Nestor Primecare Services Limited

Allied Healthcare Maldon

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this announced focused inspection of Allied Healthcare Maldon on 26, 27 and 28 June 2018. This inspection took place to check the provider had made the necessary improvements to meet legal requirements after our last inspection of 15 March 2018.

At our last inspection we rated the service as 'inadequate' in safe and well led. We had concerns about the impact and risk of missed and late calls resulting from insufficient staff, poor organisation and a lack of oversight. We found the provider in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically Regulation 12 (Safe care and treatment), Regulation 13 (Safeguarding service users from abuse and improper treatment), Regulation 17 (Good Governance) and Regulation 18 (Staffing).

We inspected the service against two of the five questions we ask about services: is the service well led and is the service safe? This is because the service was not meeting some legal requirements in these two key questions. No urgent risks were identified in the remaining key questions through our ongoing monitoring so we did not inspect them. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Allied Healthcare Maldon on our website at www.cqc.org.uk.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a reablement service to adults on a short-term basis until they are able to care for themselves or alternative social care arrangements are made. Placements are predominantly for people recovering from a hospital stay. This location also provides a standard domiciliary care service. There was no indication that there were any significant concerns within this part of the service at the time of our inspection so we did not inspect this element of the service.

At the time of the inspection there was a registered manager, however the registered manager had taken time away from the service. The manager who had been covering this absence had left suddenly in the week before our inspection. A replacement manager was recruited shortly after our visit, so we were not able to measure the impact from this new appointment. 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 improvements had been made since our last inspection, however there had not been enough time to measure whether these improvements were sustainable, especially if the numbers of people using the service increased. In addition, the lack of an established management team had resulted in inconsistency and instability, which challenged the long-term success of any improvements at the service. We therefore found a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we spoke to people who told us they were anxious and felt unsafe due to rushed,

missed and late visits. People who were now using the service gave us much more positive feedback and told us they felt safe.

There had been a marked reduction in the number of missed visits. There were very few missed visits and, where these happened, senior staff investigated each incident and took action to minimise the risk of them happening again. Staff stayed the required length of visit to ensure they carried out the agreed support tasks and people were safe.

There were systems in place to assess the level of risk of each person at the service. Senior staff assessed people's needs to ensure staff had enough information to provide the support required and to make sure they were aware of any key risks staff should be aware of before care visits started. Care plans gave staff improved information about people's needs. Staff carried out regular reviews to assess any changes in people's needs and level of risk. People were supported to exit the service appropriately, freeing up staff to take on new people in a managed way.

Staff morale had improved since the last inspection as they felt they had enough time to meet people's needs and respond to any concerns. However, communication at the service, particularly, from the senior managers to office staff, had not improved sufficiently to ensure the whole staff team were involved in driving improvements. The provider had failed to promote a culture where people felt able to speak out and together learn from mistakes and feedback.

The provider had made some improvements in the way they monitored the quality of the service, in particular, how they measured missed visits and responded to risk. However, the regular audits were not tailored to a reablement service and so were not a sufficiently robust and appropriate check on how well the service as a whole was working.

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 consistently safe.

The numbers of missed and late visits had reduced.

Systems to assess and minimise risk to individual safety had improved.

The provider demonstrated they were learning from mistakes but had not promoted this practice across the service in a consistent, open and positive manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

Senior managers had focused on reducing the number of missed visits and managing risk.

Communication with staff was not consistent and open.

The quality checks around missed visits were good. Other audits were not tailored to reablement and the provider had not developed robust systems to pick up and proactively address other concerns which we had found at our last inspection.

Allied Healthcare Maldon

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 carried out the inspection to check the provider had taken the necessary actions in response to our last inspection. We focused on the key concerns from the previous inspection and did not review all areas of safe and well led.

This inspection took place on 26, 27 and 28 June 2018, and consisted of one day spent in the office and two days making phone calls to staff, people and families. The inspection was announced. We provided 24 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure the right staff would be available for us to talk to, and that records would be accessible.

The inspection team consisted of two inspectors, an assistant inspector and one 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, and their expertise was in the care of older people. The expert by experience and assistant inspector telephoned staff and people who used the service and their families to ask them their views about the quality of the support they received. In total they spoke with five staff, 15 people and one family member.

During our visit, we met with the care delivery director, the senior manager who had been overseeing the service since our last inspection. We met with office staff responsible for quality monitoring and the management of the service plus care coordinators and four care staff. We attended an information sharing meeting regarding the reablement service which was arranged by the local authority in the week before our inspection.

