Care Quality Commission

Nestor Primecare Services Limited

Allied Healthcare Canterbury

Inspection report

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Ratings

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

Overall summary

The inspection took place on 27 and 28 May 2015, and was an announced inspection. The registered manager was given 48 hours' notice of the inspection. This was the first inspection since this location was registered on 8 December 2014.

Allied Healthcare Canterbury provides care and support to adults in their own homes. The service is provided mainly to older people and some younger adults. At the time of this inspection there were less than 60 people receiving support with their personal care. The service provided visits from half an hour up to five hours to support people. The service was awarded a contract with the local authority and this provided a rapid increase in the numbers of people who used the service.

The service is run by a registered manager, who also manages another service in Hythe owned by the same provider. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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.

Most people told us they received their medicines when they should and felt their medicines were handled safely. However we found shortfalls in some areas of medicine management. Care plans did not always reflect current medicine information. There was a lack of systems, guidance or procedures about some areas of medicine management. Some medicine records had not been audited to ensure safe practices were being followed.

Most risks associated with people's care had been identified and people told us staff used safe practices, but there was not always sufficient or up to date guidance in place for staff, to ensure people were safe.

People and/or their families were involved in the initial assessment and the planning their care and support. However care plans varied greatly in the level of detail and required further information to ensure people received care and support consistently and according to their wishes. People told us their independence was encouraged wherever possible, but this was not always supported by the care plan. Care plans were reviewed periodically, but not all of them were up to date and reflecting people's current needs.

There was not sufficient staff to meet people's needs. People had experienced missed or late visits; some people that required two staff to meet their needs had experienced only one member of staff arriving to undertake the care and support. The registered manager told us the service was actively recruiting to increase staffing levels. Most people received a service from a team of regular staff and knew who would be undertaking their visit. Each person received a schedule of visits in advance.

People had mixed opinions about whether the service was well-led and well-organised and where people were not positive most of their concerns related to staffing levels and the organisation of staff schedules. The provider had a mission statement and aims and objectives. However staff were not aware of these and they were not readily accessible within the office.

People were protected by safe recruitment procedures. Staff files contained most of the required information. New staff underwent a thorough induction programme, which included reading policies and procedures, relevant training courses and shadowing experienced staff until they were competent to work on their own. Staff received most training appropriate to their role, which was refreshed regularly, but there was a lack of specialist training reflecting people's specific needs, such as dementia and diabetes.

People were supported to maintain good health. People told us how observant staff were in spotting any concerns with their health. The service made appropriate referrals and worked jointly with health care professionals, such as occupational therapists. Information about some health conditions, such as diabetes and epilepsy was lacking in care plans. This meant if people became unwell relating to these conditions staff may not identify this or take timely appropriate action to ensure the person's good health.

People felt safe whilst staff were in their homes and whilst using the service. The service had safeguarding procedures in place, which staff had received training in. Staff demonstrated a good understanding of what constituted abuse and how to report any concerns. Accidents and incidents were reported and action taken to reduce the risk of further occurrences.

People felt staff had the right skills and experience to meet their needs, although a few people felt newer staff would benefit from further training or experience. Supervisors monitored staff practice during unannounced checks. Staff felt supported and attended one to one and group meetings with their manager.

People had mixed views about communication with the office. People felt confident in complaining. Several people had complained about missed calls or late calls, but not all felt they had received a satisfactory response. Some people had opportunities to provide feedback about the service they had received. Negative feedback about the service was being acted on.

People told us their consent was gained at each visit. People had also signed a consent form as part of their care plan. People were supported to make their own decisions and choices. No one was subject to an order of the Court of Protection. Some people had Lasting Power

Summary of findings

of Attorneys in place and some others chose to be supported by family members when making decisions. The Mental Capacity Act provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

People felt staff were caring. People said they were relaxed in staffs company and staff listened and acted on what they said. People were treated with dignity and respect and their privacy was respected. Staff were kind and caring in their approach and knew people and their support needs.

People told us they received person centred care that was individual to them. They felt staff understood their specific needs relating to their age and physical disabilities. Staff had built up relationships with people and were familiar with their preferences.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Care plans did not always reflect current medicine information. There was a lack of systems, guidance and procedures in some areas of medicine management.

Most risks associated with people's care had been identified, but there was not always sufficient guidance or up to date guidance about how to keep people safe.

