Nestor Primecare Services Limited

Allied Healthcare - Ampthill

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place over three days and was initially unannounced. The service provides personal care and support in people's homes. At the time of the inspection there were 301 people who used the service.

There was a registered manager in post. 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. The registered manager had a more regional role within the provider's organisation and was the registered manager for a number of the provider's services. Day to day management of the Ampthill service was carried out by two care delivery managers. The registered manager retained oversight of the service.

The service had up to date policies and procedures which included ones on safeguarding, whistleblowing and implementation of the Mental Capacity Act 2005. People were protected from the risk of harm by effective assessment and management plans to reduce the risks to them. These covered both personal risks to people and environmental risks. There were plans in place for emergencies that might occur and the service operated an 'on call' system that meant that people could contact them on a 24 hour basis.

Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who used the service. Staff were trained and supported by way of supervisions, appraisals and regular audits of the way in which they delivered care. Staff were provided with specialist training when this was needed to provide care for people. Where the service had been unable to recruit and retain sufficient numbers of staff in a certain geographical area to provide the care people needed, they had worked with the local authority to find alternative care providers for people in that area.

People had been involved in determining their support needs and the way in which their support was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 (MCA) were met. They were treated with dignity and respect by staff who were kind and caring. People were encouraged to make choices of their own and to maintain their independence.

People and their relatives had been involved in deciding what support they were to receive and how this was to be given. Relatives were involved in the regular review of people's support needs and were kept informed of any changes to a person's health or well-being.

There was an up to date complaints policy in place and a copy of the complaints system was included in the folder kept at people's home, which also included other information about the service.

There was an open culture and staff were supported by the care delivery managers and the registered manager. Regular quality audits were completed by the care quality staff and any areas for improvement

were addressed with individual members of staff by the care delivery managers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Personalised risk assessments and risk management plans were in place, and updated on a regular basis to reduce the risk of harm to people.

Staff were aware of the safeguarding process.

There were enough skilled and experienced staff to provide the care people needed.

Is the service effective?

Good

The service was effective.

The requirements of the Mental Capacity Act 2005 were met.

Staff were trained and supported by way of supervisions and appraisals.

People's consent was gained for the support provided to them.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity, treated them with respect and maintained their confidentiality.

People were encouraged to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People had been involved in developing their care plans and personalised plan of scheduled visits which detailed what care workers would do at each visit.

There was an effective complaints system in place.

Is the service well-led?

Good

The service was well-led.

Day to day management of the service was carried out by two care delivery managers, although there was a registered manager in place who had general oversight of the service.

There was an open culture at the service and people and staff found the management to be approachable and supportive.

The provider had effective systems to assess and monitor the quality of the service.

Allied Healthcare - Ampthill

Detailed findings

Background to this inspection

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

The inspection took place at the offices of the service on 25 November, 6 December and 8 December 2016. The inspection was unannounced on the first day but announced on the second and third day. The inspection team was made up of one inspector, who visited the offices of the service, 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. The inspector and the expert by experience carried out telephone interviews with people who used the service, relatives of people who used the service and care staff between the inspector's first and second visit to the offices.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also sent 50 questionnaires to people who used the service, 50 to relatives of people who used the service and five to community professionals to inform us of any areas that we needed to specifically look at when carrying out the inspection. We received 19 responses from people who used the service, two responses from relatives of people who used the service and one response from a community professional. We also reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During this inspection we spoke with 12 people and six relatives of people who used the service. We spoke with three care staff, a care scheduler, a care quality supervisor, two care delivery managers, the regional training officer and the registered manager. We looked at the care and visits records for 10 people and the recruitment records for three members of staff. We reviewed records of visits made to people and staffing rotas. We also reviewed information on how the quality of the service was monitored and managed, including the management of complaints and the emergency plans.

Good

Is the service safe?

Our findings

People who used the service and relatives of people who used the service we spoke with told us that they or their relative felt safe with the staff who visited them. People were provided with information on safeguarding in the folders kept in their homes together with the telephone numbers that they should contact it they needed to.

The service's policies were up to date and included ones on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. One member of staff told us that they had recently completed their updated safeguarding training. They said that they would, "Report any concerns to the office and they would refer them to the safeguarding team and CQC." Of the whistleblowing policy they said, "I would have no problem using it. If something is not right, it is not right."

