Nestor Primecare Services Limited

Allied Healthcare Wembley

Inspection report

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Date of inspection visit:
30 May 2017
31 May 2017

Date of publication:
12 July 2017

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

Our inspection of Allied Healthcare Wembley took place on 30 and 31 May 2017 and was announced. 48 hours' notice of the inspection was given because we wanted to be sure that a manager was available when we visited.

At our previous inspection of Allied Healthcare Wembley in February 2016 we found that the service was not meeting the requirements of the law in relation to the assessment and management of risk for people who used the service and the supervision of staff members. During this inspection we found that improvements had been made in order to meet the requirements identified at the previous inspection.

Allied Healthcare Wembley is a domiciliary care agency that provides a range of care support to adults living in their own homes. People who used the service had a range of support needs including physical and sensory impairments, learning disabilities, mental health needs and conditions associated with ageing, such as dementia. In addition to providing personal care, the service also assisted people with domestic tasks, such as shopping, housework and meal preparation. At the time of our inspection the service provided support to 170 people who predominantly lived in the London Boroughs of Ealing and Brent.

A registered manager was in place. 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 told us that they felt safe when receiving care. Staff members understood how to safeguard the people whom they supported. There were appropriate numbers of staff employed to ensure that people's needs were met and that there was continuity of care in the case of staff absence. The provider had carried out checks to ensure that staff members were of good character and suitable for the work that they were engaged in.

Arrangements were in place to ensure that risks associated with the provision of care and support were assessed and managed. Risk assessments and management plans had been reviewed regularly and updated where there had been changes in people's care needs.

Some people's medicines were administered by staff members and we saw that this was recorded. the service's monitoring procedures had identified an issue in relation to the clarity of one record. One record did not include information about codes used to indicate where medicines had not been administered and this was addressed immediately.

Staff received regular training that covered a wide range of topics and met national training standards for staff working in health and social care services. They were able to describe the training that they had received and tell us about how it helped them to support the people with whom they worked.

Training and information had been provided to staff about The Mental Capacity Act (2005), including the Deprivation of Liberties Safeguards. Information about people's capacity to consent was contained within their care plans, and staff were able to describe how they supported people to make decisions and choices about their care.

Arrangements were in place to ensure that staff were provided with regular supervision by a manager. The records showed that regular supervisions had taken place and this was confirmed by the staff members that we spoke with.

Care plans were in place detailing how people wished to be supported, and people were involved in making decisions about their care. People told us that they valued the support that they received from their care staff. Staff members spoke positively about their work and the people whom they supported.

People told us that they knew how to contact the office and were confident that the provider would deal with complaints appropriately and quickly. Regular monitoring of people's views of the service had taken place and we noted that this showed high levels of satisfaction with the service.

People and staff members told us they were satisfied with the management of the service. There were effective processes in place to monitor the care and welfare of people and improve the quality of the service. Changes were being made as a result of these, such as training to improve the quality of report writing and recording, and the introduction of new streamlined care plans.

The service worked in partnership with other health and social care providers to achieve positive outcomes for people.

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. People's risk assessments were up to date and guidance in relation to managing risk was provided for staff delivering care.

Staff we spoke with understood the principles of safeguarding, how to recognise the signs of abuse, and what to do if they had any concerns.

Information about people's medicines was detailed and medicines administration records were signed and dated.

Is the service effective?

Good

The service was effective. Staff members received regular ongoing supervision from a manager.

A detailed staff training programme was in place and training was 'refreshed' regularly.

The service had policies and procedures on The Mental Capacity Act and Deprivation of Liberty Safeguards, and information about capacity was recorded in people's care files.

Staff ensured that relevant professionals were informed and involved where there were concerns about people's health and well-being.

Is the service caring?

Good

The service was caring. People who used the service spoke positively about staff members' approach to care, dignity and respect.

Staff members that we spoke with spoke in a caring way about the people whom they supported and described positive approaches to ensuring that people's needs were met and respected.

The provider had arrangements in place to ensure that people were matched to appropriate care staff, and to ensure that, wherever possible, people would not be supported by a carer

that they were unfamiliar with should one of their regular carers be absent.

