Nestor Primecare Services Limited

Allied Healthcare Leicester

Inspection report

Units 7 & 8 Edwards Centre
The Horsefair
Hinckley
Leicestershire
LE10 0BB

Tel: 01162543335
Website: www.nestor-healthcare.co.uk/

Date of inspection visit:
19 March 2018
20 March 2018

Date of publication:
07 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over four days commencing on 19 March 2018. The provider was given two working days' notice of our visit. This was so people who used the service could be told of the inspection and asked if they would be happy to speak with us.

Allied Healthcare Leicester is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating.

At the time of our inspection there were 70 people using the service, who resided within Leicestershire. The provider had a contract with Leicestershire commissioners to provide a service as part of the local authorities 'Help to Live at Home' strategy.

Allied Healthcare Leicester had a registered manager. 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.

This is the second time the service has been rated Requires Improvement.

People and family members we spoke with raised concerns as to the time keeping, continuity of care, poor communication and poor assessment systems of their needs. Some conversations reflected people's concerns as to their experience of commissioners who referred them, which included when being discharged from hospital and the commencement of support packages by Allied Healthcare – Leicester.

The Provider Information Return (PIR) and our discussions with staff in a range of roles within the service identified improvements were needed. This included the recruitment of staff along with improvements to the reliability of the service to ensure people's needs were met and that they experienced positive outcomes.

Systems to assess risk did not cover all potential areas. Environmental risks external and internal to people's homes were not considered and therefore steps to minimise risk were not put into place. Assessments identifying potential risk in the delivery of people's care had been undertaken and information provided within people's records were in place, which was adhered to by staff.

People using the service and family members said they felt safe when staff were assisting them. Systems were in place, which were understood by staff that were aware of their responsibility in reporting any potential concerns, which may affect a person's health of welfare.

People received the support they needed in taking their medicine and where people were unwell, staff

liaised with health care professionals on their behalf. Staff supported people in the shopping of groceries, and the preparation of meals where required. People in the main spoke positively about the attitude and approach of staff, stating their privacy and dignity was respected.

People using the service and family members spoke of a shortage of staff, which meant they could not rely upon the service to meet their needs in a timely manner. People told us staff did not arrive at the agreed time and that in some instances staff failed to arrive. Staff we spoke with stated there was insufficient staff to meet the needs of people. People using the service and family members told us the weekly rotas they were provided with, which detailed the name of the member of staff who would be providing their care and the time they were scheduled to arrive could not be relied upon.

The process for the assessment and referral of people to the service were not regularly applied, which meant people experienced a service that was not consistent with their expectations and wishes. People using the service and family members expressed concern as to the assessment of their needs when undertaken by commissioners, as the assessment did not always accurately the service they received. Representatives of the service said assessments were not always provided by commissioners to them in a timely manner prior to a person commencing the service.

People told us they were supported to have maximum choice and control, some people told us how receiving the service meant they were able to remain at home, whilst others said it helped them to maintain their independence. The policies and systems in the service supported this practice.

People's involvement and understanding of the system to contribute to the development and reviewing of their care plan was mixed. The care plans we viewed provided information as to people's needs and had been signed by the person or a family member. People expressed dissatisfaction with the service they received, as it did not meet their needs. The main concerns for people were the unreliability of the service, with people experiencing late or sometimes missed calls. People also raised concerns as to the frequent changes in the staff that cared for them.

People were aware of how to make a complaint and told us they were confident to do so. A number of complaints had been made about the service, a significant number were related to missed or late calls. People told us they had raised concerns, some people were satisfied and had noted improvements; whilst others said, they had not noted any changes to their care because of issues raised.

There was a governance structure in place, which meant people from a range of departments within the organisation held key areas of responsibility. Meetings were regularly held across all departments and action plans were developed to improve the services. However, people continued to experience late or missed calls.

People's views about the service were sought by the provider. There was a system for collating people's views; however, the outcome of consultation and any action proposed to address people's concerns was not shared with them. People expressed concerns about poor communication from staff based in the office and raised concerns about the day-to-day management of the service and its effect on the care they received.

Staff told us they did not believe their work was valued by the service, but they felt people using the service appreciated their care and support. Staff were frustrated that they could not influence the service provided to people. Systems were in place to regularly meet with staff, which included staff meetings, and on-going assessment of staff performance through supervision and training. The provider had consulted with staff

and as a result had developed an action plan to address the issues they had raised.

We identified the provider was in breach of four of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Potential environmental risks had not been assessed. Risk assessments were in place to reduce potential risks to people when receiving care. People told us they felt safe when they received care.