People had experienced missed calls and only one member of staff arriving when the visits was assessed as requiring two, so this meant relatives had to help.

Is the service effective?

Requires improvement

The service was not always effective.

People received care and support from staff that were trained and supported. However training in subjects relating to people's specific needs was lacking.

People were supported to maintain good health. Staff worked with health care professionals, such as community nurses to resolve and improve health concerns. However, some guidance about people's health conditions was lacking to ensure staff took appropriate and timely action should a person become unwell.

Staff encouraged people to make their own decisions and choices.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff adopted a kind and caring approach.

People felt relaxed in the company of staff and people were listened to by staff who acted on what they said.

People said their independence was encouraged wherever possible.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans varied in detail and most did not reflect people's full personal care routines or their wishes and preferences. Some care plans were not up to date with people's current care and support needs.

Summary of findings

People felt comfortable if they needed to complain, but not all felt they had received a satisfactory response. Some people had opportunities to provide feedback about the service they received.

People were not socially isolated and felt staff helped to ensure they were not lonely.

Is the service well-led?

Requires improvement

The service was not always well-led.

The level of detail in records was not always sufficient and they were not always up to date.

People felt the office staff were not sufficiently experienced to resolve and prioritise important things to ensure the effective running of the service.

People had mixed opinions about whether the service was well-led. Some felt areas, such as staffing levels and staff schedules required improvement. The service had systems in place to audit and monitor the quality of service people received.

Allied Healthcare Canterbury

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 May 2015 and was announced with 48 hours' notice. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. The provider also supplied information relating to the people using the service and staff employed at the service. Prior to the inspection we reviewed this information, and we looked at previous inspection reports and the notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we reviewed people's records and a variety of documents. These included five people's care plans and risk assessments, two staff recruitment files, the staff training, supervision and appraisal records, staff rotas and quality assurance records and surveys.

We spoke with 17 people who were using the service, three of which we visited in their own homes, we spoke to four relatives, the registered manager and eight members of staff.

After the inspection we contacted two social care professionals who had had recent contact with the service and received feedback from them both.

Requires improvement

Is the service safe?

Our findings

Most people told us they felt safe when staff were in their homes and when they received care and support. Comments included, “I definitely feel safe I had a fall and they got onto management to tell them”. “I feel safe. They (staff) keeping checking with me if I am OK and asking if I am feeling OK”. “I must not be on my own in the shower and they watch over me and I feel safe”. “I am totally safe with them”. However two people said it depended on which staff visited whether they felt safe. A relative said, “Yes he is safe I am here and the girls know what to do”.

Most people told us they received their medicines when they should and they felt their medicines were handled safely. However one person told us that staff on one occasion had administered the wrong dose of one of their medicines. People had given their consent for staff to handle their medicines and care plans indicated what level of support people required with their medicines. However people were not protected against the risks associated with unsafe practice in medicines management.

There was a list of medicines recorded within the care plan, but there was no system for any changes in medicines to be updated in the care plan, so these did not always reflect the current medicines prescribed for people, to ensure staff had up to date information about people’s medicines.

Some people had pre-printed Medicine Administration Records (MAR) charts supplied by the pharmacist and others were typed up regularly and sent out to people’s homes by the office. MAR charts did not always agree with medicines recorded in the care plan. One person had medicines recorded on both types of charts for one month and staff had not been not consistent where they recorded the administration, so it was difficult to ascertain if people had received their medicines when they should. Files in people’s homes did not always contain spare or blank MAR charts and the MAR charts typed up by the office did not always contain enough space to add or make changes when these happened. This had resulted in medicines being crossed through and other medicines entered in, but these records did not properly reflect the prescription label as they should, leaving confusion and a risk that medicines may not be administered according to the prescribers instructions. In one case a pain relief cream had been added to a MAR chart and applied, but staff in the office were unable to tell us if this was a prescribed cream or purchased over the counter by the person, to ensure it was safe for staff to administer to the person.

One person told us staff had applied a prescribed pain relief patch and the daily notes confirmed this, but it was not recorded on the MAR chart and the person’s care plan stated that staff were to only administer creams.

MAR charts showed that there were gaps where a signature or code had not been entered so we were unable to ascertain if people had received their medicines on these occasions. In some cases staff had recorded in the daily notes that ‘creams applied’, but no detail about, which cream and they had not signed the MAR chart. People told us staff always applied their creams, but in some cases had to be reminded.