Is the service responsive?

Good

The service was responsive. Care plans were up to date and included detailed information about how and when care should be provided.

Care plans and assessments contained information about people's needs, interests and preferences.

People who used the service knew what to do if they had a complaint, and we saw that complaints were listened to and acted upon.

Is the service well-led?

Good

The service was well led. People and staff members spoke positively about the management of the service.

A range of quality assurance processes were in place, and these were monitored and used to ensure improvements to the service.

Allied Healthcare Wembley

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 visited Allied Healthcare Wembley on 30 May 2017 and returned to review further information on 31 May 2017. The inspection team consisted of one inspector and an expert by experience who conducted telephone interviews with people who used the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used a range of methods to help us to understand the experiences of people who used the service. We reviewed records held by the service that included the care records for 10 people receiving care and support and 11 staff records, along with records relating to the management of the service.We spoke with the registered manager, a care delivery director, two care coordinators, a field care supervisor and four care staff members. We were also able to speak with 11 people who used the service and two family members.

Before our inspection we looked at the information that we held about the service. This included previous inspection reports, notifications, enquiries and other information that that we had received from the service. We also spoke with a representative from a commissioning local authority.

Good

Is the service safe?

Our findings

People who used the service told us that they felt that the service was safe and that they were confident with the quality of care staff. One person said, "I have no problems about the way they support me. I feel very safe." A family member said, "[My relative] is well looked after and I am certain that there is no unsafe practice."

At our previous inspection of Allied Healthcare Wembley we found that risk assessments for people did not accurately reflect their identified care and support needs. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

During this inspection we found that improvements had been made. Risk assessments for people who used the service had been carried out at the point of referral to the service. These included information about a range of risks relevant to the person's needs, for example, moving and handling, mobility, falls, medicine, behaviours and risk within the community. Risk assessments also included information in respect of environmental risk, and safety of equipment. Staff members had received moving and handling training prior to working with people who required this support.

The risk assessments that we saw contained information for staff members about how they should manage identified risk, and this information was reflected in people's care plans. Guidance was in place in people's files in relation to supporting risks associated with specific conditions such as diabetes, epilepsy and dementia. The guidance that we saw in relation to specific conditions reflected good practice guidance but had not always been personalised to address people's individual needs. We discussed this with the registered manager who told us that they would ensure that the guidance was reviewed for each person and updated to ensure that it was person centred.

The service had policies and procedures in relation to safeguarding. The staff members we spoke with were familiar with the principles of safeguarding of people who used the service. They were able to describe the signs and indicators that might suggest abuse, and what they should do if they had a concern. The service's training records showed that staff had received training in safeguarding prior to commencing work with people who used the service, and that this training was refreshed on a regular basis.

We looked at records in relation to medicines. There was a policy and procedure for administration of medicines that reflected current best practice guidance. The training records that we looked at showed that staff members had received training in safe administration of medicines. The care files that we saw included detailed assessments of the medicines that people used, that included information about what they were for. Medicines administration records (MAR) that we viewed had been signed to show that medicines had been received by the person. We saw that these had been audited by the service on a regular basis. One MAR was unclear, and we saw that this had been noted during an audit. However we found that one MAR did not include information about a code that had been used to indicate a reason why a medicine had not been administered. . We asked the registered manager and a field care supervisor about this. They were able to identify what the code indicated but acknowledged that information about what the code indicated was not

included on this particular MAR. They assured us that they would ensure that all MARs that did not include codes for non-administration of medicines would be replaced.

The service ensured that staff members were suitable for the work that they were required to undertake. We looked at 11 staff files. These included copies of identification documents, evidence of eligibility to work in the UK, two written references, application forms and criminal record checks. Audits of staff files had taken place during the past year.

There were sufficient numbers of staff employed to ensure that people's care and support needs were met. Care calls were monitored by the provider and immediate action was taken if there was a late or missed call. Staff members were required to phone the office if they were running late for a care call. People told us that they were satisfied with the reliability of staff. One person said, "Occasionally they are late, but they always let me know. Another person told us, "If [my regular carer] is away they let me know and tell me who is coming to help me." The provider ensured that staff had sufficient travelling time between care calls to minimise any possibility of lateness. One staff member said, "I don't drive, and they make sure that my calls are near to each other and easy to get to if I walk or use public transport."

