Allied Healthcare Group Limited

Allied Healthcare London

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place in two parts; a three day site visit to the provider's office base on 19, 20 and 21 August 2015, and telephone calls to people who used the service, relatives, care workers and nurses over the following two weeks. The office site visit was unannounced on the first day.

Previously, when we inspected the service in October 2014, we had lots of concerns about how the service was run and we found five breaches of the regulations covering care and welfare, assessing and monitoring the quality of service provision, staffing, management of medicines and consent to care and treatment. We issued warning notices for three of these breaches of regulation.

When we returned in February 2015 we carried out a focused inspection to see if the service had complied with the warning notices. We found the service was no longer in breach of the regulations in respect of care and welfare, assessing and monitoring the quality of service provision and staffing and had made significant changes

Summary of findings

to the way it organised the delivery of care to improve safety and reliability. At that time it was too soon to assess the impact of those changes for care staff and people who used the service.

During this August 2015 inspection we carried out a comprehensive check on all parts of the service to ensure it was meeting all the current regulations. On this occasion we found the service was no longer in breach of the regulations relating to medicines and consent to care and treatment and no further breaches were found. In contrast to previous inspections people who used the service and staff were much more content with the service. The changes had impacted upon most of them in a positive way.

There are several parts to the service; altogether approximately 900 people are supported by 350 Allied Healthcare London staff. Six teams provide domiciliary care to people in one south London borough. Each team is headed by a care delivery manager (team leader), supported by a care quality supervisor (responsible for assessment, care planning and review), a scheduler (responsible for organising care workers to visit people at agreed times) and an administrative assistant.

The seventh team supports four extra care housing schemes in two south London boroughs, as well as the night owl service for one borough. This team is led by a service delivery manager with scheme managers based on site in each of the blocks of flats. They manage the care workers who are also based there. One of them takes the lead for the night owl service which operates out of the largest of the housing schemes. A care quality supervisor is also assigned to the extra care housing team.

The night owl service provides night time cover for 53 people in one London borough. It supports people who need care during the night, and includes those with continence issues, skin care and repositioning needs, as well as people who are living with dementia and are very active during the night. Two teams of two care workers are provided with a car to travel to visits.

The eighth team, known as the specialist team, supports some people with complex needs on account of their mental health or brain injury, some people requiring 24 hour care and people who use personal budgets to pay for their care. In addition their care staff work with children and young people who require care in their family homes. The office based staff for this team comprise a care delivery manager, a scheduler and a care quality supervisor.

There is a registered manager for these personal care services, but a different person is the registered manager for nursing care. Nightingale Nursing Bureau is also based in this location. Much of their work is related to supplying the NHS with agency nurses and falls outside the scope of registration. This area of their work was, therefore, not inspected. However, they also directly support up to six children and adults with nursing needs to remain at home. This area of their work was inspected.

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.

In addition all parts of the service can request advice and support in relation to people with complex healthcare needs from a regional team of nurses, one of whom acts as the link nurse for this location.

The service had made improvements to the way visits to people who used the service were organised. Every person we spoke with had positive views about their regular care staff or nurses and praised them for their commitment and hard work. In most instances people could rely on visits from well-trained staff who knew them well. However, we found cover arrangements for regular care workers were still not as good as they should have been, particularly at weekends, nor were arrangements for visits requiring two members of staff. We saw the provider was working on a number of solutions to this problem, such as targeted recruitment, but they had not completely resolved the issues at the time of inspection.

The provider had instigated weekend working for the office staff in most teams, including managers. This ensured there were always staff on hand to deal with sudden care worker absence or emergencies involving people who used the service. Other teams had their own on-call arrangements.

Summary of findings

Strengths of the service also included staff training, which was often followed up by competency checks; robust recruitment processes and service monitoring and evaluation. Care staff were now deployed for no more than 60 hours per week.