People could not be confident in the reliability of the service as there were insufficient staff to meet people's needs. People experienced late or missed calls. The provider followed safe recruitment practices.

Systems and processes were in place, which were understood by staff and were followed when staff identified concerns to people's health, welfare and safety.

People's needs about their medicine were clearly identified within their care plans. Medicine was managed by staff who had undertaken training and had their competency regularly assessed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Systems to assess people's needs and share the outcome of assessments between commissioners and the service were not consistently adopted.

The training staff undertook meant people were supported by staff that had the necessary skills.

People were supported to maintain a balanced diet. Staff liaised with health care staff to promote people's health and welfare.

People's consent was sought before staff provided care.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive care and support from a consistent group of staff.

People's views about their care and support had been sought and had been used to develop their care plans.

People spoke positively as to the attitude and approach of staff with regards to the care they received, which included staff's approach to their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People using the service did not consistently receive a service that was personalised to meet their needs. The service responded to referrals by commissioners as detailed within their contract as part of the 'Help to Live at Home Scheme'.

People's responses as to whether their raising concerns had brought about improvement were mixed. People had information on how to make complaints and the provider had systems in place to deal with these

Is the service well-led?

Requires Improvement

The service was not consistently well-led

A governance framework was in place, which had identified areas for improvement. However, these had not been effectively implemented to drive improvement within the service.

People's feedback about the service had not brought about improvement. People were not provided with feedback following consultation. People expressed concerns as to the effectiveness of communication.

Opportunities for staff to share their views had been provided, and had shown staff did not feel valued. Action plans had been developed to address staff concerns.

Allied Healthcare Leicester

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.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to adults.

The inspection site visit took place on 19 and 20 March and was announced. We gave the service 48 hours' notice of the inspection visit so someone would be available to facilitate the inspection visit.

The inspection was carried out by an inspector and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used the information the provider sent us in the Provider Information Return, which was submitted in February 2018. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events that the provider is required to send us by law.

We contacted the commissioners by e-mail requesting feedback about the service.

We spoke with 11 people who used the service and nine family members of people using the service by telephone on 20 and 21 March 2018.

We spoke with the care delivery director, the service delivery manager and a care co-ordinator as part of our site visit to the office. We spoke with four care staff by telephone on 22 March 2018.

We looked at the records of four people who used the service, which included their plans of care, risk assessments and records detailing the care provided. We looked at the recruitment files of four staff, including their training records. We looked at a range of policies and procedures and documents, including audits and action plans that monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

The provider's risk assessment policy was not consistently applied, which meant there was potential risk to the safety of those using the service and staff. Assessments to identify potential risks linked to the environment of people's homes, such as fire risks, trip hazards, lighting, access and security had not been undertaken in three of the four people's records we looked at. Our previous inspection carried out on 29 November 2016 had identified this. We were assured at the time by the registered manager that improvements would be made. The provider's internal auditing system had not identified that risk assessments were not being completed.

People could not be assured of their safety as risk assessments relating to the environment were not carried out. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment.

Potential risks to people using the service were assessed about the delivery of personal care and support. For example when people needed support to mobilise so that their personal care could be provided. Information was included as to how staff were to promote people's independence by encouraging them to complete tasks for themselves. Where potential risks were identified, the person's records detailed what action staff should take, which included the use of equipment, such as a hoist or wheelchair and how the equipment should be used. For example, a person's assessment had identified the angle in which the person's chair needed to be placed so that the person could transfer safely from one place to another. Care plans also instructed staff to ensure people who had an 'emergency pendant' were wearing these or had them close by.

A person using the service received their nutrition via an alternative method, known as a PEG (percutaneous endoscopic gastrostomy) which meant their nutrition was passed via a tube directly into the stomach. We found comprehensive guidance to be in place to ensure their safety was promoted, which took into account best practice guidance.

Risk assessments took into account a person's health condition. For example, the records of a person who had epilepsy contained clear information for staff as to the action they should take should the person experience a seizure. This included information as to the administration of medicine. The person's plans provided information staff were to take should the person's condition not improve, which included contacting the person's next of kin and emergency services.

There was an emergency business continuity plan in place; that would enable the provider to identify and prioritise the allocation of staff to those using the service should an unplanned event occur, such as adverse weather. The plan detailed the commitment by the provider to contact those using the service or their family member to provide information. This showed the provider had a system in place to ensure people continued to receive care.

People told us they had in some instances had their care provided by 'agency' staff, due to staff shortages. A

person who used the service said. "I've found them (staff) good, but sometimes they have staffing difficulties. They have to use agency staff." A second person using the service said. "Agency staff often have to stand in." A third person said. "The Allied regular staff are better than one-off staff but some agency staff are very good."