As part of the inspection, we reviewed a range of information about the service. This included a Provider Information Return (PIR). A PIR is a form completed by the registered manager to evidence how they are providing care and any improvements they plan to make. However, the PIR used had not changed since the

last inspection, as we had returned within six months. We also looked at safeguarding alerts and statutory notifications, which related to the service. Statutory notifications include information about important events, which the provider is required to send us by law.

We looked at twelve care records for people who used the service. We also looked at further records relating to the management of the service, including the systems which monitored the quality of the care people received.

Requires Improvement

Is the service safe?

Our findings

Safe was rated as 'inadequate' at our last inspection in March 2018 and we found breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. When we looked at the safety of the service, we found breaches of Regulation 12 (Safe Care and Treatment) and Regulation 18 (Staffing). This was due to concerns that the provider had failed to manage risks to people's safety and protect them from the risk of abuse. There were also not enough staff to keep people safe. At this inspection, we focused primarily on these concerns to see whether the provider had taken action, as required. Whilst we found the provider had started to address our concerns, improvements were still ongoing and we judged safe as 'requires improvement'.

People told us the service had improved considerably since the last inspection. They said, "The support workers are very professional. There were two reassessments throughout the service and I know when my service is finishing," and, "It's a really good service. I get four visits a day and the support worker stays around 20 minutes to an hour, depends really. They have never let me down."

Senior managers had focused on the concerns around the high number of missed visits and had succeeded in reducing the number of missed visits each week to single figures. Any missed visited were now logged, investigated and acted upon. Due to the improved oversight, senior staff were able to act swiftly to resolve issues before they escalated, for example they promptly resolved a glitch in the system around visits being assigned to staff who were going on leave. The improvements were supported by the reduction in numbers of people using the service and more time was needed to measure whether the improvements were sustainable as the service grew.

At our last inspection, we were concerned staff were being instructed to cancel calls due to the weight of demand. At this inspection we found this no longer took place. People received the service which had been agreed. People told us, "They turn up on time and it's not a rushed service," and, "They stay for the full half hour service." Managers and staff all told us there was no longer pressure to cancel calls. A member of staff told us, "The nonsense of ringing people and trying to get them to cancel so we could record 'client cancelled' has stopped." A care coordinator said," It is better now. We rely on the staff to do what's needed, sometimes it's 20 minutes and other times 40 minutes. They do whatever people need to ensure they are safe and well."

During the last inspection we found staff were not deployed effectively to support the people who needed them most. This was partly because the systems to measure who was most at risk were not working well, so managers were not prioritising people who were at high risk. This had now improved and managers and staff had a clear picture of the people who were high, medium and low risk. For example, rotas were planned to ensure staff prioritised people who were prescribed time-specific medicines.

People and staff said the rotas had improved significantly, though there were some concerns about the consistency of staff. One person said, "The only issue is not having the same support worker throughout the service duration." Staff also felt consistency was important to the success off the reablement. A member of

staff said, "Not being regular with a service user is not good because you can't build an effect relationship with them and see their progress." We discussed this with senior staff who told us this was an area they were still addressing.

At our last inspection we found people were at risk of abuse as they were not being supported to remain safe. There was now a greater awareness of how vulnerable specific people were to abuse, for example, the improved systems to monitor missed visits considered the impact to people's safety. Staff were more aware of people's risks and how to minimise them. Care staff told us office staff responded more swiftly when they raised concerns, such as when new equipment or a referral to another agency was needed.

When we last inspected we had concerns staff were not given enough information about people's needs and any potential risks they should be aware of when providing support. We found this had improved. Senior care staff now attended the first call for a new person starting the service which gave them an opportunity to assess the person's needs and make sure there was adequate information in place. Senior care staff were being retrained to better understand people's needs, though this was an ongoing process. For example, staff responsible for assessing people's needs had received training about equipment which was available to maximise people's independence.

We found the system to track people's progress through reablement worked well. For example, one person had progressed from a risk level of 'Amber' to 'Green' as they achieved their goals in nutrition and mobility. There were clear reviews, recorded on the system which helped care staff provide a more consistent service.

The reduction in numbers of people using the service had wider benefits, for example, a member of staff told us, "The hotline call service is so much better than before. It takes around three or four minutes to get through. Before you could be on hold for so long that you gave up." A member of staff described the benefits of office staff having more capacity to support them, "I rang the office and the senior staff sorted out a person's medicines. They would not have had time to do that before so I would have had to go back in my own time to make sure they were safe."