Staff members received a copy of a staff handbook at induction. We saw that this included information about safe practice and emergency procedures and contacts.

The service maintained a 24 hour on-call service that was available for staff and people who used the service to discuss and report queries and concerns. The provider also had a major incidents and emergencies policy included, for example, actions to be taken in case of adverse weather and disruptions to public transport.

Good

Is the service effective?

Our findings

People who used the service were positive about the support that they received from staff and felt that staff had appropriate skills and knowledge. One person said, "I think my carers have good training." A family member said, "They are very professional. I can't fault [the regular carer]."

At our previous inspection of Allied Healthcare Wembley we found that staff members had not always received regular supervision and support in relation to their performance. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

During this inspection we found that the provider had taken action to ensure that regular staff supervision had taken place. The provider had a procedure in place for supervision and appraisal of staff that showed that supervisions should take place every three months. Some of these supervisions were conducted as part of on-site spot visits. Appraisals took place annually. We looked at 11 staff records. These showed that regular supervisions, spot checks and appraisals had taken place. In some cases these had taken place more frequently than every three months. The staff members that we spoke with confirmed that they had received regular supervision and that they were satisfied with the support that they received. One staff member said, "Sometimes I'm surprised when they turn up for unannounced spot checks but I understand why they do it and it keeps me on my toes." The records of supervisions and spot checks of practice were detailed and showed that any actions agreed as a result of these were recorded have having been completed. The provider's on-line quality assurance system flagged up when supervision and appraisal activities were due.

We looked at the training records for staff and saw that a programme was in place to ensure that staff members had the skills and knowledge they required to undertake their duties. Staff members received a four day classroom based induction training prior to commencing work with any person who used the service. This was linked to the Care Certificate for staff working in health and social care services. All newly appointed staff members had completed Care Certificate workbooks that had been assessed, and 'signed off' when they had been completed satisfactorily. Following induction training and prior to being assigned to working with people, new staff members 'shadowed' more experienced members of staff until they were assessed as competent. Following the first lone care visit, the person being supported was contacted by telephone, to assess satisfaction, and this was followed by a spot check by a supervisor within the first four weeks of employment. The records that we viewed for recently recruited staff contained records showing that these actions had taken place.

The service had recruited experienced staff members to act as 'care coaches' during the induction period, and they provided and assessed the shadowing experience for new staff members. The registered manager told us that care coaches would provide non managerial support to staff for as long as the needed this. We spoke with a staff member who had been a care coach for new staff members. They told us that they found this experience rewarding and that they maintained links with the staff members that they had supported subsequent to the induction and shadowing period.

Training was 'refreshed' for all staff members on a regular basis. Staff members that we spoke with were able to list the training that they had received, such as moving and handling, medicines, safeguarding, equality and diversity and infection control, and spoke to us about the training related to the work that they did. One staff member told us, "I have been very impressed by the training." Another said, "I have to do most training every year. It helps me to think about what I do and why I do it."

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.

We checked whether the service was working within the principles of the MCA and we found that it was. The service's policies on the MCA and the Deprivation of Liberty Safeguards (DoLS) reflected good practice guidance. Training on both the MCA and DoLS was provided to staff members as part of their induction. The care plans that we looked at for people who used the service clearly showed whether or not they had capacity to make decisions about aspects of their care, and provided guidance for staff about how they should support decision making. The members that we spoke with understood their roles in supporting people who did not have capacity to make decisions and told us that they would immediately report any changes. One staff member said, "If my client is confused I talk to them, make a cup of tea, or get on with another task. Usually they are able to say what they want after a little while. If there are changes and I am concerned I will phone the office to let them know."

We saw that people had signed to show that that they had consented to the care that was being provided by the service. Where people were unable to do so, the reasons for this were fully recorded. Where family members or other representatives and signed this on people's behalf, we saw that this was recorded.

