supported staff to question practice. Staff confirmed that they had read the provider's whistleblowing policy. One staff member told us, "If something illegal is going on and I see the office can't solve it, I will report it." A second staff member told us, "If somebody is doing something wrong. I would quickly inform the manager or head office."

We looked at how the service recorded and investigated incidents and accidents. There were six reported incidents since our last inspection. Most of these were appropriately investigated and acted upon in a timely manner. However, we found one which had not been robustly investigated. We discussed this with the registered manager and told us they would explore the possibility of investigation training for staff who investigate incidents.

Care staff told us they had access to sufficient Personal Protective Equipment (PPE). We observed that care staff were able to come to the office and collect PPE as and when they required.

Good

Is the service effective?

Our findings

At our last inspection, we found inconsistencies in staff training, supervisions and annual appraisals. We also found that newly employed staff did not receive adequate post induction support. At this inspection we found that the provider had addressed these issues.

People and their relatives were mostly positive about staff and told us they were skilled to meet their needs, although some people had reservations about small minority of staff. Comments from people included, "[Carer] is the sort of carer you don't want to lose", "Majority are very good, some basic", "Yes, I think so; they go and be trained, yes", "Most of them are well-trained. There's always one that isn't very good but most of them are" and "Yes, they do everything they're supposed to do. They're very good. I'm very happy with the service. Overall I'm satisfied." A relative told us, "I would say overall, they come over as quite professional. You do get people who are being trained and you have one who's learning and one who's experienced." Another relative told us, "Yes. Well I can see they do their job nicely, moving her from the wheelchair and things."

Staff spoke positively of the training and support they received. One staff member told us, "The training is very good. It's always good to refresh your mind. I have recently done first aid, moving and handling, health and safety and medicines. I get a message with training dates." Another staff member told us, "I did training a few weeks ago. I'm up to date. This week I am doing medicines training." Training records confirmed that all staff were up to date with their mandatory training which included medicines management, moving and handling, infection control, fire prevention safeguarding adults, basic first aid and MCA.

New staff completed an induction course. This was a mixture of classroom and e-learning and included the mandatory training courses. We saw that new staff received a first shift review telephone call, followed by a one to one meeting at four and eight weeks. They then had a 12-week appraisal/end of probation meeting.

More experienced staff completed a care coaching workshop which enabled them to become care coaches and support and mentor new members of staff. We saw completed care coaching passports on the records of more recently recruited staff. This evidenced that new members of staff worked alongside care coaches before being signed off as competent. Records showed that they were observed with a variety of service users over a total of 12 hours. One care coach told us, "I take great pride in helping new staff and supporting them to give good care to clients."

Care staff had two field spot checks, two supervisions and an annual appraisal every year which was confirmed in records seen. Staff we spoke with told us that they had regular supervision, but any issues which arose in between booked supervisions could immediately be raised with their field supervisor. They said that supervision was done in a confidential manner. One staff member told us, "I feel I can talk about anything and get support if I have a challenging situation with a client."

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. At our last inspection we found that the provider was not working within the principles of MCA. At this inspection we found that the provider had mostly addressed this issue.

People told us care staff obtained consent prior to providing care. When asked if care staff asked for consent, comments from people included, "They do talk a little, but say 'is this alright?' you know, but it's virtually the same every day" and "Oh yes, yes; they've all been quite nice people." Staff we spoke with were able to demonstrate their understanding of consent. They told us how they always explained to the service user what they were about to do and asked their permission before doing so. If the person refused, a carer told us they would, "Back off but make sure I asked again a few minutes later in a different way." They told us if the refusal was consistent, they would log it and let the office and relatives know and try again on their next call. A staff member told us, "Because it's their home, it's what they want and I give them choice. I always ask."

Care files contained a consent form. In most cases, these were signed by the person themselves, or in cases where they lacked capacity to consent to their care, consent forms were signed by a person who had Power of Attorney (POA). A POA is a legal authorisation that allows someone who has been nominated to make decisions on a person's behalf where they are unable to do so. It is important to be aware that when a POA is in place decisions are made by the right person. This information is essential to ensure that decisions made on behalf of people are lawful. However, in some instances where a consent form was signed by a third party, it was not always clear that they had the authority to do so.