We found the provider and senior managers used learning from mistakes to make improvements. For example, staff told us all the systems had gone down one day and they were not able to see their rotas on their phones. Senior staff had telephoned them to let them know where they had to visit. Whilst we had concerns that on that day there was a small number of people who did not receive care, we found senior managers responded effectively and made immediate improvements to minimise the risk of this happening again. Staff now received individual rotas the day before they went out so that they could still carry out visits if the systems were down. We asked senior managers to review their contingency plans to include any new people who started the service after staff received their individual rotas to ensure these people were covered.

Despite this example of good learning by the provider, we found that the lack of communication between the provider, senior managers and staff meant lessons learnt when mistakes happened were not shared to the wider team. The service did not have a shared culture around using mistakes to drive improvements. A member of staff said, "There are no lessons learned shared with anyone." We were given specific examples where staff mistakes and raising of concerns were not managed in a positive way and so opportunities for learning were not maximised. This is discussed further in the well-led section of this report.

Requires Improvement

Is the service well-led?

Our findings

Well-led was rated as 'inadequate' at our last inspection in March 2018 and we found a breach of Regulation 17 (Good Governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014. We had concerns the provider had not put measures in place to identify and act on the risks to people's safety. At this inspection we found improvements had been made, in particular around the reduction in missed visits and we rated well-led as 'requires improvement.'
However, we had concerns the service was being affected by the lack of consistent management and poor communication by the provider to the staff team and so we found a continued breach of regulation. Although the provider had started to address our concerns, more time was needed to ensure improvements continued and any progress was sustainable.

Feedback from people and families was largely positive and reflected the improvements we had found in the support people received. They told us, "I think it is an amazing service, as soon as I arrived home from hospital they were there within the hour, they helped me to get to being independent", "They wrote down what I needed, the care slowly reduced as I improved and I was signed off yesterday" and "They are well organised. It runs like clockwork, they always turn up on time and they are pleasant and helpful."

After our last inspection, we took urgent action to limit the numbers of new referrals. As a result, the numbers of people using the service reduced from over 500 to approximately 160. Senior managers used this time effectively to improve processes before gradually taking on new people, in a measured way. Staff told us the reduction in numbers meant they now had time to provide people with the support they required. The care delivery director, the senior manager who had been overseeing the service since our last inspection, said, "Things are much better now. It's been a huge learning curve." In particular, we found the concerns around missed visits had reduced. The provider reported regularly to us and to the local authority about the number of missed visits, as required.

At our last inspection, the systems designed to move people through the service had failed. New people had been taken on before those who no longer needed care or required long term care had finished using the service. As a result, there had not been enough staff to complete the required visits. At this inspection, this concern had been addressed. Senior staff were reviewing people, and moving them through the service, in line with the set procedure. Although there were some delays in people leaving the service, for example, because a new care provider could not be found, senior staff knew what the issues were and were managing the situation.

The improvements in reviewing people meant individual risk was being managed more effectively. Managers and staff knew which people in the service were at high risk and so were better able to structure the service to ensure these people's needs were met.

Systems to manage the deployment of staff had improved. Office staff covering different geographical areas met a few times a day in meetings called 'huddles' where they discussed how they could manage staff to meet demand. These meetings were improving how well the service functioned. For example, following a

recent 'huddle', staff were being transferred temporarily to an area where demand for staff was starting to outstrip supply.

Whilst we found there had been significant improvements in reducing missed visits and in managing risk at the service, the management of the service remained fragile and inconsistent. On the day of our inspection, interviews had just taken place for a new branch manager of the reablement service as the former manager had left the previous week. We heard of a number of other key senior staff who were also leaving. Roles and responsibilities were constantly changing and these changes were not always communicated clearly to staff. For example, the provider had representatives overseeing the improvements. These representatives had communicated well with us and with the local authority, however, some office staff told us they did not know who they were or what they were doing at the service.

We had some concerns whether improvements would be sustained if we lifted the restrictions on admissions. A staff member said, "It won't take long for us not to cope again." There was insufficient guidance in place to help staff prioritise referrals, if numbers increased. A member of staff told us referrals were dealt with on a 'first come first served basis' with limited procedures in place about what to do if they were not able to provide a service within 24 hours. We discussed this concern with the provider who agreed this would be addressed in consultation with commissioners.