Care staff were involved in meal preparation for some people, and we saw that care plans and risk assessments for people who were being supported with eating and drinking were clear about the reasons why support was required. They also provided detailed guidance for care staff about how to prepare and deliver food as people required. This included information about preferred food and drink, offering choice, and when and how people should be supported.

People were supported to maintain good health and wellbeing and we saw that information about people's health and medical needs and histories were contained within their care documents. The daily care notes that we looked at showed that staff members had liaised with professionals such as GPs and community nurses where they had concerns about people's health needs.

Good

Is the service caring?

Our findings

All of the people that we spoke with told us that they felt that the service was caring. One person said, "I like them coming. They sometimes stay longer to make sure I am alright." Another person said, "They are lovely. They chat to me and ask me what I want."

The staff members that we spoke with talked about the people whom they supported in a positive, caring and respectful way. We were told that, "I really like working with my clients. I always think about how it would be if this was me or my relative and I try to ensure that I involve them and talk to them." Another staff member said, "I can be the only person they see, so it's important that they have a good experience. I talk to them about things they like and always ask them if I'm doing things OK." We asked about approaches to privacy and dignity, and were told by staff members that they had received training about this. The people that we spoke with confirmed that they were treated with dignity and respect. One person said that "they always ask me how I want things before they do anything for me."

The registered manager told us that, except where there was an emergency, it was important that people were supported by staff members that they were familiar with. We saw from people's care plans and the staffing rotas that care was provided by the same regular staff members. People that we spoke with confirmed that they received care from regular staff members. When we asked people about how they were supported when their regular care staff were away, they were satisfied about how the service managed this. We were told, for example, "They always tell me if there is a change. It is usually someone I know." One person said, "I wasn't always happy with the people they sent when my carer was on holiday but it is good now."

The service made efforts to ensure that care staff were matched to people on the basis of individual preference and needs. For example, we saw that gender specific care was provided where people had requested this. The care plans and risk assessments that we viewed included information about personal histories, interests and cultural and diversity needs and preferences. Where people communicated in languages other than English we saw that efforts had been made to ensure that they were supported by carers who understood their preferred means of communication.

The service ensured that confidentiality was maintained. Care documents and other information about people were stored in secure cabinets within the service's office. Copies of assessments, care plans and risk assessments were also maintained within the person's home.

We viewed information that was provided to people who used the service and saw that this provided clear explanations of the service that was being provided. A family member told us, "They are very good at providing information and letting us know if there are issues."

Good

Is the service responsive?

Our findings

People who used the service told us that they were pleased with the support that the service provided. We were told, "They have changed things for me when I have asked," and, "I can't fault them. Sometimes I have asked for a change in time and they have always tried to sort this out."

The care plans that we saw were up to date and ensured that care staff had appropriate information and guidance to meet people's needs. Assessments and care plans contained information about people's living arrangements, family and other relationships, personal history, interests, preferences and cultural and communication needs. The assessments also included information about other key professionals providing services or support to the person.

People's care plans were clearly linked to their assessments and were regularly reviewed and updated where there were changes to people's needs. Staff members working with people were required to sign to show that they had read these where amendments had been made. We saw that care plans provided information about each task, along with detailed guidance for care staff about how they should support the person with these. This included, for example, information about how the person liked to be communicated with, how choice should be provided, how to manage behaviours that may be challenging, and how best to support people with their mobility needs. Assessments, care plans and risk assessments were signed and dated. However, we noted that the plans in place for most people were long and included pages of 'tick box' information which meant that important information could be difficult to find. The registered manager told us that a new shorter care planning system was being introduced. We looked at two of these new plans and saw that they were person centred, easy to follow and included prompts for staff members completing plans in order to ensure that they included person centred information.

The notes of care that we saw showed that people had received support that was consistent with their plans. These records were detailed and easy to understand. The quality of care notes was monitored on a regular basis and where there were concerns we saw that these had been discussed with staff members and subsequent improvements had been made.

