Kent Social Care Professionals Limited

Kent Social Care Professionals Domiciliary Service

Inspection report

Golden Boot Chambers
27 Gabriels Hill
Maidstone
Kent
ME15 6HX

Tel: 01622764014
Website: www.kentscpdom.com

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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?	Requires Improvement

Summary of findings

Overall summary

Kent Social Care Professionals is a domiciliary care agency which provides care and support for people in their own homes. Care is provided for a range of people including older people and people living with dementia. The service operates in areas including Tonbridge, Tunbridge Wells, Paddock Wood, Sittingbourne and Medway. Not everyone using Kent Social Care Professionals receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection there were 269 people using 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.

Governance systems had not been fully embedded into the service. The registered manager had an oversight of and reviewed the daily culture in the service, including the attitudes and behaviour of staff. The registered manager promoted transparency and fairness within the workforce. People, their families and staff were encouraged to be engaged and involved with the service.

People were protected from abuse. Staff received training in how to identify different types of abuse. Risks to people and the environment were assessed and where issues were identified action was taken to mitigate the risk of harm. There were enough staff to meet the needs of those being supported. When people needed support with their medicines, they were helped in a safe way by staff that were trained. People were protected by the prevention and control of infection. Staff understood their responsibilities to report safety incidents, and improvements were made when things went wrong.

People's needs were assessed before staff began to support them. The assessments took into account peoples protected characteristics such as their ethnicity and sexuality. Staff were trained to have to skills and knowledge to deliver effective care and support. Where responsible, people were supported to eat and drink enough to maintain a balanced diet.

Staff made referrals to health professionals when required. Staff worked together to ensure that people received consistent and person-centred support when they moved between different services. When people lacked the capacity to consent to care, staff sought consent from people in line with legislation. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice

Staff were encouraged to develop caring relationships with the people they supported. People's dignity and independence was respected at all times. Staff supported people to express their views and be actively involved in making decisions about their care. People were involved in reviewing their care.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Records showed that staff worked closely with health professionals such as nurses from the local hospice, dieticians and GPs to ensure people had coordinated care at the end of their life.

People and their families were encouraged and supported to raise any issues or concerns with the registered manager. There was a formal complaints procedure in place, and details of how to complain were held with the person's care records at their home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was Safe.

People were protected from abuse.

People were kept safe from risks or avoidable harm.

There were a sufficient number of suitable staff to support people safely.

People's medicines were managed safely.

People were protected by the prevention and control of infection.

Lessons were learned and improvements were made when things went wrong.

Is the service effective?

Good

The service was Effective.

People's needs were assessed and their care was delivered in line with current legislation.

Staff received the training they needed to carry out their roles effectively.

People were supported to drink and eat enough to maintain a balanced diet.

Staff worked together across organisations to help deliver effective care when people move between services.

People were supported to live healthier lives and have access to healthcare services.

Staff were knowledgeable about the Mental capacity Act, knew how to seek consent for care and knew the processes to help those who lacked capacity make decisions.

Is the service caring?

Good

The service was Caring.

People were treated with kindness, respect and compassion.

Staff supported people to express their views and be actively involved in making decisions about their care.

People's privacy, dignity and independence were promoted.

Is the service responsive?

Good

The service was Responsive.

People received personalised care that was responsive to their needs.

People knew how to make a complaint and were confident to do so if they needed to.

People were supported at the end of their life to have a comfortable, dignified and pain free death.

Is the service well-led?

Requires Improvement

The service was not always Well-led.

Governance systems were not yet embedded into the operation of the service.

There was an open and inclusive culture at the service.

The registered manager was aware of their responsibility to comply with CQC registration requirements.

People and staff were encouraged to be engaged and involved with the service through meetings and ongoing feedback to management.

There were strong links with the local community.

Kent Social Care Professionals Domiciliary Service

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 registered persons continued to meet 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.

Due to technical problems, we did not ask the provider to complete a Provider Information Return. We took this into account when we inspected the service and made the judgements in this report. A Provider Information Return 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 also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required by law to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 12 and 14 June 2018. We gave the service 48 hours' notice of the inspection visit because staff may be out of the office supporting other staff or providing care. We needed to be sure they would be in. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using this type of service.

During the inspection we spoke with eight people who used the service and with six relatives. We also spoke with four members of a care staff, three senior care staff, the registered manager, the Operations Manager

and Regional Director. We observed interactions between care staff and people being supported. We looked at the care records for twelve people receiving a service. We also looked at records that related to how the service was managed including training, staffing and quality assurance.