The system for returning MAR charts to the office to be audited and to check people were receiving their medicines when they should was not effective as some files contained no records that had been returned. Discussions with staff showed they were not clear about the timescales for returning records to the office.

Where people were prescribed medicines on a "when required" basis, for example, to manage pain, constipation or skin conditions, there was not always guidance or sufficient guidance for staff on the circumstances in which these medicines were to be used and how to handle them safely. One person was also prescribed two different types of pain relief medicine and there was no guidance about whether these could be administered at the same time or not. This could result in people not receiving their medicines consistently or safely.

The provider had failed to ensure people were protected from the risks associated with proper and safe management of medicines. The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There had been eight medicine errors since the service was opened in December 2014. The registered manager was working with the local authority safeguarding and commissioning team and had an action plan in place. This had included retraining staff. The registered manager told us, this had been completed, although records were not available on the day of the inspection to confirm this. Additional workshops had commenced in April 2015 and

Is the service safe?

were continuing, following which, the supervisor would undertake a medicines competency check on their practice. The registered manager told us medicines administration training had also been changed from three yearly to annually.

Most risks associated with people's care and support had been assessed. For example, risks in relation to people's environment, maintaining healthy skin and moving and handling people. People talked about the safe practices that were in place to reduce these risks, but the level of detail recorded in the risk assessments was not always sufficient. For example, moving and handling risk assessments stated what move staff were required to do, how many staff were required for the move, other information stated 'follow moving and handling procedures', but personalised information about how to move this person safely was lacking in all but one risk assessment examined. One risk assessment stated that a stand aid hoist was used when this was no longer the case, as staff had assessed that this was no longer safe for the person, so they were being cared for in bed using a slide sheet until new equipment arrived, but the risk assessment had not been updated. People told us the staff "know how to use the equipment" and that new staff always came with an experienced member of staff. Most people told us that they felt risks associated with their support were managed safely and they felt safe when staff moved them.

Some risk assessments, such as skin integrity used a scoring system and depending on the score the assessment detailed what action should be taken. For example, referring a person to a health professional. However it was not clear in all cases from the assessment that the actions had been undertaken in order to keep people safe.

The lack of detail in risk assessments meant the provider did not have an accurate and complete record of the care and treatment including decisions taken in regard to people. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received a schedule of visits in advance and most people told us staff "generally sticks to it". Most people told us staff turned up "on the whole" when they were expected. However four people had experienced late calls, which had caused them problems, such as missed health appointments. A relative told us how their family member "panics and gets upset" when the staff were late. People had mixed views about whether they were contacted if staff were running late or there was a problem. One person said, "If they let me know it would be acceptable". Another person said, "You get a phone call saying that someone is sick and that a carer will be there, but it might be an hour to an hour and half later". Another person told us "I phoned the office and they say that they are on their way, but none came". One relative told us that the timing of their visit had recently been changed by an hour without any discussion. Initially they had thought this did not matter, but having tried it they had now decided they preferred the initial time, otherwise there was not enough time between their morning and their lunch visit. The supervisor agreed to discuss this with the staff that coordinated the visits in the office.

Six people told us they had experienced missed calls or only one staff member had turned up when the visit was scheduled for two, this had happened recently and records confirmed this. One relative we spoke with told us this had happened three times in a week recently and records confirmed this. People felt this was due to staff sickness and was more of a problem at weekends although recent records we examined did not confirm weekends were more affected. Relatives told us in these instances they helped. One person told us after lots of problems their visits were now "time locked" on the office system and since this had been in place things had improved.

The registered manager told us that 20% of visits each week were not permanently allocated to staff. They said the service had 13 vacancies at the time of the inspection. The supervisor told us that they more often than not filled in to cover visits. Some staff felt there was not enough staff and a social care professional felt that the service did not have sufficient staff in some areas where they delivered care.

People's needs were not met by sufficient numbers of staff. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a national on-call department, which people could access if they needed to in an emergency outside of office hours. The on-call team were supported by local senior staff from the service for their knowledge of people's needs, visits and geography of the local area.

Requires improvement

Is the service safe?

The registered manager was aware of the shortfall in staff numbers and was actively recruiting and told us several prospective employees were already in the pipeline.