A family member told us in some instances one member of staff provided care; however, there should be two. They told us in some instances they knew in advance that one member of staff would be attending and they had agreed to help in the delivery of personal care to their relative. However, they said they were not always asked in advance, and that one member of staff attending was now a regular event. They said. "Over the last few occasions they just ring to say they are sending just one carer when I need two but it's now becoming regular and now they don't even tell me first. I will help but it's not what was agreed and they don't now tell me and we're getting less than what was agreed." The registered manager confirmed on four occasions one member of staff did provide the care and this had been done in consultation with the person's family member. This was because of unplanned staff absences.

People told us that in some instances they received a rota, which provided them with information as to the name of the member of staff who would be providing their care and the time they would arrive. However, a majority of people told us this information could not be relied upon.

A family member said. "The care is good except for a few times we've been missed…but sometimes it has not been due to the weather. They don't let me know. I have to find out and they just say sorry."

The Provider Information Return (PIR) confirmed there had been five missed calls within the last 28 days.

A person using the service told us. "They (staff) now try to get here but they still turn up late and they call usually at some point, but today they just turned up an hour or more too late, no call. I just wait until they turn up." The person went onto say. "It would be better if they called at half eight and this was what I asked for and they put me to bed at half eight at night. But often it's been around seven and I have to go to bed then. They just say they have not got the staff." A second person who used the service told us. "I'm mostly satisfied. The times are all different and I don't know when they should call as it's sometimes in their papers but not mine, they do turn up but I'm not sure when or who is calling….they mix up the staff…but I don't moan."

A family member said. "The timekeeping is varied but they do try to keep to critical times when [relative] has medical appointments…but their morning slot is between up to 2 hours between 7 and 9am. I think that lots of others (people using the service) also find this…they have a lot of turn over (change of staff)." A second family member said. The time keeping is varied…they don't have enough staff. I've told them so many times I've given up."

People using the service and family members, in some instances expressed concern for staff about providing care in a timely manner. A family member told us. "It's not easy…and I can feel for the staff.....it must be a nightmare working like this…"

The Provider Information Return (PIR) stated that the computer system generated an alert when a member of staff did not 'log' in when they arrived at a person's home. When an alert is received, a member of office based staff contacted the staff member to ensure they were safe and to determine whether any action needed to be taken to ensure people received timely care. However, the service delivery manager told us that whilst the computer system had this facility, it was not actively used, as it did not form part of their contract with commissioners.

Staff told us how there were too few staff to meet the needs of people. The view of staff was that this was because staff were terminating their employment and more people were being referred to Allied Healthcare Leicester for their services. Staff told us that there was either insufficient time or no time allocated to travel between people's homes. Staff told us that they would start work earlier than scheduled to try and build some time into their daily rota, however it still meant that they were late in arriving at people's homes as the day progressed and that they finished later than their scheduled rota time. The Provider Information Return (PIR) identified the theme of complaints received was linked to early/late call time, due to lack of communication or staffing issues linked to short term absence such as sickness.

The (PIR) recorded that whilst 34 staff had started work at the service, within the 12 months, 28 staff had left the service. The PIR stated there were 24 staff vacancies. The care delivery director said that that both positions for 'field care supervisor' were now vacant and that they were actively recruiting for these positions and that of care staff. The PIR identified staffing was a key priority and that a local recruiter had been engaged who provided support by attending local recruitment events. In addition, leaflets and flyers were distributed and placed in shops to advertise the organisation and the staff roles available. The registered manager informed us that since our site visit, three members of staff had been recruited and confirmed staff recruitment was on-going.

People could not be assured there would be staff deployed at times that met their needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

People were safeguarded against the risk of being cared for by unsuitable staff through the provider's recruitment procedures. Recruitment files we looked at contained evidence that the necessary employment checks had been completed before staff started to work at the service. These included application forms with a full history of employment, identification documents and a check with the Disclosure and Barring Service (DBS). The DBS carry out criminal record and barring checks on prospective staff who intend to work in care and support services to help employers to make safer recruitment decisions.

The provider had an infection control policy that referenced best practice guidance. People's care plans provided guidance for staff as to the use of personal protective equipment (PPE), gloves and aprons when providing personal care and support. However, people's comments identified staff did not always wear an apron. One person said. "Yes, they wear gloves and an apron." A second said. "They (staff) wear gloves an apron…and do wash hands after." Another person said. "They (staff) wash hands…I think…they keep gloves on. Rubber very fine gloves…they keep them on. They have a uniform no plastic aprons." And. "They (staff) wash hands and use gloves and use an apron, but not always the apron.