Good

Is the service safe?

Our findings

People told us they thought the service was safe. One person told us, "Yes, I am comfortable with them [the care workers]." Another said, "Yes, I see the same girl. She is almost like a friend now. I don't have had the same person on the weekends, but I know them all and feel safe with them." A relative told us, "She has one regular carer, and she is extremely comfortable with her. She recognises her and feels safe."

People were safeguarded from the potential of abuse. Staff received training in how to identify different types of abuse, and those we spoke to told us they knew what to do if they saw anyone being placed at risk of harm. A whistleblowing policy was available to staff, who told us they felt confident that the registered manager would listen to any concerns they had. One member of staff said, "If I had concerns I know I could raise them with the manager, and they would be taken seriously. If I did not want to speak to the manager then I could speak to the police or CQC, but that has never happened."

The registered manager was aware of their responsibility to report any concerns to the local authority, and records showed they were involved in investigating concerns in a transparent way. Feedback we received from the local authority was positive, and the registered manager responded appropriately to their requests for information. The registered manager also ensured statutory notifications were sent to the CQC in a timely manner.

Risks to people were assessed, and staff took action to reduce the risk of harm to keep people safe. Each person had a risk assessment which identified how they were at risk and these were reviewed at least yearly, or when people's needs changed. When assessing people's risk of developing sore areas on their skin, for example, staff considered the person's weight, any incontinence, their skin condition and mobility. When one person was assessed to be at high risk of issues with their skin integrity, the area of skin was recorded on a body map and staff were advised to apply barrier cream to the area each morning.

Risks within the person's home environment were established to help ensure the safety of people and staff. An electrical risk assessment looked at appliances, loose or trailing wires and inadequate lighting. A fire risk assessment considered risks when people smoked in the property, as well as the location of carbon dioxide and spoke detectors. Equipment used during people's care was assessed to ensure it was properly maintained. When staff and people used equipment such as a hoist, the servicing date was recorded in the person's care records, and staff arranged for it to be serviced accordingly. This meant it operated effectively and remained safe to use by staff and the person being supported.

There were a sufficient number of staff available to meet the needs of people and to keep them safe. The number of staff on shift was planned around the needs of people being supported. The registered manager used an electronic rostering system to organise rotas. Care staff had recently been reorganised into small geographical areas with a small staff team covering the same calls. This meant people were more likely to be supported by staff that they knew.

Staff absence, such as annual leave or sickness, was covered by others from the team. This made sure

people were receiving support from staff they knew. One person told us, "It has definitely got better recently. It's generally the same person now; the only change is on the odd weekend." Where two care workers were required to support one person, the registered manager had introduced a system whereby staff travelled and arrived together, meaning people received timely support.

Staff were recruited safely. Pre-employment checks were made, including obtaining a full employment history, and references were sought and checked. Staff completed Disclosure and Baring Service (DBS) check before they began working with people. DBS checks identified if applicants had a criminal record or were barred from working with people that need care and support. When staff left the service, exit interviews were carried out so the registered manager could help reduce the number of staff leaving the service. It was identified that some staff left soon after they began employment because they had not fully understood the role of a care worker and found the work to be challenging. As a result, the registered manager introduced a 'buddy' system where new staff would be supported by more experienced staff in the field. This meant staff felt more supported as they learnt the role, and records showed the numbers of newly recruited staff leaving had reduced.

People received their medicines safely. Senior staff carried out an assessment of people's ability to manage their own medicines when support began. If necessary, guidance was provided for care staff on the support the person needed and people were encouraged to be as independent as possible. For example, each person's care record indicated what they can do themselves as well as what care workers were required to support with. Where people needed supporting with medicines at a particular time, such as insulin for people with diabetes, this information was passed to the office staff who compiled the rota to secure a fixed time for the visits.

Staff recorded the support they provided on a medicine administration record (MAR), and if errors or omissions were identified they were followed up by senior staff. Where changes to medicines were identified, these were also checked. For example, one care worker saw the dosage of one new box of medicine differed to that recorded on the MAR. The staff member spoke to the GP before supporting with the medicine, who confirmed the dosage had been changed following a review. The staff member fed this information back to senior staff and the MAR was amended.

People were protected by the prevention and control of infection. Staff were provided with gloves, foot covers and aprons, and senior staff checked they were using them during spot checks in people's homes. When a check identified one staff member had not used an apron, all staff were reminded by email of the provider's policy the following day. Staff received training in infection control and food hygiene. Care records provided instructions for staff on how to dispose of used continence products. This helped make sure good standards of hygiene were maintained in people's homes.