The service benefited from good management and leadership in many ways as managers knew their teams and the people they supported well and there was evidence of collaborative working to solve scheduling and other problems. Systems were in place to monitor and evaluate service provision. However, some staff, people who used the service and their relatives complained to us about inconsistent responses from staff based in the office.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe in some areas. Whilst the provider was specifically recruiting for staff who were available to work weekends, at the time of inspection, weekend cover was not as reliable as it should have been. In addition, the scheduling of visits requiring two staff still required some work, as did training staff in calculating people's body mass index.

Significant progress had been made in reducing excessive working hours and medicines management.

Staff recruitment practices were rigorous and opening the office seven days each week ensured staff, including a manager, were on hand to deal with any problems which arose.

Requires improvement

Is the service effective?

The service was effective. In particular there was a good induction programme for new staff and nearly all staff were up-to-date with their mandatory training. Specialist training was provided for staff supporting people with specific needs.

The provider was meeting its responsibilities under the Mental Capacity Act 2005. It no longer relied on local authorities to say if a person was unable make decisions for themselves; consideration of this issue was now a routine part of the assessment process and, if concerns were identified, appropriate steps were taken.

Good

Is the service caring?

The service was caring. Every person we spoke with was positive about their regular care or nursing staff. Staff knew how to treat people with dignity and respect.

We heard how some care staff walked miles during the recent tube strikes rather than let the people who used the service down.

Good

Is the service responsive?

The service was responsive. There was evidence the service took both people's needs and personal preferences into account when planning care. There were robust assessment and care planning systems in place. Every person who used the service told us staff routinely offered them choices.

Most people we spoke with knew who they would speak to in order to voice a complaint. There was a clear system for responding to complaints which was directly overseen by a manager.

Good

Summary of findings

Is the service well-led?

The service was not well-led in one area. Both staff and people who used the service told us the response to issues raised with the office very much depended on who they spoke with.

Most aspects of the service had been transformed in a very short time; new processes were in place to ensure the service ran as smoothly and safely as possible and managers monitored the quality of the service and were aware of many of the issues we identified and working to put them right.

Requires improvement 

Allied Healthcare London

Detailed findings

Background to this inspection

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

The site visit took place on 19, 20 and 21 August 2015. It was unannounced on the first day. Five inspectors, including a pharmacist inspector, were involved in the site visit, accompanied by a specialist nursing advisor. A further five inspectors made phone calls to people who used the service, their relatives and staff. An expert by experience also made phone calls to people who used the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case services for older people.

Altogether we spoke with 164 people who used the service, 26 relatives and 54 nursing and care staff. We also spoke with the two registered managers for the service.

We reviewed the information we held on the service and we examined 25 nursing and care files across all teams, eight staff files and a range of other policies, procedures and management records, including medicines administration records.

Requires improvement

Is the service safe?

Our findings

Most people told us they felt safe using the service. A person who used the service told us, "The staff are really good, I feel very safe." Another person said, "[The care staff] arrive on time but, sometimes, they are late and it's beyond their control. If there is a problem they phone to let me know." Other people said they did not always get a call to tell them of lateness or changes.

We found staff were aware of signs of abuse and how to report them. Office based staff were well informed about each of the people their care staff supported and could outline how concerns should be responded to, in conjunction with the local authority or other relevant bodies. We saw evidence of the provider working closely with the local authority and police to manage some complex and potentially risky situations. For example, one family's non-engagement with the service had triggered discussions with the local authority to assess whether or not this was a risk to the young person using the service.

The provider had a whistleblowing procedure so staff could report any concerns at work if they felt their line manager was not listening or their concern was about their manager. Whilst the staff we spoke with knew the importance of reporting concerns, they were not all familiar with the term 'whistleblowing' or the policy and procedure the provider had put in place.

The provider had a computerised system in place to monitor accidents and incidents, including safeguarding concerns. We found the system easy to follow, it showed exactly who had done what and when they had done it; making it simple for the recently appointed client liaison manager to chase progress or pull the information together. When we looked we found there were very few outstanding actions to complete for issues which had been logged. The recent investigation reports were thorough and had been completed to a high standard.