The care records we looked at contained assessments of risks associated with people's care and support. These had included risks associated with people's medical conditions as well those associated with people's mobility, their risk of falling, poor nutrition and pressure ulcers. People and relatives told us that they had been involved in discussions about these risks. Actions staff should take to manage the risks had also been identified. One risk assessment identified that the person was at risk of mismanagement of their money. The management plan instigated to reduce the risks this would pose to them included staff taking the person to one of the local authority's offices to collect their money, and then supporting them to buy their essential items for the week and pay their bills.

In addition to the personalised risk assessments, environmental assessments had been completed to identify any possible areas of risk to people and to staff accessing people's homes. One member of staff told us, "We do risk assessments all the time. The environmental assessment is updated once a year but we review it on every call we do." The care records we looked at showed that the environmental risk assessments were reviewed on a regular basis. One risk assessment for security and environment told staff where to access the fuse box, gas inlet and water stopcock in the event of an emergency. We saw that there were systems in place to monitor that the cars staff used for their work, including when taking people out, had a current roadworthiness certificates and insurance. Staff's driving licences were also checked regularly to ensure that they continued to be legally entitled to drive. People who used the service were protected from the risk of harm by effective management plans in place to reduce the level of risk to them.

Accidents and incidents were recorded within a centralised data base. The care delivery managers and the registered manager were alerted about incidents recorded and the causes were analysed regularly to identify any improvements that could be made to prevent the occurrence of similar incidents in the future.

We found that the recruitment procedures in place were robust, although there were two versions of the application form in use. We highlighted this to one of the care delivery managers who immediately arranged for the older version of the form to be destroyed. Relevant checks, including evidence of their identity and their right to work in the United Kingdom had been completed to ensure that the applicant was suitable for

the role to which they had been appointed before they were allowed to start work with the service. This meant that the provider had taken every care to check that people were cared for and supported by staff who were of good character and had the necessary skills and experience to provide the care and support they needed.

Some people required staff to provide assistance to them when taking their medicines. For some people this was just a prompt by staff to take their medicine but for other people, staff administered the medicines to them. Medicines risk assessments and care plans contained information about the medicines people were prescribed and how these were to be administered. Two people we spoke with told us that they had assistance with taking their medicines and that this was recorded in their care records each time.

We saw that medicines administration records (MAR) were completed and were subject to regular audits by a care quality supervisor. Where people had been prescribed creams and lotions, there were body maps accompanying the MAR to advise staff where the medicines needed to be applied. A care quality supervisor told us of the training that staff had to complete before they were able to administer medicines to people. They told us, "Medicines administration is part of the training programme. They learn about MAR. We discuss it with the care workers and they go out shadowing (observing experienced staff). They have to pass the class on medicine administration otherwise they have to redo it. If they make any error regarding medicines care workers have to redo the class again. We can't afford any mishaps with medicines." □

Good

Is the service effective?

Our findings

The majority of the people we spoke with told us that staff arrived on time and stayed for the correct amount of time. One person said, "It is quite good. If they are occasionally late they let me know, but this does not happen often." Another person said, "They are on time more often than not." A third person told us, "I used to have issues with them arriving late and not staying the correct length of time, but things have improved a bit." However, one person told us, "There is a terrific variation of times. They mess about with times, especially in the morning." The care scheduler told us that the visit rotas were sent to staff on Wednesday each week for the visits they were to make the following week. This gave time for any identified problems to be resolved before the visits were due. They told us that they were able to cover visits with other staff if the allocated member of staff was not able to do the visit. For example when they had received notification that a member of staff could not complete two visits at lunch time the following day, they contacted other staff and they had been able to arrange appropriate cover.

We checked the visit records of 10 people for the week prior to our inspection. These confirmed that visits had usually been made within a few minutes of the planned time and no visits had been missed. The care delivery managers told us that there was an 'on call' system in place. There was an emergency central number for people to contact and the call was transferred to the 'on call' duty officer who would either arrange for visits to be completed by another member of staff or would complete the visits themselves. This enabled the service to fulfil its commitment to people to provide the care and support that they needed.

People were normally advised of any delay in their care visits taking place. One person told us, "If there is a delay or an alteration I am notified." Another person said, "They phone up if they are going to be delayed." During our inspection we heard staff who were delayed on visits call into the office and reporting to the care scheduler. The scheduler then called the people who the member of staff was due to visit to advise them that their visit would be late. However, people were not advised when staff brought the visit time forward and arrived earlier than expected. This had been problematic for two of the people we spoke with. One member of staff told us that travel time was now included in their rota. They said, "Some care workers seem to start earlier with calls. For the past month they have started to put travelling time between my calls." However, another member of staff told us that they had not travelling time between the visits they were expected to make and a second visit was time critical for the person's transport to a day centre. This had resulted in them making their first visit early because they knew the person would be happy with this. We brought this to the attention of the registered manager and they agreed that staff should not make visits earlier than had been scheduled without first contacting the person to check that it was convenient. They also said that they would investigate this.