At the last inspection we had concerns regarding the morale of staff. We found there were improvements in this area. Care staff were particularly positive about the changes at the service. A member of care staff told us, "Work has really improved recently. I get rosters around three to four days ahead. Before, the organisation took on too much work, I was just doing care work. Now the job is getting back to being what I do: reablement."

Feedback from office staff was mixed. Everyone we spoke with told us things were much better. Members of staff said, "It's really improved from what it was like before," and, "Team morale is better. There is more light-heartedness around. Due to the numbers being suspended we have more time to catch up." However, poor communication was a constant theme throughout our inspection. None of the members of office staff we spoke with told us the provider and managers communicated well with staff. Staff told us, "I find the biggest problem is the lack of communication", "We are drip-fed information" and "None of the management come and sit with us and we are not spoken to very much by any managers."

Staff told us erratic communication from different senior staff led to an inconsistent service. One member of staff said, "We can talk to managers but you get a different answer depending on who you speak to." A member of staff told us, "It has taken three weeks back and forth to get answers to questions and procedures such as dealing with responses to nurses about referring people."

Staff told us they were anxious about the future. Whilst there were pockets of good morale and some pride in the improvements, this was not a united staff team. During our inspection we found staff did not feel confident about speaking out to us or to senior managers. A member of staff told us, "There is still a blame culture here and the way they go about dealing with things is still cold. Do one thing wrong and you get called into the office but nobody says well done when things go well." Despite this feedback we found staff to be committed to the people they supported and to the benefits of reablement to their lives.

Care staff told us they now had meetings with senior care staff, which they found supportive. Planning staff had also been supported to set up the 'huddles', but this good practice was not replicated throughout the service. At our last inspection, we had concerns about the support to the customer service and intake teams, who had been under extreme pressure. We continued to find staff and coordinators in this team to be

committed and knowledgeable, however they had not been managed and communicated with in a consistent manner.

The providers oversight of some areas of the service, such as missed visits, had improved since our last visit. There were improvements in the reviewing of people's care and senior staff used this information to better manage risk for individual people. Senior staff had been freed up to carry out ongoing monitoring tasks for example, care staff told us senior staff carried out spot checks, to monitor what care staff were wearing and how they spoke to people.

We were concerned the measures to monitor the service were still not sufficiently robust. The care delivery director sent us a copy of the recent audit which was completed quarterly for the reablement service. The audit mainly looked at records, rather than the quality of care, for example whether risk assessments were in place and the correct recruitment checks completed for new staff. Whilst these audits led to improvements in some areas of the service, we found they were not designed to pick up the concerns we had found at our last inspection. This was partly because the audits which were used had been created by the provider for their 'standard' domiciliary care agencies.

We were told by the provider they were still developing an audit which would be specific to the reablement service, but this was not yet in place. This meant there were areas of the reablement service which were not being fully monitored. For example, the audits checked that people received a review of their care at least twice a year, despite the fact people using the reablement service received support for less than six weeks and required regular reviews during this period.
We also had concerns regarding how robust the checks were. Senior staff had looked at three care records during the quarterly audit and had given the records a score of 98-100%. This scoring did not reflect the inconsistency we found in care plans when we looked at them. Some care plans provided good quality information whilst others were confusing. For example, one care plan said a person was independent with personal care but that staff should check for pressure sores. We found these audits did not provide senior staff with high-quality information which they could use to drive improvements.
The concerns regarding how well the service was being managed were a continued breach of Regulation 17 (Good Governance) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A shared understanding amongst staff, people and referring professionals of the purpose of reablement was central to how well the service functioned. Care staff were able to describe clearly the difference between domiciliary and reablement and people we spoke with gave us examples of how the service had developed their skills. Senior staff told us the reduction in numbers enabled them to focus on this area. For example, they ensured reviews of people's care considered whether reablement was appropriate to meet their needs and if not, staff had referred people to other agencies for more appropriate support.

The care delivery director told us they had spent time building relationships up with partners, such as commissioners from the local authority and representatives from local hospitals. They said they had focused on addressing concerns around discharges from hospitals in two particular areas where risk was most high. We met with the commissioners from the local authority who confirmed there had been improvements in communication and in the concerns highlighted at the recent inspection. We were advised that the provider had an action plan with the local authority to make necessary improvements to the service.

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 17 HSCA RA Regulations 2014 Good governance The systems to monitor the quality of the reablement service were not sufficiently robust and there were not measures in place to promote consistent and open communication between the provider and the staff team.