Some of the care workers we spoke with were still expressing frustration about the arrangements for visits where two care workers were required. Double handed visits were required when a person needed to use a hoist to transfer from one place to another or for less common reasons. A member of the care staff said, "Double ups are a nightmare, they are the worst thing you can do, I am waiting one hour, one and a half hours, two hours. It hasn't improved, I am tired of speaking to the manager [about it]. I have to leave [the person] in bed and go and do [another person] and come back." We were shown by office staff how two care workers were assigned to carry out all the double handed visits for a set period each day, such as breakfast visits. This was supposed to reduce the risk of delay as, after the initial meet-up, care workers would travel together. However, care workers told us variations were sometimes made to this arrangement which could leave them waiting around for their colleague and then made them late for other visits.

The service had a business continuity plan in the event their server went down or a power cut or similar event occurred. There were also business continuity plans specific to each extra care housing scheme. These covered situations such as the accommodation becoming uninhabitable or a staff shortage due to a flu pandemic. They contained information about the help people would need to evacuate the building.

We were present when the fire alarm went off and found everyone was well informed of the evacuation procedure and there were fire marshals to guide us. Most people who used the service had an environmental risk assessment in place to ensure they and the care workers who visited them were protected from foreseeable risks at home and in the immediate vicinity. Where these were not yet in place we saw there were plans to roll them out.

The night owl service had specific risk assessments in place to identify and manage additional risks to staff working at night. We were told people living in extra care accommodation had a pendant alarm for summoning emergency help. This was in addition to a pull-cord in their flat.

The provider had clinical governance arrangements in place to ensure there was appropriate scrutiny of policies, procedures and processes as well as the performance of clinical staff. The arrangements also served to keep the provider up to date with best practice in health and social care.

When clinical equipment was in use we saw records which showed it had been serviced and maintained. This was not up to date in every case. There was information about the supplier and who to contact in the event of breakdown. When hoists were in use, we noted only one care file contained information about the colour of the loops to be

Is the service safe?

used when setting up the sling for an individual. The loops alter the positioning of the person which may affect the safety of the transfer. This information should have been included in the care plan summary, the main reference document for staff in people's homes. Information about safe hoisting was in shorter supply in the nursing care plans, as they did not take into consideration issues which could make hoisting difficult, such as feeding tubes, spasm or pain or how the person could communicate discomfort or fear. We also found care files did not always include information on the care of pressure relieving mattresses. Some types of mattress need regular turning, others do not.

Most people who used the service were screened for risk of pressure ulcers. However, we found the risk was not always correctly assessed as staff were not always completing the body mass index score (BMI). This invalidated the overall score and led to an underestimation of risk.

All care plan summaries reminded staff of the importance of good infection prevention and control, with prompts to wash their hands or to wear personal protective equipment for certain tasks. We saw all staff had received some training in this area.

When we last inspected the service, there were problems getting care staff and people who used services to comply with the electronic call monitoring system (ECM) which was in use for people living in one south London borough. This system logged staff arrival and departure times. At that time compliance was hovering around the 20 per cent mark, this time we found compliance with the system to have risen to 69 per cent.

ECM was only monitored weekly, so it was not used to identify immediate problems. For this office staff relied mainly on their knowledge of people who used the service and the care staff in their team. If they thought there might be a problem with a visit, we saw they would check, but this arrangement was not always effective. The provider told us they were trialling a potentially better system at one of their other services and, if this was successful, they intended to roll it out elsewhere.

Children receiving nursing care benefited from an 'early warning screen'. This was a chart which indicated signs of deteriorating health for that child. When relevant, it included signs which showed the child might be building up to a seizure. In each case it listed actions staff needed to take and when they needed to call for emergency assistance. There was more detailed information elsewhere in people's care files, but this was a helpful 'at a glance' chart for use in an emergency situation.

We found there were systems in place for targeted recruitment to ensure there were sufficient staff who could work flexibly. Some parts of the service struggled to cover weekend visits as staff preferred not to work then, but we were told most new staff were being offered contracts which committed them to working alternate weekends. People who used the service continued to express concerns about weekend arrangements, although a few had noted a recent improvement. A typical comment was, "Weekends they send different people. They never tell me who is coming."

