Alliance Care Ltd

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Inspection report

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Date of inspection visit:
24 August 2023
25 August 2023
12 September 2023

Date of publication:
01 December 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Alliance Care Ltd is a domiciliary care service providing personal care to people in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. The service is also registered to provide treatment of disease, disorder and injury although this was not being provided at the time of the inspection. At the time of our inspection 51 people were receiving personal care from the service.

People's experience of using this service and what we found
People were not always protected from the risk of harm; we found systems were not effective in reducing risks to people that resulted from their health needs and the use of prescribed medications. Systems in place to safeguard people from abuse were not robust and processes for learning lessons were not established to drive improvements.

Quality assurance systems were not in place to ensure people received consistent, high-quality and safe care. There was a lack of oversight over safeguarding people from harm, assessing people's needs and the management of the service.

People did not always feel they were supported in a caring and compassionate way. People and relatives experienced inconsistencies in the caring, respectful approach of staff. However, people with regular staff spoke highly of their diligence. People experienced limited input into the design and review of their support.

People's person-centred needs were not effectively identified and planned for by the service. This meant people sometimes experienced support that wasn't in line with their needs and preferences.

People were not always supported to have maximum choice and control of their lives although staff generally supported people in the least restrictive way possible and in their best interests; although the policies and systems in the service were not in place to support good practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 25 August 2018).

Why we inspected
The inspection was prompted in part due to concerns received about the safety and quality of the service, including concerns about the management of medicines, care calls being missed and people being neglected. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to how people's safety was managed, how people were safeguarded from abuse, staff training and how the service was run at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Alliance Care Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. This service also provides care and support to people living in a 'supported living' setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that Alliance Care Ltd staff would be in the office to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke to 6 people and 5 relatives about their experience of the care provided. We spoke with 5 professionals who have contact with the service. We spoke with 11 members of staff including the registered manager, director, area manager and 8 members of staff. We reviewed a range of records. This included 8 people's care plans, medicine administration records (MAR) and 5 staff recruitment files. We viewed a variety of records relating to the management of the service including audit systems.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Using medicines safely

- People who were at risk of choking were not safely supported. Care plans and risk assessments lacked detail about modified diets and some daily records indicated people may have been given foods that were unsuitable for their needs. This put people at risk of avoidable harm.
- People who received nutrition and hydration via Percutaneous Endoscopic Gastrostomy (PEG), did not have care plans in place to guide staff about their needs. Staff hadn't always either received training, or recent training in supporting people with PEG. This put people at risk of harm.
- People's health needs and associated risks were not safely managed. For example, risks for people with diabetes, catheter care or epilepsy did not have clear assessments in place to detail their needs and guide staff about minimising these risks.
- Medicines were not managed safely. People's medicine administration records (MAR) showed multiple discrepancies, including doses of medicines being administered at short intervals or double doses recorded.

- Some people, including children, were being administered medicines without care plans, risk assessments or MAR in place. This meant we could not be assured the medicines were being received as they were prescribed and at the correct times and dosages.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and the welfare of people using the service. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The provider failed to keep people safe through their safeguarding systems and processes. This meant that Alliance Care Ltd staff were investigating safeguarding concerns without the oversight and review of the registered manager. As a result, people were exposed to the potential of ongoing harm.
- People who experienced distress, or behaviour that could put them and others at risk, were not safely supported. The provider failed to ensure staff had guidance to manage these risks, which exposed them to potential harm. In one case, staff had resorted to practices which could be considered restraint, in the absence of clear instruction for supporting the person.
- People were exposed to ongoing harm, after a risk became known to the provider. For example, one person's records showed they had experienced several falls and this had been raised as a concern by staff. However, care plans and risk assessments weren't updated to consider these incidents and how to safeguard the person from further harm.
- The provider failed to review accidents, incidents and safeguarding matters for the purpose of maintaining oversight and identifying any learning for the organisation. This meant that potential opportunities to

minimise ongoing risks to people could be missed.