There were procedures in place to enable lessons to be learned when things went wrong. Staff were aware of the provider's policy to report accidents and near misses, and the registered manager kept a log of all reports and action taken. The registered manager reviewed the logs on a monthly basis to look for patterns and trends, and made sure that any learning from incidents was shared with staff. For example, one safeguarding investigation identified staff were not reporting concerns to senior staff, so timely action could not be taken when a person's needs were increasing. The registered manager held a series of themed supervision sessions covering what should be reported and how, and records showed this had led to a significant increase in reporting by staff.

Good

Is the service effective?

Our findings

People and their relatives told us the service was effective in meeting their needs and staff were skilled in carrying out their roles. One person told us, "My wife is pretty consistent with her breakfast and the carer knows. I normally put out things ready for the carer." Another said, "I would say the carers are well trained, very good."

People's needs were assessed and their care was delivered in line with current legislation. Each person was assessed in their home before services began to make sure staff could meet their needs. This assessment considered the person's ability to make decisions about their support, their needs such as their mental and physical health needs and their personal preferences. The assessment also took into account any additional support a person might need to ensure their rights under the Equality Act 2010 were respected, such as their religious needs. Assessments were carried out in conjunction with people's family members, and took into account information provided by professionals including care managers from the local authority.

Staff had the skills and knowledge to deliver effective care and support. New recruits completed a full induction which included training on dementia awareness, medicines, health and safety, moving and handling and person centred care amongst others. They then had their competency checked before they were able to work alone. Care staff received ongoing refresher training on an annual basis to make sure their skills were up-to-date.

Where people had specialist needs, such as those who needed support with a catheter, records showed that training was provided to the staff supporting them. Training needs were discussed in supervision and additional training courses were provided where areas of improvement were identified. Senior staff had received recent training in delivering supervision, completing risk assessments, complaint handling and safeguarding. Staff told us the training they received helped them to support people with confidence.

When required, people were supported to maintain a balanced diet. Staff supported some people to make their meals, and all staff had received food hygiene training to help them do so safely. One person told us, "She gets the breakfast for me. I get a choice; they want to know what you want. It's more or less the same every day."

Staff sought and followed guidance from the speech and language therapy team (SaLT) for people who had complex needs in relation to their eating and drinking. For example, one person was assessed to be at risk of choking when eating. Senior staff arranged for an assessment by SaLT, who provided guidance to staff to follow to keep the person safe. When people were assessed to be at risk of malnutrition or dehydration, staff referred to a dietician and followed their guidance.

People were supported to have access to healthcare services and receive ongoing healthcare support. Records showed if a person needed support, staff took prompt action. For example, one person returned home from hospital with medicine they were unable to swallow. Staff called the GP, who arranged for alternative medicines to be delivered.

Records showed that staff were seeking advice from senior staff if they were unsure what to do about a person's health needs. One record stated that a staff member had called the office as a service user appeared to be unwell and they wanted advice. Subsequently, an ambulance was called and the service user was taken to hospital. Staff were making contact with the local authority and occupational therapy professionals and seeking advice where necessary. Concerns were being feedback to care managers.

Staff were working with organisations to deliver effective care and support. Staff had access to information about others involved in the person's care and support. Care records showed support people received from health professionals such as the podiatrist or the local hospice. One person's records showed a district nurse visited to give them a vitamin injection. Staff made sure information was shared with other professionals in a coordinated way. When an ambulance was required at someone's home because of concerns for their health, staff remained until paramedics arrived so information could be shared. When one person was in hospital, senior staff spoke to ward staff to check for any changes in need. If the length of stay was significant, a new assessment would be arranged.

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.

The service was following the principles of the act. For example, it had been identified by care staff that one person with dementia was forgetting they had been given their medicine, and were regularly taking additional medicine which put them at risk of an overdose. Despite speaking to the person and offering advice, they continued to take too much as they had easy access to it. Staff carried out a mental capacity assessment and found the person did not have the ability to understand that taking too much medicine was dangerous for them. Taking into account feedback from the person's family and their GP, a best interest decision was taken to put the medicine in a locked cupboard. This was seen by all to be the least restrictive way of keeping the person from the risk of harm.

We also saw the registered manager kept a record of relatives or friends who had a Lasting Power of Attorney (LPA). An LPA is a legal document where a person being supported can appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. When a decision needed to be made for people who lacked the ability to make them, and where there was an LPA in place, records showed these attorneys were consulted with.