People and staff told us that visual checks were undertaken on the equipment used at each visit. One relative told us that staff were "very particular" about making sure the hoist and sling were safe before they used them. People said staff were quick to spot any problems or faults and report these. For example, one relative talked about how a sling was no longer suitable, so the occupational therapist had been contacted and a new sling was provided. One person said, "They (staff) check the stair lift, check the water temperature in the shower and sinks and check the Zimmer. The two regular carers are pretty good at spotting things if they are not working". People told us equipment was new or had been regularly serviced and they arranged this.

The provider told us they had a contingency plan in place in the event of an emergency. This included bad weather and a lack of utility services. Measures included moving the office base to another registered location owned by the provider, access to two 4x4 vehicles and staff working locally to where they lived, to ensure people would still be visited and kept safe.

Two members of staff had been recruited since the service was registered. Others had transferred from another location or another provider as part of the recent local authority contract change. Recruitment files contained evidence of a Disclosure and Barring Service (DBS) check having been undertaken (these checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people), proof of the person's identity and evidence of their conduct in previous employments and an application form. One staff member had not fully completed the application form so we were unable to ascertain if they had recorded a full employment history as required by legislation. The other file lacked a photograph although one had been taken for the staff member's identity badge and a copy of the badge was held on the file. Staff undertook an induction programme and were on probation for the first three months.

Most people told us they felt safe whilst staff were in their home and would feel comfortable in saying if they did not feel safe. During the inspection people talked about the good interactions between staff and themselves and their relatives, some with good humour. People were relaxed in the company of staff. There was a safeguarding policy in place. Staff had received safeguarding training and recently the provider had introduced additional training 'early warning screening', which most staff had attended. Staff were able to describe different types of abuse and knew the procedures in place to report any suspicions of abuse or allegations. The registered manager was familiar with the process to follow if any abuse was suspected; and knew the local Kent and Medway safeguarding protocols and how to contact the Kent County Council's safeguarding team. There had been some safeguarding's issues raised since the location was registered. The registered manager was working closely with the local authority, which had included regular meetings.

Accident and incidents were reported and details clearly recorded. The registered manager allocated accidents and incidents to senior staff to investigate and take action to reduce the risk of further occurrence and keep people safe. These were monitored by the registered manager and senior management on a computer system until all appropriate action had been taken. In addition the registered manager and senior staff audited and analysed accidents and incidents for patterns and trends. Where there had been any poor practices by staff these had been investigated and disciplinary procedures had been followed by the registered manager. For example, staff not following reporting procedures when they could not gain access to a property. In other incidents staff had received additional training and close supervision to reduce the risks of further mistakes and procedures had been discussed at team meetings.

Requires improvement

Is the service effective?

Our findings

People and their relatives were "generally" satisfied with the overall care and support they received. Comments included, "I am happy at the moment". "The care is good, we are satisfied". "It is brilliant". "I am satisfied with the carers and I am grateful for what they do". "I am generally happy with the service".

People "on the whole" felt staff had the right skills and experience to meet their needs. A few people felt that the "younger or newer ones" could do with a bit more training and "some are better than others". One person felt that not all staff who visited them had been trained to deal with their specific continence needs.

Staff understood their roles and responsibilities. Staff had completed an induction programme, which met Skills for Care common induction standards. Skills for Care common induction standards are the standards people working in adult social care need to meet before they can safely work unsupervised. Staff told us that their induction training lasted four days and in addition they shadowed experienced staff until it was felt they were competent in a range of tasks, such as personal care, moving and handling and medicine administration. Staff had a three month probation period to assess their skills and performance in the role. The registered manager told us staff received initial training and this was refreshed periodically. Training included moving and handling, food hygiene, safeguarding, first aid awareness and fire safety. When refresher training was overdue the registered manager told us staff would be unable to work until this was completed. A few staff had received specialist training in dementia awareness and sensory impairment. The registered manager had recognised this was an area for improvement. Staff felt the training they received was adequate for their role and in order to meet people's needs. However one staff member felt that more specialist training would be an improvement. The service had 29 active staff and eight staff had achieved a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

Staff told us they had opportunities to discuss their learning and development through spot checks, one to one meetings with their manager and an annual appraisal. Spot checks were undertaken unannounced by the supervisor, whilst staff were undertaking visits to people. During these observations staff practice was checked against good practice, such as communication with the person, infection control, food hygiene and respect and offering choices to people. Staff said they felt supported. A team meeting had been held since the location was registered, where staff were able to discuss any issues and policies and procedures were reiterated.