We looked at the new recruitment process which involved local staff advising head office staff about the specific needs of the service. Advertisements were tailored accordingly and applicants were screened by telephone interviews before being referred to the service for face to face interviews. They also had to complete a written test. Staff who had worked in the service for a while told us the prospective staff they saw for interview now had a higher standard of skills and knowledge and this was confirmed by the interview packs we read. There was plenty of evidence of persistence when chasing up references or relevant documents in order to ensure people were safe and eligible to work.

We heard how the provider was about to start collaborating with two colleges to prepare people for working in care. We asked how they supported staff members with disabilities and a care delivery manager was able to give us some examples of how they used a sensitive, personalised approach. We found there were positive attitudes amongst the office based staff to supporting staff with mental health issues or disabilities, as it was believed people who had experienced some of the difficulties faced by people who used the service could use this experience to better assist them.

Previously we had been concerned about the excessive number of hours some care workers were working week after week, as they did not have sufficient time to rest. Now no one was permitted to work over 60 hours per week without special dispensation from a senior manager. We saw this had been very rarely used, despite it being the summer holiday period. Contracts with guaranteed hours

Is the service safe?

were available and each care worker, whether or not they had guaranteed hours, was able to nominate the number of hours they wished to work up to the 60 hour limit. When we checked, the system showed schedulers took these preferences into account when offering visits. Most staff we asked were happy about the number of hours they worked. One care worker said, "[The provider] allows me to have a flexible approach to my hours. It meets my own needs but also helps me to work with [people who use the service] to make sure I care for them when they most want it."

Office staff member described how some of the pressure had been lifted off their shoulders by seven day a week office cover for many of the teams. One member of office based staff said, "Put it this way, I no longer feel sick with dread on Sunday evening, wondering what I will face on Monday morning." There was now a weekend rota in place, including management cover, so office staff could deal quickly and effectively with any issues. Other office staff told us it had improved their work-life balance. Teams not covered by the weekend rota had their own on call arrangements in the event of emergencies.

The service had a current medicines policy which set out how medicines should be recorded and administered safely. The policy did not define how mental capacity should be assessed before administering medicines covertly, if this was decided to be in people's best interests. We looked at records for people who were receiving support with their medicines and we saw that care workers had recorded the medicines they had administered to people on a medicines administration record (MAR). These charts were returned to the office for checking and we saw they had been audited and, when there were concerns, these had been raised with the care workers.

We looked at the care plans for people who had support with their medicines and saw that these reflected the support that care workers were giving. We saw that instructions from healthcare professionals was acted on and recorded and people were supported to maintain or increase their independence with their medicines where appropriate. However, in at least one risk assessment, a continuous supply of oxygen in a person's home was not identified as a fire or explosion risk and there was no risk management plan in place for it.

Care staff who supported people with their medicines had received training and their competence to do the task was assessed. We saw care staff referred to their managers if they had concerns about a person's medicines and care plans were updated with new information.

Records from the extra care housing schemes showed there were specific instructions for the storage of medicines in each person's flat which corresponded with their personal preferences and any identified risks.

Good

Is the service effective?

Our findings

One person who used the service told us, "I tell my carer what I want and they do it." Another said, "[My care worker] is ever so good. I do not want to part with [them]". A third said, "[My care worker] seems to know what [they are] doing. I think they do get training – [they have] the right skills." A few people noted their care workers did not have some life skills, such as putting on a duvet cover, using a microwave or shaving, which were not usually covered by formal training.

Staff were positive about face to face training. One told us, "The trainers make sure you're ready [to implement what you have learned] before they sign you off [as competent]." Another said, "The training has given me extra qualifications, it makes me loyal to Allied and to want to stay with them for a long time." Staff were less enthusiastic about e-learning which was used to underpin some courses.

All staff members attended induction training and mandatory courses, such as first aid. There were additional courses for those who were supporting people with specific needs. If staff were not up to date with their training we saw the provider's electronic system would prevent schedulers from allocating visits to them until the training had been completed. Therefore, there was a very high level of compliance with training. We looked at some of the provider's training materials and saw they provided lots of opportunities to focus on real life situations which staff might encounter. In one of the rooms within the office there was a hospital style bed and a mobile hoist which was used to demonstrate appropriate moving and assisting techniques.