The provider had failed to take action to safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We received mixed feedback from people about staff timing and availability. One person said, "Timekeeping is immaculate; I ask if I need help with anything else." However, another person told us, "I pay for 30 minutes and they stay for 10. Sometimes they don't turn up at all and I still have to pay for the call." One relative advised that they had experienced several difficulties with only 1 care worker arriving, when 2 were required to support their loved one safely.

● There was a system in place to log when staff attended visits and how long they spent with people. However, there was not an effective system in place for highlighting any discrepancies with call times. For example, we found 1 person's call times were not being logged by the system. Another person's records showed that staff were logged in for several days, without it being identified.

● Staff had been recruited safely, although records did not always detail how gaps in employment history had been explored through the process. Pre-employment checks had been carried out including Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● Many staff had not received recent infection control training. However, spot checks showed staff had a sound understanding of good infection control measures.

● People told us that care staff wore personal protective equipment such as gloves and aprons. People reported that care workers maintained good standards of cleanliness and washed their hands.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Many staff had not received recent training in key areas to enable them to carry out their duties safely. For example, only approximately a third of the staff team had received training in the 12 months prior to the inspection, in subjects such as medication administration, moving and handling or infection control.
- Staff had not always received the training required to meet people's specific health needs. For example, care workers that supported people who received nutrition or hydration via PEG, had not always completed training. This put people at risk of harm.
- Staff members did not always have a sound understanding of how to support people's needs. In particular, care staff who supported people with distressed behaviour did not always feel they had the training and guidance to do so safely. One care worker told us, "It's easy to write on paper 'do this, do that' but when you are in people's homes it is very different and very challenging."
- The provider had failed to review staff skills and competence. While spot checks were undertaken to observe some aspects of staff practice, there was no system in place to review how staff managed key risks such as medication administration or moving and handling. This, along with the majority of staff not receiving recent training, meant we could not be assured that staff competence was safe and in line with good practice guidance.

The provider failed to ensure staff received regular training, including observations of staff competence and skills. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- The needs of people who required modified diets were not always clearly assessed and documented. For example, people who required thickened fluids or hydration via PEG, did not have care plans in place to support this. This put people at risk of not receiving the correct consistency of fluids or adequate levels of hydration.
- Where people had regular care staff, those staff members had a good understanding of people's likes and dislikes and how to support people to eat and drink enough.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● There were inconsistencies in how well the provider worked with other agencies and supported people to access healthcare. For example, one professional told us Alliance Care Ltd had been very supportive and involved in a recent review meeting for a person who required a high level of support. Other professional reported poor experiences of the service, such as staff sleeping during shifts, or people being left without personal care.
● One person told us how they had been supported by care staff to attend a medical appointment. They told us, "They were very kind, they waited and took me home."

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● Care plans did not consider people's capacity to consent to care. We did not find evidence of capacity being assessed for specific decisions. However, staff had a good understanding of people's abilities to make day to day decisions and we found that people with capacity were able to make decisions which could be considered unwise.
● People told us that care staff asked for consent before providing care and support.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- We received mixed feedback about whether people were treated with dignity and respect. Some people were very happy with the support they received and spoke highly of the care staff who visited. However, 1 person had been distressed by new care staff observing their personal care, without their permission. They said, "It's very embarrassing, especially when you don't know people."
- Some people and relatives told us of inconsistencies in the caring nature of care workers. One person said, "They are in and out like a shot. One [care worker] does help me more than the others."
- Staff understood how to promote people's independence. One person told us, "They are very kind, they don't take over and organise you. They leave me with a bit of independence."
- Staff spoke positively about their roles and the people they supported. One staff member said, "I love my job and I'm lucky who a work with. I work with [person's name] and I love them to bits, they remind me of my own family."