Most people told us they received a service from a regular team of staff and were happy with the numbers of different staff, who provided their care and support. However three people told us they "have all different ones"; "I have quite a few different ones" and "never know who was coming". Records we examined confirmed that people received continuity of support from a team of regular staff. Coordinators told us that following an initial assessment of people's needs they matched staff members to cover the visits. The matching process was based on geographical area and staff skills and experience. Where people had requested a staff member did not visit them again, people told us this had been actioned. Staff told us when this had happened a note was made on the computer to ensure that the staff member did not visit in future.

People told us their consent was gained at each visit. People said consent was achieved by staff discussing and asking about the tasks they were about to undertake. People said staff offered them choices, such as what to have to eat or drink or what to wear. One person said, "We do talk, but we have got a routine". The registered manager told us that no one was subject to an order of the Court of Protection; three people had a Lasting Powers of Attorney in place. Sometimes people chose to be supported by family members. The registered manager told us that the service had been involved in one best interest meeting regarding the future care arrangements of a person. They understood the process, which had to be followed when one was required. At the time of the inspection only six staff had received training in the Mental Capacity Act (MCA) 2005, although this training was part of an action plan, which the registered manager had in place. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Requires improvement

Is the service effective?

People's needs in relation to support with eating and drinking had been assessed during the initial assessment and recorded. These were reviewed during the care plan review. The registered manager told us there was no one at risk of poor nutrition and most people required minimal support with their meals and drinks if any, which was supported by records. One person's care plan reflected that they liked their food cut up by staff. Another person's stated the temperature they liked their drinks. People told us that staff prepared what they asked for or looked in the cupboard and offered them a choice. One person said they were a diabetic and staff understood this and offered choices accordingly. People said staff encouraged them to drink enough and would leave a drink for later if relatives were not around. One person said, "They make sure I have at least a litre of water by my chair".

People were supported to maintain good health. People told us how observant staff were in spotting any concerns with their health or if they were 'not themselves'. People and relatives told us how staff always commented when they noticed any changes. One person told us about how staff had encouraged them to call the doctor when they had had a fall. Another person said, "If I am ill they want to know if I need a doctor". People said staff worked well with health professionals involved in their care, such as the community nurse and an occupational therapist. Where people were at risk of pressure sores staff were observant and reported any concerns if they were worried about an area. Recently a community nurse had been called following staff observing a red area on the person's skin. However, information about managing some health conditions was lacking in the care plans, such as diabetes and epilepsy and this was identified as an area for improvement, as it presented a risk that if people became unwell as a result of these conditions staff might recognise the signs and symptoms or call health professionals in a timely way to ensure people remained in good health.

Good

Is the service caring?

Our findings

People told us staff were caring and listened to them and acted on what they said. People and relatives told us this sometimes included the use of appropriate banter and good humour. People and relatives were complimentary about the staff. Comments included, "They're a good bunch". "I can't fault any of the girls". "Some are really friendly and we have a laugh and a joke". "All have been so very kind". "They are nice and gentle". "They are all kind and they do the best for me, but they don't get enough time". "They are very good". "I feel comfortable with them. The two that come are lovely". "They are kind to me and they take into consideration how I feel and what I want done and they are compassionate". "When they have finished they sit and chat to me". "They do my legs very carefully and they are very polite". "They are very nice carers; they are pleasant and do everything that I ask".

Some people talked about staff that "went that extra mile". One relative, speaking about a family member said, "One girl he can talk to and explain personal things he will not say to me and then she will say he thinks he might see the doctor about something. He is really at ease with her". During the visits we made to people's homes as part of the inspection the supervisor took the time to listen to feedback and answer people's questions. When the supervisor thought that people forgotten an event they quietly intervened and reminded the person, so they did not become distressed. People were relaxed in the company of the supervisor and communicated happily.

People told us they received person centred care that was individual to them. They felt staff understood their specific needs relating to their age and physical disabilities. Staff had built up relationships with people and were familiar with their life histories and preferences. Care plans contained some details of people's preferences and personal histories. During the inspection staff talked about people in a caring and meaningful way.