People we spoke with or their family members told us they were safe when staff were assisting them. They felt there was no abuse, neglect or tension felt when staff were present. They also said they did not feel tense when the staff were about, but that they just felt more at ease with staff they knew. One person said. "The carer (staff) helps me safely and comfortably. There's no rough handling…yes they are gentle." A second person told us. "I feel at ease and safe. I've had no accidents with them." Another person said. "The care is safe and dignified."

Staff had received safeguarding training and other training relating to safety, such as action to take in relation to incidents or accidents and that these should be reported to the management team. They understood what procedures should be taken if they suspected or witnessed abuse and knew the potential signs to indicate abuse maybe occurring, such as a change in a person's behaviour, bruising or emotional changes. Staff were aware of their role in contacting outside agencies such as the police, CQC and local authority safeguarding teams. Safeguarding was also discussed as part of staff supervision, to confirm staffs

knowledge. Staff had access to and were aware of the whistleblowing 'hotline', which they could use to raise concerns.

To promote safety of people using the service, the provider had in place guidance for staff, known as the 'Early Warning System' (EWS). Staff we spoke with were confident in their role using the EWS. Any concerns about people's safety under this system, such as a person appearing to be unwell, staff would alert the relevant person, such as next of kin or the person's doctor. Where staff raised concerns in line with EWS these were documented. Records we looked at evidenced how EWS was used proactively to promote people's welfare and respond to potential safeguarding concerns. For example, a person's doctor, next of kin and social worker had been contacted to alert them to concerns. As a result of multi-agency involvement, the person received the support they required.

Staff received training and had their competency assessed annually, to ensure they were able to administer and manager people's medicine safely. A majority of people were prompted by staff to take their medicine, which the person took without any support from staff. One person told us. "I do my own tables but they (staff) remind me." A second person told us. "They (staff) check I've taken my tablets." Another person said. "I have tablets and they get them from my supply and give them and make a note. No mishaps." People's needs with regards to their medicine were detailed in their care plan, which included where the person's medicine was located.

The provider had a medication management policy, which stated that the level of support needed including specific requirements people had with medicines was to be recorded within the care plan. In addition a list of medicines the person was prescribed should be recorded. The policy and procedure did not refer to best practice guidance, which we raised with the care delivery director on the first day of our site visit. When we returned on the second day we were shown information that this had been escalated, confirming the policy and procedure would be reviewed.

All incidents were reported, which included the nature of the incident, who was involved and the action taken by staff. Reports were sent to the registered manager and then to the care delivery director to be 'signed off'. Information of incidents was recorded on an internal system that was used to track all incidents and the action taken, which included informing external agencies.

Requires Improvement

Is the service effective?

Our findings

People using the services of Allied Healthcare were referred by the commissioners as part of the local authorities 'Help to Live at Home scheme'. People's files we looked at did contain a copy of the assessment completed by the commissioners. The care delivery director and service delivery manager informed us that assessments of people's needs were undertaken by commissioners and shared with Allied Healthcare at the time of their referral. However, they went onto say that in some instances assessments conducted by commissioners were not always made available at the point of referral. The care delivery director informed us they had raised this with commissioners.

We were told that in all instances a member of the management team arranged a visit to the person's home to meet with them and a family member where appropriate, at which point an assessment was undertaken and information as to their care and support discussed. This information was then used to develop people's care plans. However, comments from people using the service, family members and staff identified this was not always carried out in a timely fashion. This meant staff had on occasions provided care, without access to information in relation to people's needs. Staff told us information and care plans were sometimes not available. We spoke with the registered manager about the comments we had received. They informed us that care plans were in place prior to people commencing a service.

People's care plans detailed equipment used by people within their home to promote their independence, such as hand rails, perching stools and toilet raisers. This information enabled staff to work collaboratively with people to promote and maintain their independence. A person using the service told us of the positive impact the care they received had on their independence. "It's very good, it's helping me and it's fairly reliable and I am able to do things for myself."

People were confident in the knowledge of staff and their ability to meet their needs. A family member said. "They (staff) are well enough trained." A second family member said. "The care is good when they get here….it would be excellent if they were just more reliable…they (staff) are well trained." A second family member said. "The staff all seem well enough trained. They do shadowing. The new staff are always with one who knows." A person who used the service said. "Yes it's a good service very good, it's just one person (staff) each visit and they are well trained and good as they know what they do." A second person told us. "Well enough trained. New staff do read the plan and check it and look through the log (daily notes) about who I am."