People told us that staff had the skills needed to provide the care they required. One person told us, "My carers are very good." Another person said, "Most of the carers have been very good. They are good on bathing and showering." However, one person did say, "Some have more skills than others."

Staff told us of the induction training and regular refresher training that they received. This included medicine administration, food and hygiene and moving and handling. The regional training manager was at

the service during our inspection, delivering the face to face induction training that staff received before they undertook a period of shadowing (observing experienced staff) and accompanied visits prior to working on their own. The service had introduced care coaches who initially showed a new member of staff how a specific care task should be completed. They then completed the task with the new member of staff, followed by them being observed by their care coach completing the task unaided. It was at this point that they were validated as having achieved competence in the task.

One member of staff told us, "I did my training. It was about a week in the office and then I was shadowing quite a lot. I felt comfortable but was quite nervous. I said I was not ready to work on my own, so I shadowed until I felt comfortable." They went on to tell us of the benefits refresher training had for them. They told us, "I recently did moving and handling refresher training. This showed us different ways if people needed extra help. There are different ideas all the time and the training tells you about them which helps you and the client." Another member of staff said, "The moving and handling training showed us new positions and new equipment that is available. We had a video on a new standing aid and how to use it."

Staff told us that they were able to request additional training to improve their performance or was needed to provide effective support for people with specific medical conditions. We saw that staff involved in the care of a person with the 'ventricular assist device' had received appropriate training. A care delivery manager showed us the compliance regulation tool that had been introduced by the provider. This detailed the training that individual members of staff had completed. The service was 94% compliant with the training requirements, with one of the members of staff with training outstanding being on holiday. This showed that people were cared for and supported by staff who were continuously encouraged to develop their knowledge and skills.

Staff said that they received supervision every three to six months. One member of staff said, "There are written questions that are discussed in supervision that cover all areas of your job. You can come in and have a one to one whenever you like." Another member of staff told us, "We talk about all different stuff, any concerns I might have, any other carers who are not working right, clients reviews or anything I need help with." In addition staff said that there was an annual appraisal system at which their development needs were discussed. One care delivery manager told us, "It is a 360 degree appraisal review. Colleagues and other staff you manage are asked to identify your strengths and weaknesses. Areas for improvement are included in your development plan." We looked at the centralised supervision records for the staff team. This provided updates from staff supervisions, the date the last supervision had been completed and the next due date for supervision for individual members of staff. People were therefore cared for and supported by staff who were in turn supported to develop their skills and experience.

Staff told us that they received training on the requirements of the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications for people who live in their own homes must be made to the Court of Protection. There had been no applications made at the time of our inspection. We saw evidence that some people had advocates who had legal authority to make decisions on their behalf.

Staff were able to demonstrate that they had understood the requirements of MCA, although they had not been involved in the assessment of people's capacity to make and understand decisions about their care.

One member of staff told us, "We assume that everyone has capacity, even if they have been diagnosed with dementia. You can't take the right away from people unless you know with certainty that it would be unsafe or a danger to them." Staff understood that where people did not have the capacity to make their own decisions, then decisions that were in the person's best interests would be made by community professionals and people's relatives

People we spoke with confirmed that staff always asked for their permission before providing care to them. Staff told us that they always asked people whether they were happy to have their care and provided choices. A member of staff said, "They have choice. If you know they have not had a wash you can encourage people but you can't take away people's choice. That would be a form of abuse. I would report t to the office if they continually refused." Another member of staff told us, "We can't force them [people] to do anything. If they have dementia you can try to encourage them, help them by giving them different choices." The care records confirmed, that people had given their consent for the care planned and they, or advocates on their behalf, had signed a document, which was held in the care record, to agree the care.

Staff said that they monitored whether people had eaten and drunk sufficient amounts to maintain their well-being and encouraged people to eat and drink. One person told us, "They always ask if I want a drink." A member of staff told us that if they had any suspicions that someone was not eating or drinking sufficiently, they would report this to the care delivery manager and would document what the person was having at every meal. They would monitor the person's intake and question why if the person started to refuse the meals they had been offered, so that prompt action could be taken to refer the person to appropriate health professionals.