Good

Is the service caring?

Our findings

People told us staff treated them with kindness and compassion. One person said, "If there is anything I am worried about I can always talk to them." A relative told us, "They take care to make sure she is given some dignity." Another said, "I think she is very happy with them. They are very friendly."

People were treated with kindness and respect. We saw staff taking time with people to explain what support they were going to provide. Staff got down to eye level when speaking with people and we heard them speaking to people in a respectful way. Staff were given time to listen to people. One relative said, "They always ask him this or that, what he wants done. She will have a joke with him."

Staff knew people well and used this knowledge when providing support. People were supported by the same person where possible. One staff member said, "We go to the same person so we get to know them. One person is particular about what he wears at night because he'll get hot." Another said, "I'll talk to people about their family or interests like football or the soaps when providing personal care. It makes it less embarrassing for them."

Staff members we spoke with were cheerful and friendly. Staff understood the importance of treating people equally. The provider had a policy for promoting equality and diversity within the service and people told us that staff treated them on an equal basis. One staff member said, "It doesn't matter if someone has a disability, or comes from a different country. People are individuals but we treat them the same."

People were supported to express their views and were involved in making decisions about their care. The registered provider told us they knew how to access external advocacy for those who needed help expressing their views but had nobody to support them. Reviews of a person's support took place if their needs changed, and senior staff would implement a temporary care plan to ensure staff had access to the most up-to-date information. Where one person had been prescribed antibiotics for an infection, a temporary care plan for one week was held on the file. This meant staff knew what the medicines were for and when they needed to be given to the person.

People were treated with dignity and their privacy was respected. A member of staff told us, "When giving someone care I'll make sure they're covered up, especially if family are around. I keep the bathroom door closed if we are in the shower." One relative said, "If he wants to go to the toilet the carers will wait outside for him." People were also supported to be independent. Staff followed care plans which took into account what the person could do, as well as the support they needed. One staff member said of one person they supported, "I wouldn't do it all for them. I offer them the flannel so they can wash their face themselves. They can dry their front without my help. They choose what shower gel they use, and the perfume."

Information about people was treated confidentially. People's care records and files containing information about staff were held securely in locked cabinets. Computers were password protected.

Good

Is the service responsive?

Our findings

People told us they found staff to be responsive to their needs. One person said, "My carer will report back anything so if there was anything I thought needed changing she will report it." Another said, "I have never made a complaint, except at first, when the lady in charge came to sort my care package out. Apart from that, I get on alright with them." A relative told us, "They send somebody round every six months and do a review of the care plan and go through it. And we get a revised care plan if there's a change. The last one was a few months ago."

People were involved in the planning of their care, and received support that was responsive to their needs. Each person had their own care and support plan which took into account when the person wanted support, what the person's goals were, how care workers knew if the goals had been met, and the support the person needed in meeting the goals.

People's care plans were focussed on how the person wanted to be supported. For example, one plan detailed how staff were to gain entry to the property, which aspects of support were to be directed by the person being supported, and what the person was able to do themselves.

People were involved in the reviews of their care and support, as were health professionals including care managers from the local authority. People were able to choose support from a female or male member of staff. An electronic tagging in system was used in people's homes, and information was available live to office staff so they could respond to late calls and to effectively plan care worker visits.

The service was meeting the accessible information standard. The accessible information standard sets out a specific approach to recording and meeting the information and communication needs of people with a disability, impairment or sensory loss. People with a sensory loss were offered a choice of how they wanted to communicate with staff, such as with picture boards or writing pads.

People and their families were encouraged to make complaints if they were not satisfied with the service they received. People we spoke with said they knew how to complain and would do so if the need arose, with one person saying, "Yes, I would ring the office and play merry hell." Details of how to complain were available to people in their homes.

There had been a number of complaints received about the service since the last inspection which related to punctuality of care staff, continuity of carers and staff turnover, and responsiveness of office-based staff, including that of the registered manager. However, at this inspection we found the registered provider had taken significant steps to improve the service provided based upon previous experiences of the people using it. This included employing additional office-based staff and other actions mentioned elsewhere in this report such as improving staff retention and reorganising rotas into patches to improve continuity of carers.

People told us they were benefitting from the improvements. When speaking about the improved rostering system, one person told us, "Yes, I feel safer, especially now that it's regular carers." Another said, "There are

regular ones, I see three or four most of the time now." We looked at recent complaints. One related to a complaint about a staff member not understanding the needs of the person who had complained. Records showed it was replied to in writing in line with the provider's policy, explaining to the complainant what action had been taken and offering an apology.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Senior staff told us that they worked closely with health professionals such as the GP and local hospice to ensure people had coordinated care at the end of their life. They followed guidance from the hospice staff and involved the district nurses to ensure people had timely access to anticipatory medicines for nausea or pain.