Staff records detailed their initial induction upon recruitment. Newly appointed staff underwent a period of training in a range of topics to equip them with the necessary knowledge to provide safe care to people. Staff had a three month probationary period at the end of which the registered manager confirmed whether the member of staff was competent to work unsupervised. During the initial probationary period staff worked alongside an experienced member of staff, this was referred to as 'care coaching'.

Staff records detailed their initial induction upon recruitment. Newly appointed staff underwent a period of training in a range of topics to equip them with the necessary knowledge to provide safe care to people.

Staff we spoke with confirmed that 'spot checks' were carried out by managerial staff to enable them to improve the care they provided. We looked at 'spot checks' reports that showed they covered a range of areas, such as the effectiveness of staff's ability to communicate and provide the care and support as detailed with the person's care plan. This meant people receiving a service could be confident that staff providing their care and support had been assessed as to their competency.

Staff received on-going support following their initial induction. This took various forms, which included meeting with their line manager for formal supervision and appraisal, which provided staff with an opportunity to reflect and talk about their work. Support was also in the form of competency assessments. Staff were observed by their line manager providing care and support to people. This meant the registered manager could be confident that staff worked in accordance with their training and the policies and procedures of the provider. Where shortfalls in staffs practices were noted additional training and guidance would be provided.

Staff stated they received training, which enabled them to meet people's needs and that their training was on-going. This was consistent with information on training provided by the care delivery director. One member of staff spoke about the specialised training they had received to support a person's individual and tailored health care needs. They told us their competency to perform these tasks had been assessed by a health care professional.

.

Care co-ordinators using the provider's computer system allocated people's care packages to staff members on a day-to-day or weekly basis by developing a rota for staff. The rota informs staff the people whose care they will provide along with the date and time of the visit. The computer system alerts the care co-coordinator should a member of staffs training be out of date or should a member of staff have not undertaken training specific to a person's needs. The use of this system supported the care co-coordinator in making decisions when allocating staff to people to meet their care needs on the staff rota.

People spoke to us of the support they received about meals and drink. A person using the service said. "They (staff) do my meals in the microwave nice and it's served and put out like the best places." A second person told us. "It's nicely presented and what I chose." Staff supported people to eat and drink a healthy balanced diet. People's care plans detailed the support required, which included the recording of people's dietary intake where there were concerns for people's health. People's dietary needs were recorded within their care plan, which included their likes and dislikes, along with any specific dietary needs.

Care plans detailed the level of involvement of staff, in the preparation of meals and snacks. Where snacks, such as sandwiches were prepared in advance, information as to where these were to be left so the person could help themselves later in the day was documented. In some circumstances the service was commissioned to support the person with their grocery shopping, either shopping on their behalf or supporting them to do their own shopping. For example, a person who had their shopping undertaken for them had a care plan that stated staff were to write a shopping list with the person's involvement and for staff to use their initiative to check for the supplies of standard stock items such as tea bags.

Staff worked with other agencies in response to peoples' changing needs, to ensure consistent care was provided. People's care plans contained information about their medical history and current health needs. People's health needs were monitored and discussed with them, and if appropriate their family members and other healthcare professionals.

People shared their views about the support provided by staff about health care. A person using the service said. "They (staff) will alert me if they see anything or get me the doctor. I have a few things wrong. I need a

bit of TLC (tender loving care)." A second person said. "They (staff) alert me to get the doctor if it's needed. Yesterday they got the doctor they wanted to make sure I'm okay." A family member said. "When [relative] was not well they called the doctor which was very important, they do alert me if [relative] is not well."

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. Whey 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. Applications to deprive a person of their liberty in their own home must be made to the Court of Protection. At the time of the inspection, it was confirmed that no one was being deprived of their liberty. The registered manager and staff understood the principles of the MCA. People and their relatives confirmed that staff always sought consent before carrying out any care tasks and staff understood the importance of always seeking consent before providing people with their care. A person who used the service said. "They (staff) don't take advantage and they do ask they are considerate."

Requires Improvement

Is the service caring?

Our findings

Family members told us in some instances they did not receive support from a consistent group of staff and that this impacted on their relative, in developing relationships and being confident with people. A family member said, The main problem for my [relative] is that [relative] gets confused as they change their carers too much. No, it's not good continuity, it can be distressing if [relative] gets very upset when they (staff) change." A second family member said. "My [relative] has dementia and it makes it hard for them to know what is happening. It can be confusing. They have a lot of turnover (change of staff) again it's unsettling and harder for [relative] to settle with different staff." A person who used the service told us they had one regular carer and chose not to have other staff attend if they were not available.