Management and leadership training was being rolled out to all staff with these responsibilities. Some care workers had undertaken a care coaching course which helped them to mentor their colleagues, in particular, those who needed to shadow visits as part of their induction.

We saw evidence nursing staff were given very specific training to enable them to care for people with complex healthcare needs, including rare conditions. There were checklists in place to show staff assigned to an individual had all received training in managing the person's condition. Photographs had been taken, with consent, of clinical equipment used to aid training. Staff working on nursing packages had to shadow existing staff or, especially in the case of new referrals, the lead nurses. Once the new staff member had been trained in a procedure they were assessed for competency when carrying it out before they were left to work alone with the person. Thereafter, their competency was re-tested on an annual basis to ensure they were still performing the procedure correctly.

We found the same electronic system also rejected staff for visits if they had not received supervision and appraisal in line with the provider's policy. Again, this provided a strong incentive for them and their supervisors to keep up to date with this. We found each team's administrator printed out a quarterly report on which member of staff was due for what in terms of training, supervision and appraisal, so everyone knew what needed to be completed in each quarter. The service specification for the extra care housing schemes succinctly described the vision for care delivery as 'See me; involve me; connect with me" and the service delivery manager told us they tried to keep this in mind at all times, by embedding these values in their staff appraisal process.

We found most staff were much better informed about the Mental Capacity Act 2005 (MCA) than during previous inspections. Care quality supervisors, the staff members who were often responsible for carrying out assessments and drawing up care plans, broadly understood the MCA and the provider's assessment package prompted them to ask questions about people's capacity. If concerns were identified, there was a further tool to assist them with the assessment. Whilst we found procedures were usually followed, the outcome of the assessment was not always fully reflected in the care plan. In particular, information about whether or not a lasting power of attorney or deputy was in place was not always prominent. This is important as, when appointed, these people have the power to make certain decisions on behalf of a person so there is a duty to consult them.

The nursing team was weaker than other teams in this area as the new assessment and care planning tools had not yet been fully implemented. In the case of people who lived in an extra care housing scheme we found one person was deemed to lack capacity to make decisions, but there was no evidence of assessment to support this view. However, there was also evidence of some excellent practice in this area in relation to using Global Positioning System (GPS) monitoring equipment. Appropriate procedures had been used to decide this was the least restrictive way of ensuring

Good

Is the service effective?

the person's safety whilst still allowing them freedom of movement. In some of the 24 hour care packages we also saw evidence care was being delivered in the least restrictive way. For example, one person had hour long breaks twice a day from their care workers so they had some privacy.

We found significant liaison took place with local authorities in respect of people's capacity. All staff we spoke with were alert to the need to seek advice if someone's ability to make decisions appeared to have changed and MCA training had been made available to all staff members. A course took place during the inspection.

One of the new assessment forms screened people for eating and drinking issues. If people needed support to eat or drink this was detailed in their summary care plan. People's food preferences were recorded, as was the temperature they liked for food and drinks. We saw staff were advised how to position people when helping them to eat or drink. When necessary, staff had received appropriate training in tube feeding and their competency had been checked. In the case of one person, we saw staff were following GP advice to restrict fluids and give a pureed diet, but there was no evidence of input from a dietitian. Best practice requires a multi-disciplinary approach for people in need of nutritional support.

During telephone calls to people who used services we heard concerns from people who were diabetic or their relatives about care staff not always arriving on time to assist with meal preparation. This could impact on diabetes management. The issue was more pronounced when regular care staff were off duty. We brought this to the attention of the provider and, within the hour, they started to place each person they supported to manage their diabetes on a 'time critical' list they maintained. Visits included in this list have to be made at the scheduled times. This should improve reliability. Other people mentioned that care staff who covered the absence of their regular care staff did not always read the care plan and sometimes overlooked meal preparation. However, the majority of people did not voice concerns about support for eating and drinking.