Supporting people to express their views and be involved in making decisions about their care

- People and relatives told us they were able to contact Alliance Care Ltd to discuss their care and raise any issues. People generally felt any concerns would be dealt with appropriately.
- Care plans were completed and reviewed in people's homes, in collaboration with people and their families. However, care plans were dated on completion and a review date noted for 6 months post initial assessment. As a result, it was unclear whether people's care plans had been reviewed or just marked with a projected date.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People didn't always feel their preferences were considered. One person stated that their social worker had arranged a teatime call, but the provider had cancelled this and told them to microwave a meal themselves. A relative told us how the care worker would come at times that suited the organisation but didn't suit their loved one's needs.
- Care plans did not always detail people's needs, wishes and goals. For example, 1 person had a desire to work towards greater independence. However, there was no guidance on how care staff could support this, and daily records suggested there were limited attempts to work towards this goal.
- People's needs and preferences were not always accurately assessed and documented. We found that 1 person's care plan stated they had epilepsy, when this wasn't the case. However, we found no indication that this had impacted the person in any way.
- People's records contained details of people's life history and staff knew people's likes and dislikes. One person told us, "Oh yes, they fully understand me."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Care plans contained minimal information about people's communication needs. However, staff had good knowledge of how to engage with the people they supported.
- One relative told us how the provider sent care staff who spoke the first language of their family member. This was particularly important as their loved one had dementia, which was an additional barrier to communication for them.

Improving care quality in response to complaints or concerns

- People and relative knew how to raise a complaint or concern to Alliance Care Ltd and generally felt this would be responded to.
- The provider had a system in place for recording and responding to any complaints or concerns that came into the service.

End of life care and support

- People's end of life wishes were not explored in their care plans. However, there was no one receiving end

of life care at the time of inspection.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection, the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality assurance systems had failed to identify the areas of concern we highlighted during our inspection. Audits had not been effective in finding the issues we established in relation to the safety and quality of the service.
- Governance systems had failed to highlight and rectify deficiencies in the assessment and care planning of people's health conditions and associated risks. In addition, systems for escalating allegations of abuse and neglect were inadequate, which put people at risk of continued harm.
- Training systems had failed to ensure staff had received up to date training, in line with the provider's own policies. In addition, processes were not established to monitor the skills and competence of staff through observations. This meant we could not be assured that people were being supported safely.
- The provider failed to implement a robust system for the oversight of accidents, incidents and safeguarding concerns. As a result, 1 serious allegation of abuse was not fully investigated for several months. This exposed service users to the risk of ongoing harm.
- Governance systems failed to identify and address shortfalls in recruitment processes. This meant gaps in employment histories or discrepancies with references and dates were not fully explored and documented to show safe recruitment practices.

The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Governance systems were not effective in providing staff with the information, training and skills they required to support people with their wide-ranging needs.
- Systems were not effective in monitoring people's care calls to ensure people received the time and support they required. While technology was in place to record this, audit systems had not picked up the issues we identified on inspection in relation to calls not being logged, or care workers failing to log out of people's homes. This meant we could not be assured that people were always receiving the time and support they needed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open

and honest with people when something goes wrong

● The provider had not always notified CQC of allegations of abuse involving people who received personal care from the service. Alliance Care Ltd has a statutory duty to ensure CQC are notified of all relevant matters.

● The provider did not always work in collaboration with CQC through the course of the inspection. The meant CQC did not have full access to the information and systems requested as part of the inspection process.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● There was no effective system established to seek feedback from people, relatives and professionals. A survey had last been conducted in June 2022 and had prompted largely positive responses and comments. This had been followed up with calls to people the following year, but the questions asked were limited just to comments on staff and management.

● People and relatives knew who the area manager was and felt able to contact them with any issues or concerns.

● Staff generally felt supported by management and felt the management team were approachable.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and the welfare of people using the service. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed positive conditions on the provider's registration and asked the provider to send in monthly reports detailing the improvements they have made.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to take action to safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed positive conditions on the provider's registration and asked the provider to send in monthly reports detailing the improvements they have made.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems and processes to drive the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed positive conditions on the provider's registration and asked the provider to send in monthly reports detailing the improvements they have made.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider failed to ensure staff received regular training, including observations of staff competence and skills. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have imposed positive conditions on the provider's registration and asked the provider to send in monthly reports detailing the improvements they have made.