Community Nursing & Care Agency Ltd

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Inspection report

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Ratings

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

Overall summary

The inspection took place on 7, 8 and 9 July 2015, and was an announced inspection. The previous inspection on 2 May 2013 found no breaches in the legal requirements.

Community Nursing & Care Agency Limited provides care and support to children and adults in their own homes.

The service is provided to children as young four years old; adults and people aged 65+. At the time of this inspection there were less than 20 people receiving support with their personal care. Community Nursing & Care Agency Limited provides two types of services, supported living and domiciliary care. Within the domiciliary care service visits range from half an hour up

Summary of findings

to two hours to support people. Within the supported living service people were receiving up to 24 hours support per day unless they were attending day centre activities. The supported living service operated in Hythe, Tenterden and Smeeth and the domiciliary care services covered the geographical area of central Ashford.

The service is run by an established registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they received their medicines safely and when they should. However we found shortfalls in some areas of medicine management.

Most risks associated with people's care and support had been assessed, but not all. The guidance in place for staff was not always sufficient or clear to ensure people remained safe.

People did not all have their needs met by sufficient numbers of staff. Two people told us the service had not been able to cover the full hours of their care and support for some time. The service did have several vacancies and were actively recruiting. People received continuity of care and support from a team of regular staff and senior staff also covered care and support shifts or visits. People knew who would be undertaking their care and support in advance.

People had equipment in place to aid their mobility. People told us the equipment used to aid their mobility, such as hoists had been serviced regularly, which they arranged. However there was no system within the office to ensure that equipment was serviced according to manufactures guidelines.

People were involved in the assessment and planning of their care and support. Care plans contained information about people's wishes and preferences. They detailed people's skills in relation to tasks and what help they may require from staff, in order that their independence was maintained. People had reviews of their care and support where they were able to discuss any concerns.

People felt safe using the service and when staff were in their homes. The service had safeguarding procedures in place and staff had received training in these. Staff demonstrated an understanding of what constituted abuse and how to report any concerns in order to keep people safe.

People were protected by safe recruitment procedures. Staff files contained most of the required information. New staff underwent a thorough induction programme and shadowed experienced staff, until staff were competent to work on their own. Staff training included courses relevant to the needs of people supported by the service. Staff had opportunities for one to one meetings, team meetings and appraisals, to enable them to carry out their duties effectively.

Most people were satisfied with the service they received. They felt staff had the right skills and experience to meet their needs. People felt staff were kind and caring.

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 a Lasting Power of Attorney in place and some others chose to be supported by family members when making decisions. The Mental Capacity Act 2005 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. The registered manager understood this process.

People were supported to maintain good health. People told us staff were observant in spotting any concerns with their health. The service made appropriate referrals and worked jointly with health care professionals, such as speech and language therapists. There was information about people's health conditions, such as diabetes and epilepsy to ensure people remained healthy.

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

Summary of findings

specific needs relating to their age and physical disabilities. Staff had built up relationships with people and were familiar with their preferences. People's individual religious needs were met.

People felt confident in complaining, but did not have any concerns. People had opportunities to provide feedback about the service provided both informally and formally.

Most people had mixed views about whether the service was well-led and communication with the office. There had been changes in the senior staff team and there remained a vacancy. Senior staff worked shifts or covered visits to people. The registered manager took action to try and address any concerns or issues straightaway to help ensure the service ran smoothly. Staff felt the senior team motivated them and other staff.

The provider had a set of aims and objectives, which included treating people as individuals and being respectful, promoting people's independence and supporting people to the best of their ability to live a fulfilled life. Staff were not always aware of these and how they followed through into practice.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this 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.

Medicine administration practices and records needed to be improved.

Most risks associated with people's care and support had been assessed, but not all. In some cases guidance needed to be improved in order to keep people safe.

There were not sufficient numbers of staff to fully cover people's support and care needs.

Is the service effective?

Good

The service was effective.

Staff received induction and training relevant to their role. Staff were supported and received meetings with their manager.

People received care and support from a team of regular staff who knew people well. People were supported to maintain good health. People were referred to healthcare professionals when needed.