People and their family members told us how their views were sought and the involvement they had in the development of the care plan. A family member told us. "They (staff) came out at the start. The care plan was agreeable with some things that seem a bit silly now, but the girl who did it has now left and I cannot recall everything now its set up. I can't recall any review or chat with them in the last three months." A second family member said. "They (staff) came out to check the care plan with us and it was agreeable." A person who used the service told us. "I've used them for a few years. They came out to review it (care plan) it used to be about every six months formally, but I've not seen them for over a year." A second person using the service said. "They (staff) came out at first to see me. It's not yet been checked to see if it (care plan) is okay but I can ring them."

We received positive comments from people and family members, who told us staff respected their privacy and dignity. A person using the service said. "I get different girls (staff) they are all polite and respectful." A second person told us. "The staff are a lovely bunch of people. The ladies (staff) are lovely." A third person told us. "Yes, I'm very much at ease with (staff) my relative as well. We know them well; we are always on nice terms." A fourth person using the service said. "They (staff) respect me and they are polite. I'm very much at ease with them…but I'm a bit uneasy if they are completely new."

A family member said. "The care staff are polite and pleasant." A second family member said. "They (staff) are respectful of [relative's] privacy. They wait outside the toilet. The care is done with dignity and safely." A third family member said. "They are excellent carers who are really nice. [Staff name] is lovely and polite."

People's comments reflected how staff were sensitive to people's disabilities, age and gender preferences. A person using the service spoke of their positive relationship with a member of staff. "Staff I know, we are on first name terms and [staff members name] is like a friend and relates best to my age and earlier life in this area. She is professional and she knows the boundaries."

People shared with us positive comments about the service. A family member said. "I would recommend the carers." A person who used the service said. "I would recommend the carers. I enjoy having the Allied staff, generally they are good and it helps me stay at home." A second family member said. "The care staff are fine themselves. A number of written compliments had been received by the service in the form of thank you cards from those using or had used the service from family members, which named staff. Staff supervisions

were used to acknowledge share and record the compliments received.

Requires Improvement

Is the service responsive?

Our findings

People's views and that of family members showed that the service was not consistently responsive, as it did not meet their needs or expectations.

A family member told us the support package their relative received did not meet their relative's needs. "It's too short between the tea time call and the evening call, but then too long a wait between the last night and morning call. So, if [relative] is incontinent soon after the last call, I can't help."

The service delivery director told us that they worked to meet the contract they had with commissioners as part of the 'Help to Live at Home Scheme'. They told us that commissioners when undertaking assessments would ask people for their preferred times for care to be provided. The assessment was then forwarded to the service where it was considered. Where people's preferences for the time of call could not be met then alternative times would be put to commissioners. Commissioners should they accept the revised times did not always inform people of the changes. The care delivery director said this was a contributory factor to people being dissatisfied with the service they received as their expectations were not met as the service could not meet people's preferred times for the delivery of their care.

We found significant inconsistencies in the time staff arrived and departed a person's home to the times as detailed within a person's care plan. For example, one person's morning call stated staff were to arrive between 9 – 9.30am, however the daily notes completed by staff showed staff had arrived as early as 8am and as late as 11am. We spoke with the care delivery director, who said they would investigate the issue.

When we looked at people's care plans, we found they had not been consistently updated. For example, a person's care plan recorded the person received four visits a day from staff, however the times did not reflect the times staff recorded as to the time they arrived and left the person's home within their daily notes . We spoke with staff based in the office, who informed us the person had requested the time of their visits for care to be changed. The care plan did not reflect this. The care delivery director said they would ensure the person's care plan was updated.

Staff told us in some instances people did not have a care plan when they first started using the service. Staff told us in these circumstances they were reliant upon the person being able to tell them what support and care they needed. We were told this situation usually arose when commissioners referred the person to the service on the same day the support was to start, which in some instances occurred when the person was being discharged from a hospital setting.

The provider had failed to ensure the care people received was appropriate, met their needs and was based on their preferences. These matters constituted a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care.

People's view as to their involvement in the development and reviewing of their care plan was mixed. People in some instances had been involved, however our discussions with people showed they did not

experience a consistent approach to having their needs reviewed. People's records we looked at showed that people's care plans had been signed by them or their family member.

The care delivery director informed us care plans were reviewed annually unless people's needs changed in which case they would be reviewed earlier. They stated the service liaised with the commissioner funding people's care so that their care package could be reviewed and updated. Where changes were not significant, such as a request by the person for a visit to be cancelled or a change of time for a specific event these did not require the approval of commissioners. In these circumstances, the provider informed the commissioner by submitting a form. A person using the service told us how the service had supported them in being re-assessed by commissioners to increase their care package.