People were supported to maintain their health and well-being. One person told us, "The people at the office called the doctor out when they were concerned about me." A relative told us, "Allied were absolutely brilliant and on the ball. Three calls to me and follow up calls when my [relative] had a problem with heating. The carer wouldn't leave my [relative] until a heater arrived. We are grateful for what they do." The provider had also introduced a process to improve communication between the service and hospital to prevent missed care visits. Staff were instructed to tell the office if someone went into hospital or if they heard that they were to be discharged. The provider had developed a hospital discharge handover checklist for use in such situations.

Good

Is the service caring?

Our findings

People told us that staff were friendly, kind and caring. One person told us, "My girls are lovely." Another person said, "My carers are all very polite, respectful and humorous. They are all extremely good." A relative told us, "The carers are lovely with my [relative] and [they are] happy with them. I have nothing negative to say."

People told us that staff treated them with respect. One person told us, "I have a good carer who is very understanding. My carer treats me as an adult, not just someone with a disability. Any problems I can speak with her." Another person said, "They treat me with respect. They are not condescending to me." A member of staff told us, "I talk to [people]. Ask them if they are comfortable and happy. I have good relationships with people and talk and joke with them." Another member of staff told us that they knew the people they cared for and talked with them about things that interested them.

People also told us that staff protected their privacy and confidentiality. One person told us, "They are professional. They don't talk about each other or other people. I appreciate that." We asked staff how they protected people's privacy and confidentiality. One member of staff told us, "When providing personal care, you use towels so they are not exposed, and make sure doors and curtains are closed so no one else can see." Another member of staff told us, "You shouldn't talk about any other clients or staff to any clients."

People were able to make decisions about their care. One person told us, "My carers are ever so nice. I rely on Allied to take me out." A member of staff said that when they visited they always asked people, "What do you want this morning?" Another member of staff told us, "I ask them what they would like done and how they would like it done." One person told us, "My independence is encouraged." A member of staff told us, "I don't take over completely. If they can do it I let them."

People were provided with information they needed about the service in the folders that were in their homes. This included copies of the care plan consent form, an introduction to the service, a summary of the person's care plan and a personalised individual environment risk assessment. The welcome pack provided to each person with the information folder also included information about the out of hours service. People were able to request that they be sent information about the time of their visits and the staff who would support them on the Friday of the previous week. They were also able to contact the office at any time to talk to one of the scheduler's or care delivery managers. One person told us, "The [staff at the offices are absolutely amazing."

Good

Is the service responsive?

Our findings

People told us that they had been involved in the initial assessment of their support needs, sometimes with the involvement of a social worker, and subsequent reviews of this. They told us that their care and support plans were focussed on their individual needs. The care records we looked at showed that they had all been reviewed recently and people and their advocates had been involved in this.

The care records identified the desired outcomes of the care that was provided. For example one care record stated that the desired outcome was for the person, "To stay in [their] own home with [their] things around [them] for as long as possible." The initial assessment provided information about the individual, their support networks and other health and social care professionals involved with them. The records included information on the person's likes and dislikes, activities and hobbies and, where appropriate, their end of life care plans. The records were kept electronically as well as in hard copy. The care scheduler told us that if the data system contained information that a person wanted only female staff to support them, it would not allow male staff to be scheduled for their visits. The care records included plans to address people's identified needs, such as breathing, communication, mobility, nutrition, hobbies and interests. One care plan stated that an individual could become breathless on exertion and staff were to allow them to take their time and rest whenever they needed to when out and about.

Each person had a personalised plan of scheduled visits. For each visit that a member of staff was to make to the individual, there was detailed information about exactly what the member of staff r was expected to do and how this should be completed. For example on the first visit of the day for one person, the plan stated that the member of staff should knock on the door to be let in. It then detailed what equipment was needed and where this would be found to assist the person with their personal care.

Staff told us that if people requested changes to the care that they wanted, their needs would be reviewed and if necessary, the local authority would be contacted to request a review for funding purposes. One member of staff told us, "I would not do anything that was not written in the care plan. I would explain why I could not do it. I would not be covered if anything went wrong." We saw that the personalised plan of scheduled visits was updated to reflect changes in the care and support to be provided to people. We saw that one plan had been updated following a change to the person's support needs from two visits three times a week to just one visit once a week, but for a longer period.

Care plans had been developed to support people with their interests and hobbies. One person had been encouraged to attend a day centre but had told staff that having tried it, they did not want to go as it was "full of old people." Instead a member of staff talked to them about history, which they shared as an interest. Another person said that they liked to spend time with their family and watch their favourite programmes on television.