Staff understood that people should make their own decisions and followed the correct process when this was not possible.

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?

Good

The service was responsive.

People's care was personalised to reflect their wishes and preferences.

The service sought feedback from people and their representatives about the overall quality of the service. Any complaints and small concerns were addressed promptly and appropriately.

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

Summary of findings

Is the service well-led?

Good

The service was well-led.

There was an established registered manager who was supported by a senior staff team.

There was an open and positive culture within the office, which focussed on people.

The registered manager and senior staff worked alongside staff, covering shifts or visits, which meant any issues were resolved as they occurred and helped ensured the service ran smoothly.

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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 7, 8 and 9 July 2015 and was announced with 48 hours' notice. The inspection was carried out by one inspector.

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, three staff recruitment files, the staff training, supervision and appraisal records, visit schedules, accident and incident reports, medicine and quality assurance records and surveys results.

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

After the inspection we contacted seven health and social care professionals who had had recent contact with the service and received feedback from three.

Requires improvement

Is the service safe?

Our findings

People felt safe using the service and whilst staff were in their home. People told us they received their medicines when they should and felt staff handled their medicines safely. There were some shortfalls in the management of medicines. Details about what medicines people were prescribed were not always up to date in documents within the care plan folders.

Where people were prescribed medicines on a 'when required' basis, for example, to manage constipation or skin conditions, in some cases there was individual guidance for staff on the circumstances in which these medicines were to be used safely, but not all. Those that were in place were not always individual or lacked information about how and when medicines should be given and when staff should seek professional advice for their continued use. This could result in people not receiving the medicine consistently or safely.

Records showed that in some cases Medicine Administration Records (MAR) charts were pre-printed by the supplying pharmacist and in others they were handwritten by staff. MAR charts viewed showed staff had not always recorded a signature when administering people's medicines or a code to indicate why medicines had not been given. Therefore we were unable to ascertain whether people had received their medicines on these occasions. The providers policy stated that the quantities of medicines received should be recorded on the MAR chart by the staff receiving them; however MAR charts examined showed this was not happening. Handwritten MAR charts were not dated or signed and were unclear. They did not reflect the prescription label on the medicine and at times two medicines had been squashed into one space on the MAR chart, with just the name of the medicine or topical medicine recorded and no administration details. This left a risk that medicines may not be administered according to the prescribers instructions.

During our visits to people we observed staff administering medicines. However we saw that the on one occasion staff signed the MAR chart before they witnessed the person taking their medicines. This is not good practice and not in line with the provider's policy.

Most risks associated with people's care and support had been assessed, but not all. Risks in relation to people's environment, medicine management, accessing the community and using public transport and maintaining healthy skin had been assessed and guidance was in place to keep people safe. Some information recorded to reduce risks did not show evidence of regular review to ensure it remained up to date. One person used a handling belt. There were product instructions in place about how to put the belt on and the care plan stated that it was used when the person was walking, but there was no guidance about how staff should do this safely. The person also used equipment to access the bath, but there was no risk assessment in place. Risks associated with people developing their independence skills, such as cooking and meal preparation had not been assessed to help ensure people remained safe whilst undertaking these tasks. A risk assessment had been undertaken for one person regarding their fluid and diet; however the guidance in place to reduce these risks was at times conflicting.

The provider had failed to fully assess risks and do all that was reasonably practical to mitigate any such risks. The provider had failed to ensure the proper and safe management of medicines. The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were not met by sufficient numbers of staff. One person had experienced a missed call recently during a weekend. However two relatives told us the care and support for their family members had not been fully provided for some time and they had had to step in to support their family member during these periods. One relative told us, "The last two months, it's all gone haywire". Another relative said, "They don't seem to be able to retain staff". One social care professional felt the service had gone through a difficult period of staff retention and recruitment. People told us they were advised in advance that there were no staff to cover their care and support. The registered manager told us within the domiciliary service each person had permanently allocated staff for all their visits, but within the supported living service 20% of visits each week were not permanently allocated to staff.