Care plans contained a personalised best interest plan which included an initial assessment which confirmed if the person had a diagnosis of dementia, whether they had short or long term memory issues and whether they required others to make best interests decisions on their behalf. Based on the information provided, a best interest plan was then devised which guided care staff on how to support the person to ensure they were involved in day to day decisions regarding their care. One person's best interest care plan stated, "[Person] has capacity to make decisions, however they stated that they sometimes forget things. [Person] is able to make day to day best interest decisions." Another person's best interest care plan stated, "[Person] has capacity, however family are fully involved in major decisions. [Person] chooses their outfits and plans their own [health] appointments." A third person's care plan stated that although they had been diagnosed with schizophrenia, they were presently stable and had capacity to make their own decisions. A relative told us they were involved in best interest meetings. They told us, "Yeah, I have to be there. They always involve me because they have to."

At the last inspection, we found that approximately 50 per cent of staff had not received training in MCA. At this inspection the registered manager told us that most staff had now received training in MCA and further training had been booked for February 2017. Out of 190 staff currently employed, records showed that 175 staff had received training in MCA. The registered manager told us that MCA was now included in the induction programme. Staff demonstrated an understanding of MCA and how that impacted on their role.

People's needs in relation to support with eating and drinking had been assessed during the initial assessment and recorded in their care plan. In one person's care plan, clear instructions about the person's dietary needs had been recorded. This included supporting information from a dietician which provided guidance on the correct texture of food and positioning when the person was eating. In another person's care plan, their vegan diet was noted and guidance was given to staff to support the person to take nutritional supplements.

Where people required support with meal preparation or eating and drinking, we received positive feedback. One person told us, "They usually sit with me while I eat my dinner and they wash the plate afterwards." A second person told us, "I have frozen dinners each day and they make my porridge in the morning." A third person told us, "Yes, breakfast, lunch and supper. I always have what I like except if they give me the same thing twice in a week, I don't like that. But they can't help it if the shop doesn't have what I want."

Some people told us that they were supported to access health services. However, many people and relatives we spoke to did not require assistance from the provider to access healthcare services as domiciliary care agencies do not generally support people with healthcare appointments as they provide care such as washing, dressing, medication and food preparation. However one relative told us, "I tend to do that, though occasionally the regular carer will phone the pharmacy when she notices mum's tablets are getting low." People and relatives relayed instances of when care staff assisted them in an emergency situation. One person told us, "Yes, the morning carer had to call an ambulance because I had a fall." Another person told us, "They had to call 111 because I was having a job to breathe."

Good

Is the service caring?

Our findings

Most people told us that most staff were generally caring and kind. Comments from people included, "Very kind and supportive", "They are great", "Yes, yes. Both of them are very very good" and "[Carer] chats while working. [Carer] is the best." One person told us, "One of the carers who comes at the weekend brought Christmas cards." Comments from relatives included, "They're very caring; they're very gentle with [my relative]" and "They treat him well. They're very patient with him." One relative we spoke with told us about a recent incident where her relative who is living with dementia went missing. The carer alerted the police and assisted the family with locating the person and safely returning him home. The relative told us the carer's communication was excellent and the family were very pleased with the support received. Another relative told us, "The weekday carer had taken a photograph of my mum and put it in a little frame for her birthday. She notices when things are not right and has alerted me and then I contact the GP, things like if she's trodden on her glasses or there's a problem with her hearing aids. She does go the extra mile. When my mum was in hospital, she remained in contact. She's very fond of her. Now she collects her paper on the way. She asked: 'If you want, I can call in to the paper shop' and that's a help. I buy ready meals but sometimes there's a limited choice, so the carer got me onto [name of food provider] meals and that makes it easier for me because they can be delivered. She's very helpful."