People's care plans provided information as to people's needs, providing staff with information as to the care and support people needed, taking into account people's preferences and recognising how staff were to support them to maintain their independence. For example, one person's care plan said the person didn't like water on their face when they had a shower and informed staff of specific brands of moisturising cream they wished to be applied to their skin.

The care plan of a person who received health funding as they had specific health care needs, was comprehensive. Staff who had undertaken training to enable them to meet the person's needs were provided with clear instructions, within the person's care plan. This meant they were able to understand and respond to any changes in the person's well-being. The person's care plan provided specific guidance as to how the person communicated through body language, sounds and behaviour.

During our inspection, we observed how the service responded quickly to provide care and support, promoting the welfare of a person. A family member contacted the service to advise them of their relatives discharge from hospital. They informed the service that the support arranged to provide the initial care prior to Allied Healthcare taking over the care, had not been received, which meant their relative had not received the care they needed. They spoke of the impact on their relative. The operations director contacted the person's commissioning officer. A number of telephone conversations took place. The operations director explained the circumstances of the person's discharge from hospital and the conversation had with the family member about the person not receiving the care as agreed and organised. As a result of their conversations, the operations director, made a decision that in the best interests of the person staff from Allied Healthcare would visit the person and provide their care, starting the care package earlier than had been agreed. A member of staff was contacted and asked to visit the person to provide personal care and support.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publically funded care to ensure people with a disability or sensory loss can access and understand information they are given.

People's care plans did provide information on people's communication. For example, one person with a sensory impairment directed staff to ensure the person was wearing their glasses. Another person's care plan identified the person had significantly reduced hearing in one ear. Whilst the care plan stated staff should repeat information if the person had not heard, it did not suggest that when speaking with the person staff directed their conversation towards the ear which did not have reduced hearing.

The service operated an out of hour's service, from 5pm to 9am during the week and from 5pm on a Friday

until 9am on Monday morning. This meant people using the service, family members and staff could contact a representative of Allied Healthcare Leicester, at any time. The out or hours service was operated centrally across the region and issues were managed by staff who had access to information via the provider's computer system. Staff based in the office informed us they also had an on-call rota, and were contacted by the central regional out of hour's service if they could not answer or deal with a specific issue.

The provider, as part of its contract with local authority commissioners, 'Help to Live at Home Scheme, provided End of Life care to people in their own homes. At the time of our inspection, no one was receiving this type of care. We were told that staff had been provided with End of Life care training and this was confirmed by a member of staff. The member of staff spoke of the specific training they had received, to enable them to care for people at this stage of their life. They told us the training providing guidance on how people's ability to eat and drink changed, and how people were at risk of choking. They told us how they liaised with district nurses to report any significant changes in the person, such as changes to their breathing. However, information as to staff training did not show that staff had received training in End of Life Care. The registered manager informed us staff had not received training on End of Life Care, however this was being planned.

The Provider Information Return (PIR) stated 38 complaints had been received within the last 12 months and that the theme for complaints was from people using the service complaining about early and late call times. The PIR stated these were commonly caused due to lack of communication and insufficient staff due to staff absence. Action had been taken by the registered manager by ensuring people using the service were notified in advance, where possible, of any changes which would have an impact on the time of their visit. However, comments from people using the service and their family members showed that people continued to be dissatisfied with the service they received.

A person using the service told us. "I complained once when one (staff member) was late. They did apologise and sent a letter, they took is seriously." A second person using the service said. "I've had no problems no complaints. They carers are very helpful. They will do what I ask. "A third person said. " I've not really complained as I don't like to but I would if it was really needed." A family member told us. "We've had no complaints". They went onto say staff had contacted them by phone to check if they were happy with the service. They had not raised concerns about not being notified of changes to the rota. A family member told us how they had expressed concerns that in their view had not been listened to. They said. "I may need another firm to take over. It's still not right after about four weeks. Needs to improve or be much better."

Requires Improvement

Is the service well-led?

Our findings

The records of a person who used the service contained a copy of a welcome letter from the registered manager, which detailed the vision of the service. The vision statement included 'delivering moments that matter, we will create services that are built around people, not processes or tasks. We will work with you, listen to you, support and encourage. Provide flexible, safe and reliable care.' Conversations we had with people who used the service or family members did not reflect the service they received and was not was reflective of the vision statement.

People's views were sought through surveys, which were sent out annually. The results were collated and had identified people had raised concerns as to the lack of consistent staff in the provision of their care and commented about poor time keeping. This showed that any action taken had not brought about improvement. The outcome and any action taken as to the findings of consultation was not shared with those who used the service.