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

The service at the time of the inspection was actively recruiting and one relative said they had been advised of

Is the service safe?

this. The registered manager told us the service needed to recruit 15 staff to cover existing shifts and visits, holiday cover and new business in the pipeline. People told us they knew which staff were coming to undertake their care and support. Most people told us staff turned up when they were expected. One person said, "Most times they turn up when expected, unless its 'operation stack', but the carers do ring when they are on their way or get a message to us". People had mixed views on whether staff always stayed the full time, but people told us staff always did everything required. The registered manager told us to safeguard against missed visits staff had to text into the office or on call on their arrival at a visit, if this did not happen an alarm was automatically raised. People receiving a domiciliary service confirmed gaps were filled by existing staff and senior staff.

People had given their consent for staff to handle their medicines. There was a clear medicines policy and procedure in place. Staff had received training in medicine administration, which was refreshed every year. This was followed by a competency check to test staffs knowledge and understanding of the training.

There had been one medicine error within the last 12 months. This had been investigated and the staff member refrained from medicine administration until they had completed further training and competency checks had been undertaken.

People had equipment in place to aid their mobility, when there were complex issues regarding a person's mobility health professionals had been involved in the risk assessments and these contained clear guidance about how to move the person safely. People told us the equipment used to aid their mobility, such as hoists had been serviced regularly, which they arranged. However there was no system within the office to ensure that equipment was serviced according to manufactures guidelines. Staff told us and people confirmed that staff made visual checks on equipment before they started to use it; they were quick to spot any problems or faults and report these. For example, one person's sling was no longer suitable, so the occupational therapist had been contacted and a new sling was provided. People told us that they felt risks associated with their support were managed safely and they felt safe when staff moved them.

Some people could display behaviours that challenged. There were clear strategies in place, which had be developed with health professionals, to manage these behaviours and keep people safe. In one case we saw this included a 'social stories' document, which had been put together using pictures, photographs and words to help a person cope with changes to their routine, such as a staff member going on holiday.

There were on-call arrangements in place, which people could access if they needed to in an emergency outside of office hours, which were 9am to 5pm Monday to Friday. The on-call was covered by senior staff who had knowledge of people's needs, visits and the geography of the area.

People in receipt of the supported living service had an individual contingency plan in case of an emergency, such as arrangements for bad weather. The registered manager had a contingency plan for the domiciliary care service. This included using technology and checking weather forecasts ahead of time and then putting arrangements in place to ensure people still received a visit. For example, staff working locally to where they lived.

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. There was a completed application form on each file and in one case an additional employment history. One application form examined did not require the prospective employee to record dates of their education or employment so it was not possible to ascertain whether a full employment history had been recorded as required by legislation. The application form had since been updated to ask for dates. Files lacked a recent photograph although these had been taken for the staff member's identity badge and the registered manager told us they would make sure a copy was retained on files. Staff undertook an induction programme and were on probation for the first six months.

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. Staff were able to describe different types of abuse and knew the procedures in place to report any suspicions of abuse or

Requires improvement

Is the service safe?

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 in the last 12 months. The registered manager had worked closely with the local authority and taken action to resolve the concerns. The registered manager told us they had learned from incidents to recognise when staff were under stress and introduce new staff to people particularly within the support living service in a very planned way.

Accident and incidents were reported and details clearly recorded. Senior staff investigated any accident or incident and took action to reduce the risk of further occurrence and keep people safe. These actions were recorded on a debrief form, which were signed off by the registered manager. Accident, incidents and investigation outcomes were monitored by the registered manager and chief executive during the team handover held each morning in the office. In addition the registered manager audited and analysed accidents and incidents for patterns and trends. Where there had been any poor practices by staff these had been investigated and action taken. For example, staff not properly managing behaviours that challenging according to the management strategies. Staff had received additional training and close supervision to reduce the risks of further occurrences and procedures had been discussed at team meetings.

Good

Is the service effective?

Our findings

People and their relatives were satisfied with the care and support they did receive. One person said, "We work our routine between us". Another person said, "I am 199 per cent satisfied. They are so professional". One person had recently commented in a quality assurance questionnaire "Very pleased with the support from CNCA".