We heard examples of good and prompt liaison with healthcare professionals. A care quality supervisor described how they contacted the GP when someone came out of hospital and was not eating well. They were concerned about this and they also knew the person had tablets which should not be taken on an empty stomach. There was evidence in at least two care files that care staff had contacted the office to ask staff based there to make GP appointments for two separate people with symptoms of ill-health and this had been followed through.

Good

Is the service caring?

Our findings

A person who used the service said, "[My care staff member] is very polite and knows me so well." Another person said, "During the [tube] strikes staff were walking two to three miles to get here, I felt humbled." Other comments from people who used the service included, "My carer is very nice, very good. I get on well with [them]"; "My carer is lovely, they always seem interested in me and ask how I am feeling today" and "They care for me with respect and dignity."

A relative told us, "[I have] no problems or concerns, the carer is polite and helpful and has a good relationship with my relative [they are] someone we can trust."

Office staff came across as being passionate about providing a good service. They had a very good knowledge of the people their team was supporting and could tell us about the support provided to each individual and what was 'normal' for them. They knew when to be concerned. Care delivery managers described how they and other office based staff now had time to visit some people at home, especially if the care and support was not running smoothly. A scheduler had recently visited someone who appeared to be rejecting lots of care workers and found this was only because they did not want anyone new to care for them. Once they understood their regular care staff member needed time off the scheduler was able to negotiate the introduction of another regular care staff member to cover absence.

We saw some care summaries advised staff about conversational topics which were likely to go down well with the individual, for example, one person had a passion for horse racing so staff were encouraged to ask about this. They also made reference to maintaining privacy, advising staff where to carry out personal care in the person's home and reminding them to draw the curtains if the room was overlooked. There was also evidence within the care plans of people being supported to maintain their independence. For example, in one care plan staff were advised where to place furniture and equipment so the person could move around their home independently.

Staff described to us how they maintained people's dignity and respect. Typical comments were, "I always ask before I do anything. Sometimes I also need to remind [the person] why I need to do it"; "I know the house so I know where they are comfortable receiving care"; "I close the curtains and shut the door before undressing [the person]" and "I don't take all their clothes off [at once]. I talk to the clients and let them know what I'm doing."

At the time of the inspection no one was receiving end of life care, but there were policies and procedures in place to guide staff in this area and training was provided.

Good

Is the service responsive?

Our findings

A person told us, "[My care staff] knows me well. I do not have to ask [them]. [They] see what needs doing and do it." Another person said, "Carers listen all the time and offer options." A care staff member told us, "When I go [to a person who uses the service] I treat [them] how I would like to be treated, I ask questions such as 'would you like me to [wash] this area?"

A member of staff within the extra care housing team described how they supported people moving in to their housing scheme, "The manager makes sure we each get an in-depth introduction to new people and we make sure they meet the other tenants as well. We get [the new person] off to a great footing by making sure they feel welcomed straightaway."

A night owl care staff member told us, "We always work in pairs and [the person who uses the service] is always known to at least one of us. Only in the case of a really unusual staffing emergency would neither of us know the person and this has never happened to me. We get the care plan in advance as well so if we're new to the person we can check out the important information before we arrive."

There were at least two assessment and care planning systems in use within the service. This was because the new system had yet not been rolled out to everyone, including some people in extra care services and those receiving nursing care. We were told there were 44 people with 'old style' assessments and care plans. We found that, when completed correctly, both types of assessment and care plans served the same purpose of detailing the health and care needs of individuals and provided staff with guidance about how to meet identified needs and manage any risks.

We saw evidence people's care was personalised, for example, one person was supported to get up at 5.30am as this was their wish. Staff told us it could sometimes be difficult to schedule care exactly when people wanted it as, for example, most people wanted to get up around the same time. When this was not possible office staff said they tried to explain the situation and kept it under review.

The extra care team could work more flexibly as people who used the service were next door neighbours. They were working to an 'outcomes based model' which focused on what each individual needed or wanted to do each day. It allowed people to vary their routine. In order to facilitate this, each shift had to be planned on the day, which required flexibility from care staff. A scheme manager told us, "It is definitely a system which works."