People said their independence was encouraged wherever possible. One person said, "They help me to dress, I am very shaky on my feet and they are aware of this, but they are also aware I am very independent. I wash myself and shower myself they come in then when I call them and they do the bits I cannot reach". Another person said, "I wash my face and my chest and they do my back and arms and legs". One relative talked about how staff encouraged their family member and how the occupational therapist had commented on this the last time they did a joint visit.

Most people told us they were involved in the initial assessments of their care and support needs and planning their care. Some people had also involved their relatives and one person told us they had left this to their family. People said the supervisor visited periodically to talk informally about their care and support and discuss any changes required or review their care plan. People felt their care plan reflected how they wanted their care and support to be delivered. The registered manager told us at the time of the inspection most people that needed support to help them with decisions about their care and support were supported by their families or their care manager, and no one had needed to access any advocacy services.

People told us they were treated with dignity and respect and had their privacy respected. One person talked about being given privacy whilst in the shower. Staff had received training in treating people with dignity and respect as part of their induction and had their practice observed in relation to this during spot checks. Information given to people confirmed that information about them would be treated confidentially. People told us staff did not speak about other people they visited and they trusted that staff did not speak about them outside of their home. Confidentiality had recently been discussed and the policy reiterated at a team meeting.

The registered manager told us that the provider had recently started to encourage staff to sign up as a dementia friend and this had been included in a recent newsletter to staff. This is a national government funded initiative to improve the general public's understanding of dementia. The provider also had a scheme to recognise staff called the shining star award. The registered manager told us that one member of staff had been nominated by the team for this award for all the hard work they had achieved. The registered manager had recently introduced a carer of the month award for staff 'who have shown a fantastic work ethic and who thrive to make a difference in our client's lives'.

Requires improvement

Is the service responsive?

Our findings

Most people told us they were involved in the initial assessment of their care and support needs and in planning their care. One person said, "They went through everything and explained it all". Another person said, "I had someone come out I think a long time ago and talk about it". Some people told us their relatives had also been involved in these discussions or their relatives had undertaken this for them. People had signed their assessments showing their consent for care and support to be delivered in line with their assessment and care plan. When the service was first registered assessments had been undertaken by an implementation team, but were now undertaken by the supervisor. In addition when contracting with the local authority they had obtained information from social care professionals involved in people's care and support, to make sure they had the most up to date information on the person. Although the same paper work had been completed by different staff undertaking the assessment, people did not have access to the same records. For example, some people only had a copy of the summary care plan and not the full assessment within their homes. This meant that important information contained in the assessment was not available to staff in the person's own home, such as if they suffered from diabetes or epilepsy or the emergency contact details of their next of kin.

Care plans were developed from discussions with people during the assessment visit. Care plans should have contained a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. However they varied greatly in detail and most required further detail to ensure that people received care and support consistently, according to their wishes and staff promoted people's independence. For example, one person told us they only needed help with washing and drying their back, they could do all the rest themselves, but this was not evident in the care plan.

One person's care plan stated they were bed bound, but they were not, staff helped them to get up each day. Another care plan missed out a part of a person's routine so parts of the personal care routine were confusing and did not give staff guidance about how or where this should be undertaken. One care plan did not have any routine or tasks detailed for the evening visit, which staff were undertaking. Another did not say where personal care should be undertaken. One care plan stated a person had a shower, but they did not, they always had a strip wash and some staff wash their hair. The supervisor told us that when the package was started it was to encourage the person to have a shower, but this had not been possible and the care plan had not been updated. Other care plans stated the tasks to be undertaken, but had no detail about people preferences, their preferred routine or what they could do for themselves. For example, 'full strip wash'.

Daily notes made by staff included tasks not included in the care plan, such as emptying a catheter bag, doing the laundry, taking out the rubbish and recycling. Care plans were reviewed annual by the supervisor, but reviews were not proactive when people's needs changed, resulting in care plans not always being up to date and showing people's current care and support needs. People felt they got the care and support they wanted that did reflect their preferences and wishes. Although this meant that people would have to explain their preferred routine to any new staff that visited or may not receive consistent and safe care particularly when their regular staff member did not visit.