Health and social care professionals felt staff had a good understanding and knowledge of their client's care and support needs. One felt this was achieved after they had worked with them for a sustained period. Another felt staff were very skilled and dedicated and provided consistent care and support. People reacted and chatted to staff positively when they were supporting them with their daily routines. Staff talked about how people had developed since using the service. For example, one person had had a shower after a long period without, which had involved lots of encouragement and using a patient approach by staff. People felt staff had the right skills and experience to meet their needs.

Care plans for people within the supported living service contained information about how each person communicated, such as use simple short sentences using one or two key words and this was reflected in staffs practice during the inspection. In addition people used different communication aids, such as communication boards, objects of reference, an iPad, communicators (the person presses a button, which shows a picture and this displays as a message) and Makaton. Makaton is the use of signs and symbols to support speech. Staff had made referrals and one person had recently been accepted to an iPad scheme via health professionals, to enable the person to access an iPad to develop their communication, which was not as limited as the equipment they were currently using. Staff also used pictures and photographs to communicate and enable people to make informed choices.

Staff understood their roles and responsibilities. Staff undertook an induction, which included orientation to the service and shadowing experienced staff until they were competent. Within the supported living service additional individual induction training had been developed in relation to supporting each individual person. Staff had previously undertaken the common induction standards, which were competency based and in line with the recognised government training standards (Skills for Care). Skills for Care had recently introduced new standards in the form of the Care Certificate, an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. Both new and some experienced staff, to refresh their knowledge, were undertaking or had completed the care certificate. The registered manager told us there was a six month probation period to assess staff skills and performance in the role.

Staff attended training courses relevant to their role, which were refreshed annually. These were linked to the care certificate and included health and safety, first aid awareness, infection control and basic food hygiene. Some specialist training had been provided, such as training on percutaneous endoscopic gastrostomy (PEG) (this is a tube that feeds directly into a person's stomach), autism, managing conflict and positive behavioural support, Makaton and Buccal Midazolam administration (**Buccal Midazolam** is an emergency rescue prescribed medicine). Dementia and further autism training sessions, linked to Skills for Care, were planned. One relative told us they felt further autism training was needed. Staff felt the training they received was adequate for their role and in order to meet people's needs, although one member of staff felt they would benefit from more practical moving and handling training. Nineteen of the 28 staff had obtained 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. Two other staff were also working towards this qualification. Other staff had gained qualifications in nursing, counselling and psychology.

The registered manager told us staff had opportunities to discuss their learning and development through team meetings, spot checks, one to one meetings with their manager (supervision) and an annual appraisal. Spot checks were undertaken by the senior staff, these could be unannounced or announced, 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. Within the supported living service team meetings were organised

for each team that supported each individual. Items discussed included results of health appointments, joint working with other services and any current risks and strategies. Within the domiciliary care service a team meeting for all staff was held. Staff were able to discuss any issues and policies and procedures were reiterated. Staff said they felt supported, but team meetings were not held so often now and some staff could not remember having a spot check on their practice.

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. One person told us this had not always been the case and getting continuity had taken some time. Another person said, "They are so good and so organised". A social care professional told us that the current difficult period of staff recruitment and retention could lead to the introduction of more staff and that would not be ideal. People knew who was coming to support them because they were made aware by staff or they telephoned the office. One person said, they used to have a list, but this had stopped coming and staff that visited told them. Records we examined confirmed that people received continuity of support from a team of regular staff. The registered manager 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 people's needs and staff skills and experience, hobbies and interests. Within the domiciliary service the timing of visits and geography was also taken into account. Where people had requested a staff member did not visit them again, people told us this had been respected. 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 had signed consent forms and they 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. In some instances pictures were used to help people make their own choices. The registered manager told us that no one was subject to an order of the Court of Protection; two 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 best interest meetings regarding whether a person should receive medical treatment. They understood the process, which had to be followed when one was required. Staff had received training in the Mental Capacity Act (MCA) 2005. 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. One person could present challenging behaviour; restrictions were in place in the form of gates at their bedroom door and the kitchen door to keep them safe. Records showed that this had been agreed at a best interest meeting and was considered the least restrictive option. Discussions demonstrated that the gates only restricted the person with challenging behaviour and not others within the house. Records showed the gates were only used during incidents of challenging behaviour in that area of the house and this was closely monitored by the registered manager.