The provider's lengthy assessments, often over 100 pages long, fed into the care plan. This document contained a summary of the person's agreed needs and described how they should be met on each care staff visit. Some care plans were very detailed, especially if the person could not speak for themselves, containing information about preferred bath products and breakfast cereals. We found them easy to follow. The more recent they were the better written they tended to be as the staff members compiling them had become more confident in their use. However, assessment documents could have been applied more proportionally to people with straightforward needs, as being subject to so many questions may distress some people.

Care plans for people receiving nursing care were person centred. We saw they contained clear explanations about people's medical conditions. In one case this involved detailed descriptions of the type of seizures the person was likely to have and how staff needed to respond to them. Some forms were completed from the perspective of the person receiving nursing care and outlined the individual's routines and preferences.

All but the 44 people who were yet to be reassessed with the new procedure and associated forms, had had their needs assessed within the last year. Whenever possible we found the person was routinely involved in discussions about their care and, when they consented to this, their family were also consulted. Staff had also improved their cross-referencing with other information provided, for example, by the local authority, so we did not find any contradictions during this inspection. Whilst there was evidence people receiving nursing care had their care plans adjusted as specific needs changed, we found little evidence of formal review alongside the person or, in the case of children, their family, to consider their overall nursing needs. In the case of the extra care housing team, we heard from staff that they took steps to ensure people's participation. One staff member said, "In all meetings relating to them…they should be involved, no matter what they can contribute". This was confirmed by meeting minutes.

Good

Is the service responsive?

Office based staff described good working relationships with local authorities. They said their ability to evidence the need for extra time to meet people's needs helped with this; they could justify requests. If care staff reported the time allowed or the tasks detailed on the care plan were insufficient, the care quality supervisor or another member of staff would make a home visit to re-assess the person's needs before liaising with the local authority. We saw emails from local authority staff which confirmed a level of trust had been built up.

Care staff spoke confidently with us about how they would respond if the health of someone they cared for deteriorated. They were able to describe the actions they would take in an emergency situation and the steps they would take if they identified a more gradual decline. They told us how, in the absence of any relatives and when necessary, their routine visits were covered so they could support the person to attend appointments with health and social care professionals and pass on their observations.

We asked staff what they would do if a person who used the service refused the care outlined in their care plan and staff gave appropriate answers. For example, one person said, "First and foremost I'd talk to [the person]. I'd want to know what has gone wrong since the last time I saw them. I'd look at the communication book and see who has been providing them with care since I last saw them. Maybe something happened that I don't know about. Sometimes I'd go to the next [person on my list] and return to this one later and see if their mood is any better." All staff we asked told us if a person was refusing a vital aspect of their care, such as medicine, they would escalate the matter to their manager if this was unusual for them and it was not covered by the care plan.

A person who used the service told us, "I complained about the timings [of my visits] – it was resolved." People who used the service received a welcome pack which included information about how to complain about the service. We saw there were systems in place to receive and investigate any complaints about the service and trends could be monitored using a database. The number of complaints had reduced since the provider had improved its systems for scheduling care. We saw complaints were investigated and responded to within a timeframe set by the provider. Any deviation from policy was flagged up to appropriate people within the service. The new client liaison manager, amongst their other duties, monitored responses to complaints. Some people who used the service told us their complaints "never went anywhere". It was hard to ascertain if they were all referring to recent events or not, but there may still be work to do on identifying complaints and responding accordingly.

Requires improvement

Is the service well-led?

Our findings

A care staff member commented, "Since the new [managers] took over there is a big change, they know how to control the job better."

The provider had put in an exceptional amount of time, money and effort to improve the service and the changes were impacting positively on people who used the service and the staff who supported them. Some people who used the service recognised this, "They do a professional job – it has improved a lot recently." When there were problems there were newly established systems (known as One Best Way) for resolving them quickly by staff who were trained in care or nursing and also in the provider's policies, procedures and processes.