The provider had failed to maintain an accurate and complete record in respect of care and support provided to people and the decisions taken in relation to that care and support. The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Some people were supported by staff to ensure they were ready to go to day centres, so they were not late or socially isolated. Some people told us they looked forward to the staff visits and this helped break up their day. One person said, "They are really lovely and it is someone to talk to and look forward to seeing them".

People felt confident in complaining and most people did not have any concerns when we asked them. However six people told us they had complained about staff not turning up or running late and not all felt they "really received a satisfactory answer". Most people said they were now advised when there were such problems in advance, but not all. Another person felt their complaint had not been responded to in a timely way as they were promised by staff a person would get back to them within a week and this had not happened. People had information about how

Requires improvement

Is the service responsive?

to complain within the folder kept in their home, so people would know how to complain. This included the timescales in which they would receive a response and contact details of other agencies, such as the local authority. When the service received a complaint or any concern it was logged onto the computer. It was then allocated for investigation, an action plan put into place and monitored until completed and the complainant had received a response. Complaints were also monitored by the customer service department to ensure appropriate action had been taken. A social care professional felt that the complaints system and monitoring was good. They had been happy with their responses to any issues they had raised and the service had always included people in any responses.

People had mixed views about whether they had yet had opportunities to provide feedback about the service provided. The supervisor visited to people to carry out their care and support, so during this time, people were able to feed back about the service they received. Some people told us they or their relatives had completed questionnaires to give their feedback about the service provided. The service had also made some telephone calls to people to gain their feedback this way. The responses held in the office were mainly positive. Negative comments related to the timing of calls or missed calls and action had been or was being taken to try and resolve these concerns.

Requires improvement

Is the service well-led?

Our findings

The registered manager was unable to produce some records required during the inspection; other records were incomplete or not up to date. For example, the system for returning MAR charts and daily records made by staff was not always effective, resulting in these records not being available within the office. There was not always clear information about which cream should be applied where and when. Some risk assessments lacked detail about the systems and practices that were in place to keep people safe. One risk assessment was not up to date with current information about the risk. Care plans should have contained a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. These varied in detail and required further information to ensure that they really reflected people wishes and to ensure staff promoted people's independence. One care plan did not detail all the visits. Some records in people's homes lacked important information, such as emergency contact details.

The provider had failed to maintain an accurate and complete record of the care and support provided and decisions taken in relation to people's care and support. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were stored securely and there were minutes of meetings held so that staff would be aware of issues within the service. Where some records had been returned from people's homes recently these had been audited for legibility and content. Shortfalls and action to address these had been identified and staff were in the process of taking this action, such as writing to staff about their record keeping.

The registered manager was unable to locate details of the provider's mission statement or the aims and objects of the service on the day of the inspection. The registered manager agreed these needed to be more readily accessible and would put them as an agenda item at the next staff meeting. Information sent to CQC when the service was registered indicated that the provider's mission statement was 'to be a leading and valued partner in UK health and social care'. The aims and objectives of the service were 'to provide personal and practical care to people in their own homes', 'to assist customers to achieve and maintain their independence' and 'to provide services of a general nature, which may include specialist provision within the available human resources and the ability of the customer (or their representative) to fund such services'. The provider's vision was 'to be the choice for care that gives people the freedom to stay in their own home' was included in a recent post bag newsletter.

People and relatives had mixed opinions as to whether they felt the service was well-led and well organised. One relative said, "We get what we expect". Another told us "There is room for improvement, in staffing levels". Some people felt the service would improve if staff worked more locally rather than travelling between visits. One person said, "It is well run, but some of the staff have to travel about a lot, the scheduling could be better". One staff member told us "The managers need to go out and check the travelling time I can be given 10 minutes and it takes me 20 to 25 minutes". The registered manager had plans, once the second supervisor had been recruited to split the area into two zones and have a supervisor and a co-ordinator working in each zone with staff working in small geographical areas within that zone. The registered manager felt there had been an improvement in the operations of the provider's out of hour's service and said staff had fed back that they felt they were getting a better service, which was confirmed by a staff member we spoke with. Communication had improved between the two managers and a system had been implemented to colour code and link double handed visits so out of hours staff knew that if they changed a visit another visit would be affected.

Two social care professional felt their concerns about the service were "not so great" and that missed calls had reduced. This was confirmed by some people we spoke with. The social care professionals felt that the service was more proactive now and were chasing up communications with their team.