People's needs in relation to support with eating and drinking had been assessed and recorded. The registered manager told us there was no one at risk of poor nutrition. Within the domiciliary care service most people required minimal support with their meals and drinks if any, which was supported by records. People told us that staff prepared what they asked for or looked in the cupboard and offered them a choice. People said staff encouraged them to drink enough and would leave a stock of drinks ready for later. Within the supported living service health professionals had been involved in the assessment of people's nutritional needs. Where there was a risk people's weight was monitored and recorded and a healthy diet encouraged. Other monitoring in place included fluid and food intake records. Where records highlighted possible concerns we saw staff took quick action, such as organising a review meeting with professionals when one person had gained weight. In another case information was not always clear about the fluid and some types of food a person required, so the registered manager had telephone the health professional and gained confirmation by telephone. People's care plans reflected any support that was required, such as food to be cut into small pieces or cups to be only half filled and drinks to be warm. Where people required equipment to aid their independence when eating and drinking this was in place.

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 'down' or 'not themselves'.

Good

Is the service effective?

People and relatives told us how staff always commented when they noticed any changes. One person said, “They are so concerned. When I was ill once they came back to make sure I was all right”. We heard that when people were unwell staff called appropriate health professionals. For example, recently one person had been ‘off their food’ for two days and was taken to the doctor for a check up to make sure it was nothing serious. Where people were at risk of pressure sores staff were observant. Information about managing health conditions was detailed in the care plans, such as diabetes and epilepsy, so that people remained in good health. Within the supported living service people told us they were support by staff to attend appointments and check-ups with dentists, doctors and opticians. Information about people’s health conditions had been obtained and was available within people’s care plan. These included any signs and symptoms and management recommendations, so staff were informed.

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 their relatives told us this sometimes included the use of appropriate banter and good humour. People were complimentary about the staff. Comments included, "We can have a joke". "I like (staff member) because she is calming". "(Staff) are respectful". "I have a good relationship with the staff". "They are a nice crew". "Caring, very much so. Those that have just been, they have a sense of humour and are more jovial and very understanding". "They are absolutely brilliant".

One person had recently commented in a quality assurance questionnaire "The team of carers are lovely. I couldn't manage without them". The service had received a number of compliments from relatives.

A social care professional told us in their experience staff were caring.

During the inspection staff took the time to listen and interact with people so that they received the support they needed. People were relaxed in the company of the staff, smiling and communicated happily using verbal communication.

Some people talked about staff that "made a difference". One relative said, "(Staff member) thinks for herself, learns quickly and is competent. She is good and I trust her". During the visits we made to people's homes as part of the inspection staff present took the time to listen and answer people's questions. When a member of staff thought that a person did not quite understand the question they quietly intervened, so the person did not become distressed. Another person told us, "(Staff member) is experienced and has a good attitude, in fact there is not a bad one amongst them".

Staff talked about how one person had really developed since being supported by the service. The registered manager told us this person displayed far less challenging behaviour than they had previously. They felt this was down to the whole team that supported the individual who saw the person an individual and not as a behaviour. Staff understood their behaviour through specific training and knowing them well as a result of good continuity of care. Good recruitment using value based questions during interviews had enhanced the team. This in turn had resulted in the person being supported to attend the X Factor final live at the O2 arena and having a wonderful time.

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 demonstrating a person centred approach and understanding people's specific needs was checked during spot checks of their practice. Staff had built up relationships with people and were familiar with their life histories and preferences. Care plans contained details of people's preferences, such as their preferred name and some information about their 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, "Yes they encourage independence. I wash all the bits I can reach". Within the supported living service we saw and people told us that this may include people preparing meals and drinks and laying the table. Health and social care professionals told us there were opportunities for their clients to develop their independent living skills. One said that over the time they had spent with the service their ability and understanding of their choices had increased greatly.