One issue marred the otherwise positive evidence we found in relation to management and leadership. We were not sure the new systems were always being implemented exactly as planned. A recurring theme amongst people who used the service, relatives and care workers was the quality of response varied, depending on who they spoke with in the office. There seemed to be different management styles in each team, with some care staff describing their managers as "supportive" and others reporting their manager "unwilling to get involved in complex issues". One member of the care staff said, "My line manager never deals with problems and always passes all the responsibility back onto the care staff." Some office staff had also noticed differences in approach and told us they were a bit uncomfortable with how a small number of colleagues sometimes spoke with care staff on the phone, although they told us they were always pleasant when dealing with people who used the service or relatives and all office staff were certainly polite and helpful when speaking with us.

At previous inspections people had mentioned difficulties getting through to the office on the phone and messages not being reliably passed on, but this was hardly mentioned this time. We saw the provider now had a regular receptionist and more telephone lines. A new company telephone answering standard had been introduced. Care staff had had similar difficulties, but they were now regularly provided with the direct telephone numbers of everyone working in the office, so they could usually get through to an appropriate person quickly. A care staff member confirmed, "Someone is available if I need to relate something."

The provider had improved its methods of communicating with its large staff team. Staff rotas were sent out weekly and other important 'all staff' information could be sent at the same time. The provider used a separate 'mail out' company for this task. Team updates were produced quarterly and covered topics such as stroke awareness, covert cameras and results of the staff engagement survey. We saw one update provided staff with very helpful practical advice, for example, by answering the question 'Can I buy alcohol for my customer?'

The service carried out spot checks on nurses and care staff to ensure they were carrying out their work to a good standard. These were often combined with visits to the person who used the service to gather their views on the care provided. A care quality supervisor told us, "I try to arrive when the care staff is there so I can see them in action. Then I stay behind to talk to the customer." We saw evidence these checks were taking place in files for both staff and people who used the service. The checks were scheduled throughout the year, but we saw they sometimes slipped. Office staff told us this could be for a variety of reasons, such as care staff holidays or the hospitalisation of the person who used the service. Sometimes more urgent work had to be prioritised. However, by having all checks scheduled for the year it was easy to see which were overdue and office staff worked through them systematically.

Each person who used the service had a log book in their home which staff completed each time they visited. They were used to confirm the care plan had been carried out and to inform other staff assigned to the package of any issues. Care staff also used them to show if they had escalated any concerns. We saw completed log books were routinely audited when they were returned to the office. Where the auditor identified issues it was not always clear if these were addressed with the care workers concerned. One problem in some log books was illegible handwriting. We saw the provider had introduced a short written test when short-listed candidates arrived for interview to identify those with poor writing skills, so they expected legibility to improve.

The service had recently implemented a 'carer of the month' award. Five members of the office staff separately told us they were overwhelmed by the humility of those accepting the awards for their high standard of work and said they were incredibly proud of them.

Requires improvement

Is the service well-led?

Following a recent incident in which the provider's no reply policy was not correctly followed when a person did not answer their door, all staff had been extensively briefed about their responsibilities in this situation. This was confirmed in minutes from meetings and demonstrated there was learning from experience. One member of office staff said, "I have attended at least three meetings where this message [the provider's no reply policy] has been drummed home." We also saw other evidence to confirm lessons learned were regularly passed on to minimise the risk of a reoccurrence.

We saw evidence of good collaborative working between many of the teams, for example, those who met around a whiteboard three times each day to discuss progress with covering visits. One team would help another team out if they were struggling with cover. We found, in contrast with previous inspections, staff rotas were being compiled well in advance, so, for the most part, the only last minute cover required was in relation to sudden staff sickness, although there was still some pressure to cover weekends.

We saw the provider carried out a range of monitoring and analysed and evaluated the results. For example there was an on-going customer satisfaction survey which was sent annually to a sample of people who used the service, as well as those who had only been receiving a service for eight weeks. We saw 80 % of people were likely to recommend Allied Healthcare London to others needing care.

The provider had been working through an action plan to improve the service and we were able to confirm they had completed most tasks identified. The remaining challenges were to roll out their One Best Way systems to all parts of the service and to establish more consistency across the teams.