If needed, staff had access to an end of life care plan which would hold details about people's wishes relating to before and after their death. When appropriate people's wishes about the care they wished to receive and whether they wanted to stay at home or be admitted into hospital were recorded in this plan. Some people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form in place. DNACPR forms indicate where a medical decision has been made by a doctor with the person or their representative that cardiopulmonary resuscitation will not be attempted if the person stops breathing or their heart stops beating.

Requires Improvement

Is the service well-led?

Our findings

People told us that since the last inspection they had not always found the service to be well-led. One person told us, "They would occasionally phone to say 'how is the care going?'. Nothing ever happened from our feedback." Another said, "I think it's the carers that manage well, but not from the office. It seems it could do with a sorting out sometimes." A relative told us, "I would leave messages and they wouldn't get back to me. I don't know why."

However, in the six months prior to this inspection the registered provider had made significant changes to the structure and organisation of the service to improve people's experiences of the care and support they received. An operational support manager had been employed to provide daily support to the registered manager. This included devising quality assurance processes to ensure, for example, that complaints were followed up.

The service also had a local reporting system in place which identified shortfalls in care provision, such as with punctuality of care staff or where a person was seeing too many different care staff. When issues were identified they were being followed up by the registered manager and other office staff so people received support when they wanted it, and from staff who knew them.

The registered manager held weekly meetings with the registered provider's central quality assurance team, who supported staff with looking for trends in complaints, incidents and accidents, medicine errors and safeguarding concerns. The registered manager had begun to input data into the online quality assurance reporting system, which would generate reports on the service as a whole. These reports were to be used by the registered manager to drive improvement. However, these reports were not yet being reviewed by the registered manager in a systematic way. This meant that although significant progress had been made, work remained to embed the changes to governance systems into the operation of the service.

The registered manager had an oversight of and reviewed the daily culture in the service, including the behaviours and attitudes of staff. There were a set of core corporate values and behaviours which set out how the staff were to conduct themselves. These included, for example, 'We care about, respect and protect our service users.' and 'We strive to continuously improve our services.' Staff we spoke to were aware of these values and we saw them on display in the service. The registered manager spoke about these values during team meetings. They told us, "Our meetings are a bit like supervision; we give staff case scenarios and ask what they would do. If we heard someone was rushing a call we would run a session on dignity. I can see how staff react and know if they need any more support."

The registered manager was respected by staff we spoke to. Transparency and fairness was promoted within the workforce. One staff member told us, "I've not been supported like this in a job before. It was the best induction I've ever had." Another said, "[The registered manager] is approachable, she will make time for us. I don't think there is a blame culture here, we're trying to learn together." Rotas were drawn up considering the needs of staff, such as giving them time for hospital appointments. Staff cultural needs, such as observing religious festivals, were taken into account. Good practice was encouraged and some staff told

us they had been promoted to more senior positions from within the service. The registered manager kept up to date with best practice by being part of the local Skills for Care Registered Managers network, and attended the local authority provider forum.

People and staff were involved in the development and improvement of the service. Surveys were sent out annually and staff were encouraged to make suggestions in team meetings. Minutes of the meetings were circulated to all staff, and indicated staff were confident to speak up and raise concerns. For example, one set of minutes showed staff raising concerns about there being not enough travel time between visits. Records showed these comments led to the rotas being reviewed and a new system of smaller areas for staff to cover being introduced. Other concerns were raised about communication with office staff being sometimes difficult. As a result of this feedback, the registered manager had asked staff in each area to nominate one person to be a staff representative. Representatives would meet with office staff in order to better improve the relationship between office and care staff.

There were strong links with the local community. For example, the registered manager had met with a local hospice to discuss the end of life needs on one person they supported. The hospice had agreed to attend a meeting of care staff and offered to provide some training. The registered manager and Operations Manager had worked transparently with the local authority commissioners on an action plan to improve the service provided to people.

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 was aware of their responsibility to comply with our registration requirements. The registered manager was also aware of the statutory Duty of Candour which aimed to ensure that provider's are open, honest and transparent with people and others in relation to care and support. We saw that any incidents that had met the threshold for Duty of Candour had been reported correctly.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. The provider had conspicuously displayed their rating on their website.