All staff we spoke with told us that they provided care for the same people on a regular basis and knew their needs with some staff having cared for the same people for a number of years. We asked staff how they built a relationship with the person they were caring for. Many carers told us they cared for people living with dementia. One staff member told us, "This is best especially since so many of our clients have dementia. It is really important not to add to their confusion." A second staff member told us, "I always communicate with them. I introduce myself and I relate to the previous day. I love my job. I like working with people and I am willing to help them in any way I can." A third staff member told us, "I always make sure I talk to them so they are aware of who I am. I give one person breakfast. If he says he already had it, I always check to make sure." A fourth staff member told us, "It takes time for them to get used to you. I keep them happy and I talk to them. I may be the only person they see that day. I'm a chatterbox!" A fifth member of staff told us that they supported a person to become more independent. They told us, "One client had a hip operation and they wanted to go into their garden. It took time and encouragement last summer to build their confidence, walking her to the door to the garden. She did it at one stage and she was pretty happy."

People told us staff respected their privacy and dignity and were treated with respect. One person told us, "Oh yes, they are very respectful." Another person told us, "Oh, I must say, yes; they're alright, yes." A third person told us, "Yes the staff respect me. I respect myself." Staff told us they gave people privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain the person's safety. For example if they were at risk of falls or were too confused to be independent. One care worker told us, "I never assume a person cannot do something and try to encourage them to be as independent as possible. It may be that what a person cannot do today, they will be able to do it tomorrow."

We reviewed compliments received from people and relatives who used the service which included a number of thank you cards from relatives of people who had recently passed away. Comments on the

correspondence received referred to people being very happy with the care and support they received. One letter commented on the 'positive impact on their relative's emotional wellbeing' the care staff had made. A number of care staff had also been nominated for a Dignity in Care Award by people who used the service. One person nominated a staff member because the carer was very understanding of the person's religion and culture. The person also mentioned that the carer always respected their dignity by knocking on their bathroom door.

People and relatives told us they were involved in the planning of their care. A relative told us that the care plan was discussed by talking through any changes to their relatives needs and the family were involved in the best interest meeting. It was evident from looking at care plans that people and their families were involved in their care planning. Care plans were person centred and contained individual plans regarding the specific needs people had. For one person, their communication care plan noted that they were non-verbal and gave staff specific guidance on how to communicate with the person using gestures, keeping sentences to a maximum two to three words and using a flip chart.

Good

Is the service responsive?

Our findings

At our last inspection we found that care plans were not person centred and not reflective of people's current care needs. We found that care plans were not in place for all people who used the service. At this inspection we found that the service had addressed this issue.

The service had developed new care plans and comprehensive guidance was available to staff to assist them to work with the person and their families to create a comprehensive and person centred care plan. Care plans were set out in individual sections which addressed a number of areas people may need support with, such as communication, mobility, nutrition, continence, medicines, skin integrity, washing and dressing, domestic support, finances, sleeping, breathing and access to the community/activities. Where people required support in any of these areas, an individual care plan was created for the person which gave guidance to staff on how to support the person in that area. Where a person had multiple daily calls from the agency, each of these calls were written separately within the care plan and the tasks to be performed for each visit were clearly identified. Care plans also documented people's medical conditions by detailing the type of medical condition and the symptoms a person may display if they were experiencing ill health. Guidance was given to staff on what to do should the person experience ill health.

Care staff we spoke with said they found care plans to be informative and in a format which was easy to read. One member of staff told us, "I always refer to the care plan and never assume that I know everything that is in it." Another staff member told us, "I look in the log book and I go straight to the care plan." People and staff told us that care plans were available in people's homes which was confirmed when we visited people's homes.

Care plans were generally reviewed on a yearly basis or when people's needs changed. Following the last inspection, the majority of people's care plans had been reviewed in accordance with the conditions placed on the provider's registration. The registered manager told us that where people were not due for a care plan review, they would be completed as and when their next review was due. People told us that they were involved in their care reviews. One person told us, "They come round about every six months and talk." Another person told us, "Yes, they came down and reviewed it a little while back." A relative told us that they were involved in care reviews, as they acted as the person's interpreter.

Care staff recorded their visits in a log book. We saw that they were detailed and clear to read, however, we noted that on occasion entries were not dated or initialled by the carer. Log books were audited on a six monthly basis and documents showed that care staff were reminded to correctly complete care records in this regard.

Documents seen confirmed that care workers raised concerns such as noticeable deterioration in mobility, increased confusion, poor skin integrity and weight loss. We saw evidence that such issues had been referred to the GP. The registered manager told us there was frequent contact with the local authority and we saw emails to and from social workers concerning individual packages of care. We saw that concerns were frequently raised with social workers when, for example, the person who used the service refused

support with their personal care or medication.