Most people that communication with the office was good. One person said, "I can talk to (coordinator) in the office and he is always polite and he says if I have a problem I can always ring him". However this was not the case for everyone. One person told us they felt communication with the Canterbury office "goes in one ear and out the other". They told us they had telephoned the office twice and the telephone had been picked up "for a couple of seconds and then put it back down". They had complained to the

Requires improvement

Is the service well-led?

head office and were awaiting a response back. Another person told us "We went through a really bad patch a couple of months ago and I did not know when they were going to turn up, so I rang the office and I spoke to them and said that I want punctuality and that I was an early riser and happy for them to come at 7am in the morning. It has worked for me. I don't blame the girls for when they were late, the office people should get in a car and drive around, it is impossible for the carers". People felt when they had spoken to the office staff they were polite.

The registered manager had recognised some of the key challenges and had an action plan in place, which had been agreed with the local authority. This included improving medicine management systems and records, improving information within people and staff files and further specialist training. They felt that the sharp increase in people using the service and a lack of staff and staff training had resulted in the recent safeguarding alerts, but this had provided an opportunity to learn and improve the service. They said there was now improved communication between the service and local authority care managers and that staff were more open and dealt with problems as they were reported, so things could be resolved more effectively.

The registered manager had been in post since the service was registered. They also manage another location owned by the same provider in Hythe. The registered manager worked full time and split their time between the two location offices. They were supported by a supervisor and were recruiting another supervisor, two co-ordinators and an administrator. One person told us they felt it was the inexperience of the office staff and them not being able to sort out staff and prioritise things that were important that had resulted in the shortfalls within the service. The supervisors worked some hours office based, undertook assessments and care plan reviews and also undertook some care and support visits as well. Staff told us they felt listened to, but were not always sure their ideas or opinions were followed through. One staff member told us they felt the service had so much work and was going so fast that everything was urgent and not planned. Staff did value the support they received from senior staff. Two senior staff members were highlighted as being very good when staff had a problem. An independent agency undertook an anonymous staff survey on behalf of the provider in April 2015. This gave staff the opportunity to feedback about their experience and views to help shape action plans to support improvements. Results were not yet available at the time of the inspection.

The registered manager told us they adopted an open door policy regarding communication. Only a few people had had any contact with the registered manager. One person told us they were open and helpful.

The service were members of the National Skills Academy Social Care and Social Care Commitment in Kent. These memberships, the internet, the post bag newsletter and attending managers' meeting within the service and meetings with other stakeholders, such as social services was how the registered manager remained up-to-date with changes and best practice.

There were audits and monitoring of the service to help ensure the service ran effectively and people remained safe. These included the number of hours delivered, care reviews due and completed, permanently scheduled or unscheduled visits, missed calls and supervisions due and completed. A monitoring call system was in place. Staff reported that they had arrived at a person's visit by logging in, using the telephone. They also logged out on departure. If staff did not arrive, within a set tolerance of the time the visit should start, the office computer system flagged this. Staff told us the system was checked regularly during the day. This helped monitor the timing of visits and reduced the likelihood of any missed calls. Where there was an issue with individual members of staff they were shadowed by the supervisor to resolve the problem. The auditing and monitoring systems in place were monitored by the provider and discussed as part of the manager's supervision meeting to help improve the service delivery and ensure it was meeting organisational targets. In addition the service will receive an audit by the provider's quality assurance team, although because the service was only registered in December 2014 this had not yet taken place at the time of the inspection.

The provider undertakes a postal quality assurance survey eight weeks after people have started to use the service and on the anniversary of the start date. Seventeen surveys had been returned by 30 January 2015. The service had also made some telephone calls to people to gain their

Requires improvement

Is the service well-led?

feedback this way. Those held in the office were mainly positive. Negative comments related to the timing of calls or missed calls and action had been taken to try and resolve these concerns.

Staff had access to online policies and procedures, which they familiarised themselves with as part of their induction. These were reviewed and kept up to date by the provider. Staff were informed of any updates via the post bag, which was a weekly newsletter.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure people were protected from the risks associated with proper and safe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The lack of detail in risk assessments meant the provider did not have an accurate and complete record of the care and treatment including decisions taken in regard to people. Regulation 17(1)(2)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People's needs were not met by sufficient numbers of staff. Regulation 18(1)