The provider had a clear governance framework implemented by an infrastructure of support internally, with departments across the organisation having clear areas of responsibility. All of which reported to the advisory board, this was made of the Chief Executive Officer, and representatives from other departments including human resources, contracting and legal. However, people's experiences as to the reliability of the service showed that the governance framework had not brought about the necessary improvements to ensure people received good quality and reliable care.

A number of audits were undertaken by members of the management team. These had evidenced that the time of staff arriving at people's homes were not always consistent with their care plan. We found people's care plans had not been updated to reflect changes to people's circumstances. These issues had in some instances been identified, which had included times of calls. The issues identified had not resulted in sufficient action being taken to bring about improvement.

The provider had failed to ensure the management, leadership and governance of the service to ensure the delivery of high quality care, which could be relied upon by those using the service. These matters constituted a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The Provider Information Return (PIR) and discussions with the care delivery director evidenced regular meetings and discussions took place across all departments, where information was shared and escalated. The registered manager met regularly with their line manager, who in turn met with their regional director. All members of the management structure had access to information that enabled them to continually monitor services. Information that was monitored included, staff development, internal quality audits, complaints and responses to complaints and incidents. Action plans where shortfalls had been identified were regularly reviewed which included action plans set by external stakeholders such as commissioners of the local authority.

We sought the views of commissioners prior to our inspection site visit. They confirmed that the provider was working with them to bring about identified improvements, which were consistent with the inspection findings of the Care Quality Commission (CQC).

There was a registered manager in post. They did not take part in the inspection as they were on leave. The registered manager has responsibility for two locations, which includes the Leicester branch. The office based staff team to support the day-to-day running of the service had vacancies. People shared their views as to the management of the service. A person who used the service when telling us of their concerns with regards to the timing of staff visits said. "They've so far not sorted things out for me at the office. I would recommend the care but would not recommend the firm." A second person said. "Generally some (staff) are very good and some not as good but the managers are the problems." A family member when speaking of their concerns said. "It's much worse than just teething problems…it's a mess." A second family member said. "The office seniors are stressed and just try to make things work….They (office staff) are good people and the carers (staff) are fine but they just don't cope with it."

A majority of staff employed to provide people's personal care and support spoke of their frustration in not being able to influence the service they provided to people. Staff told us of the impact this had on both themselves and those using the service. Staff's views were that there were too few staff to meet the needs of people. Staff said in their opinion this was due to their colleagues terminating their employment and more people being referred to Allied Healthcare Leicester for their services.

The care delivery director acknowledged improvements were needed and that they along with the registered manager were committed to providing high quality care for people. Part of the commitment to bring about improvement was the recruitment of additional staff, which was on going, both in the delivery of care and the appointment of field supervisors who would provide support to staff.

The provider was investing in a computer package to assist office based staff in producing staff rotas. We were told that the computer package used information such as a person's address to plan travel time for staff, and support staff in working within a specific geographical area effectively.

Staff did not believe they were valued and said any specialist knowledge in care and additional responsibilities they had were not financially numerated. The Provider Information Return (PIR) recorded they [registered manager] were looking into better rates of pay for staff and that some staff had been placed onto guaranteed hour's contracts of employment. Additional incentives for staff included a monthly prize draw, where staff names (from across the UK) were automatically placed into a draw for an opportunity to win a prize.

Staff views had been sought through a survey, which asked staff specific questions, which included whether staff felt listened and whether they felt valued. An action plan which responded to the outcome of staff questionnaires had been developed. One aspect of the action plan had recognised the need for the development and distribution of a monthly newsletter to all staff. Newsletters had been produced, which celebrated success across the wider organisation (across the UK) and provided information on training and staff benefit schemes.

We found the minutes of recent team meetings recorded the expectations and views of the management team. Minutes of team meetings had thanked staff for the support shown following the recent office relocation. Staff were reminded of the importance of completing records and ensuring confidentiality. Staff were advised of the absence management policy in relation to staff sickness. It was also highlighted to staff of their need to be flexible with their rotas, as new clients would be continually referred to the service.

The development of the service to meet the needs of people resulted in meetings held between the management team of Allied Healthcare Leicester and doctors, who met at a local hospital. The focus of the meeting being how to prevent unnecessary admissions of people to hospital. This was a meeting involving a number of providers of domiciliary care and commissioners.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure the care and treatment of people was appropriate, met their needs and reflected their personal preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure potential environmental risks to the health and safety of people were assessed and steps taken to mitigate any identified risks.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient staff employed to meet people's needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure shortfalls identified through its monitoring system had brought about the required changes to improve the quality and experience of people

The enforcement action we took:

Notice of Propose to restrict further packages of care.