The provider had a complaints policy which provided details of the complaints process and escalation process if complaints were not dealt with effectively. People were given a copy of the complaints procedure when they started to receive a service and told us they called the office if they had problems. People and relatives confirmed that they could complain if needed to. Comments from people and relatives included, "I would complain to the office", "Well, I haven't had to complain, but I'm sure I would be, yeah" and "Oh yes, I can go to the office if need be and if I'm not satisfied with the carers or something, I call them." Where people and relatives had made a complaint, we received mixed feedback on whether they were satisfied with the response. One person told us, "I didn't get any outcome of it." Another person told us, "I complained once about a carer being late. I phoned the office and it was dealt with."

We looked at the service's complaints file. We saw that 36 complaints had been recorded since the last inspection. The registered manager told us that most complaints were in relation to late visits or the attitude of the carer which was reflected in the complaints seen. The registered manager told us that the carer involved would be monitored closely with additional supervisions and training, if required. These complaints had been investigated and a response had been provided to the complainant or local authority. We discussed with the registered manager how complaints were analysed for trends. The registered manager told us that complaints were recorded on the providers centralised Complaints Incidents Accidents Monitoring System (CIAMS) and from this data information about trends and specific staff could be extrapolated and analysed. We saw that where complaints and incidents had been logged, there was senior management oversight of the case and updates were regularly requested from the office based management team.

Where people were supported by care staff to attend activities or access the community, their care plans detailed the information and risks were assessed. However, most people and relatives told us that they did not require assistance from care staff to go out into the community.

Requires Improvement

Is the service well-led?

Our findings

Overall, people and relatives were positive about the service they received and told us they thought the service was well managed. Most people we spoke with told us they did not know the registered manager. For a service this size, this was to be expected and people told us they could call the office to speak with a care co-ordinator or a field care supervisor, if needed. Comments from people included, "Oh yeah, I think it's very very good", "Yeah, it is well-managed," "Yeah, I think so. They're organised" and "As far as I'm concerned Allied are doing a good job, the staff and communication are good for the service you expect."

However, we also received some poor feedback from people and relatives regarding their experiences with office based staff. One relative told us, "The problems seem to be in the office. There's lots of confusion and lack of co-ordination. I'm highly confident in the care staff themselves overall but there's something lacking in the office/management." Another relative told us, "Usually they don't call if they're going to be late but there's been a kind of improvement in the last month and around Christmas, they did call and say they were going to be late. Usually I'd call the agency if they're late; I give them 10-20 minutes."

We asked people and relatives if they would recommend the service. We received mostly positive responses. Comments included, "Yes, as far as I'm concerned, I'm quite satisfied with the service I get here", "Oh yeah, I would 'cos they're friendly and we have a laugh", "At the moment I would cos everything is sorted out" and "I would recommend [carer] but on the whole, no."

We received mostly positive feedback from staff regarding the management of the service and the support they received. One staff member told us, "The manager has always got time for us." Another staff member told us, "It is like a family here, we work well as a team." A third staff member told us, "Things are so much better since the last CQC inspection – better organised and better care plans." Staff told us that they received support from office based staff if they had any queries or concerns. One staff member told us, "Office based staff always respond to my calls and listen to what I have to say." A second staff member told us, "We are working well together. [Registered manager] is supporting and getting involved a lot. Now that there is a care delivery manager. There is more balance."

At our last inspection, we found a lack of managerial oversight in relation to care planning, risk assessments, obtaining consent, medicines management, staff supervisions and appraisals and aspects of staff recruitment. Following our last inspection, we imposed conditions on the provider's registration that required the provider to send a report to CQC each month with details of audits of care plans, risk assessments, medicines management, staff supervisions and appraisals.

At this inspection we found significant improvements had been made in these areas as detailed throughout the report. The registered manager told us that staff had worked very hard to make improvements. Risk assessments identified individual risks and provided guidance to staff to understand and mitigate the risks posed to people. Care plans were comprehensive and person centred. Improvements had been made to ensure safe staff recruitment and staff received effective and regular supervisions and appraisals. However, we found that there were some aspects of medicines management and ensuring continuity of care and

communication at weekends and out of hours which required further improvement.