There was an up to date complaints policy in place and was included in the information folders in people's homes. One member of staff told us, "If someone wants to complain I would suggest that they phone the office or would offer to do so on their behalf." We looked at the computerised system that covered incidents,

accidents and complaints. We noted that a complaint had been opened following a complaint that a member of staff had spilt something on a person's carpet. The care delivery manager had carried out an investigation and had arranged for the carpet to be professionally cleaned. However the stain could not be removed and the care delivery manager was in the process of arranging for the carpet to be replaced at the service's expense. As the complaint had not been resolved at the time of our inspection it remained open within the computerised system. Another complaint had been received and recorded on 19 October 2016 and closed on 28 October 2016. This had been investigated and a system had been put in place to prevent a similar occurrence. The care delivery manager told us that complaints could be assigned to members of staff and brought up in their supervision or appraisal. This allowed for the monitoring of complaints about individual staff and also enabled them to identify any trends. Staff told us that learning from complaints was shared at staff meetings in order to prevent similar complaints from occurring. This showed that the provider listened to people's concerns and took action to address them.

Good

Is the service well-led?

Our findings

The service was split into four geographical areas and managed on a day to day basis by two care delivery managers. The registered manager had a more regional role within the provider's organisation and was the registered manager for other of the provider's services. However, they told us that they were at the service on a regular basis and were alerted to any problems that arose via the care delivery managers and the electronic data systems. One of the care delivery managers told us that the service had handed back a number of care packages in one location as they were unable to maintain enough staff in the area to deliver the care needed. They told us that they had worked with the local authority to hand the care packages over once a new provider had been identified.

People were encouraged to contact the office if they wanted to discuss anything about their care or the service provided to them. One person told us, "Allied are very good. They are far supreme to the previous company I was with. They are more clued up with people's needs, they have a better understanding and take an interest. [I have] no complaints." Another person said, "The staff at the offices are approachable and responsive." Staff told us that they found the members of the management team to be supportive and approachable.

We saw that people and their relatives were regularly asked to provide their feedback on the service that they had received and any changes they would like to be made to it. One person said, "[There has been] no survey recently but I have been asked in the past." A survey completed in June 2016 within one care record included comments such as, "generally happy", "lovely carers" and "great work."

The service held quarterly meetings with staff. We saw that at the winter branch meeting in 2016, topics they had discussed included the on-line learning centre, mandatory training, IT system, pay and rewards. In addition they had discussed specific risks to people caused by the time of year, such as hypothermia and carbon monoxide poisoning. They also discussed forthcoming events such as 'National Heart Month' in February 2017. This had enabled staff to have input into the way the service delivered care and support. An information booklet given to staff gave details of ways in which the service had changed following their input. These had included the introduction of guaranteed hours, care coaches and changes to uniforms worn by care staff.

This information booklet also reminded staff of the values of the service which were stated as 'the foundation stones of our culture and signify what we stand for.' It also reminded staff that the vision of the service was, "to be the choice for Care that gives people the freedom to stay in their own home".

Care quality supervisors carried out regular audits of care records and medicines administration charts. One of the care delivery managers told us that if any discrepancies were brought to their attention, they would either speak with the member of staff immediately or they could include information about the discrepancy in the member of staff's electronic file and discuss it at their next supervision.

In addition to the internal audits, the provider carried out a regular independent audit of the service and an

action plan was developed from this to address identified areas for improvement. This action plan was monitored by the care delivery managers and the registered manager, as well as the provider's centralised quality team.

There was an incentive scheme in place across the provider's services with various awards for innovation and good service, both locally and nationally. Staff were able to nominate their colleagues for the awards. We saw that some members of staff had been presented with award certificates for good service and we were told that these were accompanied by monetary awards, such as shop vouchers. There was also a 'carer of the month' award, which carried rewards such as weekend breaks, spa treatments and even a car. This scheme gave staff additional incentives to provide the best possible service to people. Staff were also encouraged to recommend the service as an employer to their friends and family, as staff recruitment was one of the biggest challenges that faced the service. A successful referral earned the member of staff the sum of £100.

We found the provider had effective data systems for the storage of information about people who used the service and the visits made to them. This data was protected by passwords and was only available to people authorised to access it. Hard copies of people's records were stored securely within the office. We saw that these were accurate and up to date. Hard copies of the files of people who no longer used the service, log books and medicines administration records were kept for six months on site before being archived by a professional confidential storage service. The papers were kept in accordance with regulatory requirements before being destroyed confidentially.