The service had a procedure for identifying 'early warning signs' for identifying changes in people's conditions that required to be reported immediately. Information about this was contained within people's files. this included a number of indicators in relation to changes physical wellbeing and mental capacity that staff members, for example falls, physical changes, increased confusion, that staff members were required to be observant of and report immediately they identified a change. Where risks to people had already been identified information about how staff should respond and report was included in their care plans and risk assessments. At the time of our inspection 50 staff members had received training in identification of such signs and how to record and report concerns. We saw from the service's training plan that this training was due to be provided to all staff by end of June 2017.

Staff members told us about how they read and reviewed care plans and care notes at each visit, and how they were kept informed about any change in need. People that we spoke with felt that their care staff were

well informed about their needs.

We saw that the service had a complaints procedure that was available in an easy read format. This was included in the Service User Guide that was provided to all people who used the service at the commencement of their care agreement. People we spoke with confirmed that they knew what to do if they had a complaint. One person said, "I don't have any complaints but I would phone the office if I did. They are usually very good." A family member told us, "We had a problem a while back but when we spoke to the manager it was sorted out. We looked at the complaints records for the service. We saw that complaints had been investigated and managed in a timely manner and to people's satisfaction.

Good

Is the service well-led?

Our findings

People who used the service told us that they were satisfied with the management of the service. We were told, "I think it's very good. It's much better than it used to be" and, "I can't fault them. They are very efficient." During our inspection we heard members of the office based team speaking with people and following up any concerns with other health and social care professionals.

Staff members that we spoke with were happy with the management of the service and how they were supported. One staff member said of the registered manager, "She works very hard and is always available if we want to speak to her." Another staff member said, "There is really good team working here. We have regular training and meetings where we can meet with others and share our knowledge and experiences." One staff member who had taken on the responsibility of coaching new staff told us that, "They are always opportunities to develop our skills." This approach was confirmed by a staff member who had recently been promoted from care worker to field care supervisor..

The registered manager was supported by three care co-ordinators and three field care supervisors, each responsible for one of three localities. During our inspection we observed that there was a friendly atmosphere at the office, with a number of care staff calling in to discuss their work or collect items of personal protective clothing. A field care supervisor told us,"We all help each other out and cover for each other during absences. This is good as we know what each other does."

The care files that we viewed showed that quality assurance processes such as on-site spot monitoring, and telephone checks with people who used the service to assess their satisfaction with their care took place. Records of care calls were monitored weekly, and we saw that there were regular audits of care files, daily care notes and medicines administration records. An electronic system was in place which provided reports and alerts on, for example, care plan reviews, staff training and supervision. Weekly reports were run from this and the registered manager was required to provide a reason for any activity that was overdue. Central electronic monitoring of the outcomes of any safeguarding concerns and complaints was also in place.

The provider undertook regular quality assurance monitoring visits to the service. The records of these showed that action plans had been put in place to address areas of concern, and that progress against action plans were reviewed on a regular basis. The service conducted regular satisfaction surveys of people who received support from the service. The feedback that we saw in relation to the most recent survey showed that there were high levels of satisfaction with the service.

We saw records of team meetings that took place periodically to ensure that staff members were provided with information relevant to the service, and enabled to discuss any issues or concerns that they had. We saw the notes from these and saw that they were used to provide training and updates on practice in addition to opportunities to discuss issues of concern or interest to staff members. Regular newsletters were also sent to staff members updating them on local and corporate issues and providing reminders about best practice in, for example, safeguarding, reporting concerns and infection control. The provider held a regular national forum meeting that was attended by a manager and member of the care team. We spoke with a

staff member who had attended this as the care team representative. They said that they had found this very informative and that information gained from the forum was shared with all staff members.

Other initiatives to promote positive working and team cultures were in place. The service had a care worker of the month award that was given to staff members who had performed exceptionally. All staff members had a copy of the criteria for achieving this award which was also displayed in the office. The provider held monthly staff draws with prizes such as holidays and televisions as part of their programme to incentivise staff.

The provider had submitted regulatory notifications to CQC in relation to concerns that had arisen during the past year. We looked at the detailed records maintained in relation to these, and saw that they had been managed appropriately.