Since our last inspection, there had been changes to the management structure at the service. Two managerial roles had been created and filled. A care delivery manager had been appointed and was in place. This person supported the registered manager in a deputy capacity and had responsibility for line managing the care co-ordinators and overseeing recruitment. A field care team leader had also been recruited to ensure effective quality monitoring of care planning and line managing field care supervisors. Both of these roles had recently been filled and how these roles will embed and improve care quality can only be assessed at a future inspection. However, the newly recruited team leader told us, "I feel really happy about how things are now. We plan to keep it up and not to fall back. I make sure I am monitoring quality."

At our last inspection we found that the field care supervisor's workload meant that appropriate care planning and support of care staff via supervisions and spot checks was lacking. Following the last inspection, we imposed a condition on the provider's registration which restricted them from taking on new care packages, which resulted in a loss of approximately 100 care packages. Since the last inspection, the number of field care supervisors had also fallen from five to three. The registered manager told us that the two vacancies had been filled with experienced and competent field care supervisors from another branch of Allied Healthcare and an additional field care supervisor was also being recruited for. The area manager told us that the focus moving forward was on ensuring the improvements made following the inspection would be sustained and appropriate support at provider level would be available to the registered manager.

Since our last inspection, the service had worked closely with both placing authorities. We received positive feedback from both placing authorities prior to the inspection regarding the progress the service had made in the areas of concern identified during the last inspection. Prior to the inspection we had checked the provider's website and found that the rating from the last inspection in May 2016 had been displayed with a link to the inspection report. We also saw that the rating had been displayed in the office. Records confirmed that people and relatives had been contacted and made aware of the findings of the last inspection and what action the provider would take to address the findings.

The registered manager and senior management carried out regular audits of the service provided. The registered manager completed a monthly self-audit where approximately 10-12 care files were picked at random. Checks made included: whether there was a care plan in place; that a quality review was completed every six months; risks were appropriately assessed; and, log books and MAR charts were completed appropriately. Staff files were also picked at random and checks made included confirming staff competencies in medicines and whether staff supervisions and appraisals had taken place as set out in the provider's supervision policy. This linked with the monthly audit the registered manager submitted to the CQC as required by the conditions on their registration. We discussed the sustainability of the quality monitoring measures in place with the registered manager and area manager who both reiterated that the increased level of quality monitoring in place since the last inspection would remain and continue to embed.

The service requested feedback from people and records confirmed this. People received regular quality monitoring calls and a questionnaire was sent to people and relatives between June and September 2016 and 64 responses were received. The responses were analysed and an action plan was completed following the survey. The feedback received was overall positive with 27 per cent of respondents rating the service received as excellent, 26 per cent rating the service as very good and 29 per cent rating the service as good. Four per cent of respondents rated the service as poor. The resulting action plan identified that timekeeping,

consistency of carers at weekends, communication regarding change of carer and response times to complaints and service issues should be improved. A meeting was held with office based staff in November 2016 to discuss and implement the action plan. However, feedback we received from people and relatives during and after the inspection indicated that these previously raised concerns had not been sufficiently rectified.

We looked at customer quality review forms, the majority of which indicated that people were satisfied with the service they received. The most common complaint was around care worker punctuality. Where a person raised a concern, we saw that this was followed up and any resulting actions communicated to the person. Some of the actions taken included amending calls times or changing the care worker.

Regular staff meetings took place which included a monthly branch staff meeting and a series of meetings for care staff to attend. We saw that topics discussed at recent meetings included the outcome of the last CQC inspection and improvements made, rotas, medicines management and holidays. One staff member told us, "We have regular team meetings. It is a good place to talk about things and be told of any new things within the organisation." A second staff member told us, "I always voice my opinion, although they are not always glad to hear it!"

Since the last inspection the registered manager and office based staff had been proactive and committed to improving the service. Managerial oversight of the service had improved since the last inspection. Good practice had been developed, but further time was needed to address outstanding issues and for the service to demonstrate that the improvements that had already been made had been fully embedded and could be sustained.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) The service did not always ensure staff were deployed effectively to meet peoples needs at all times.