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. People had mixed views about whether senior staff visited periodically to talk about their care and support and discuss any changes required or review their care plan. People and relatives felt care plans reflected how they wanted the 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 care plan identified that the person wished to be left in the bath 'until ready'. A social care professional felt their client was treated with dignity and respect. 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

Good

Is the service caring?

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.

The registered manager and chief executive officer were both dementia friends and dignity champions. Signing staff up as a dementia friend is a national government funded initiative to improve the general public's understanding of dementia. The chief executive told us it was about gaining and updating knowledge, volunteering and giving back to the community and raising awareness. All this information was cascaded to staff. Dignity champions are part of a national scheme and a **dignity champion** is someone who believes passionately that being treated with **dignity** is a basic human right, not an optional extra. There is a ten point challenge, which describes the values and actions quality services should adhere to that respect people's dignity and this was displayed with the office. The chief executive told us these principles were checked during spot checks of staffs practice and used in recruitment and interview questions to recruit the right staff.

The service had also held an event to build relationships with people and their families. This included a cake baking competition and a box games evening, which raised £1,150 for charities supporting people with a learning disability and another supporting people with dementia.

People's religious needs were met. Within the supported living service most people did not wish to practice religion. However one person was supported by staff to visit their place of worship every week.

Good

Is the service responsive?

Our findings

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, yes". Some people told us their relatives had also been involved in these discussions. People had signed forms showing their consent for care and support to be delivered in line with their assessment and care plan. Assessments were undertaken by senior staff. In addition when contracting with the local authority the service had obtained information from health and social care professionals involved in people's care and support, to make sure they had the most up to date information on the person.

A new format of care plans was being implemented at the time of the inspection. The registered manager told us that only four people were still to be changed over to the new format. The new care plans were an improvement on the previous care plan as they contained all the information in one place about people's care and support needs. Care plans contained information about people's morning and evening routines, such as personal care, bathing and continence management. These included detail about people's preferences, such as whether they liked a bath or a shower and when they liked to have this. They also included what people could do for themselves and what support was required by staff in order to promote people's independence. Some strategies for managing behaviours that challenge included pictures and symbols to aid communication and make them more meaningful to the individual.

People were involved in reviews to discuss their care and support. Within the supported living service this was achieved through a review meeting, which was held with people, their family and their care manager and staff. Within the domiciliary service reviews were undertaken by senior staff as part of a quality monitoring visit. Reviews were undertaken periodically depending on the complexity or changes in people's needs.

Within the supported living service people had a programme of leisure activities in place, which they had chosen to help ensure they were not socially isolated. People were supported to be ready to attend local centres to undertake activities or supported to access the local community. People told us they enjoyed the activities they attended. Some people told us they looked forward to the staff visits and this helped break up their day. One person said, "Sometimes I get down and they will stay and chat".

People felt confident in complaining, although people did not have any concerns when we asked them. People had information about how 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. The registered manager told us when the service received a complaint or any concern it was logged onto the computer. It was then allocated for investigation usually to the senior staff responsible for that service and monitored until completed and the complainant had received a response. Complaints were also monitored at management meetings. The registered manager told us that no formal complaints had been received within the last 12 months, but they said that any minor issues were also recorded. The registered manager told us this helped "nip things in the bud, however minor" and kept things running smoothly.

People had mixed views about whether they had yet had opportunities to provide feedback about the service provided. People and their families had the opportunity to feedback during review meetings. People confirmed that senior staff also visited them 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. Within the domiciliary service people were asked about the quality of care and if they had any concerns during their review visit. The responses held in the office were positive.

Good

Is the service well-led?

Our findings

People and relatives had mixed views about whether the service was well-led and well organised. Comments included "Yes it is now". "They seemed to have turned themselves around, it's a lot better" and "It's a wonderful company". One person told us they would "Recommend the service to anyone", but two relatives told us they would not recommend the service. However this was only related to the current staffing issues.

Most people felt communication with the office was good. One person said, "They treat you with total respect on the phone". Another person said, "Communication is very good". However another person told us about when they had emailed the service and they had not responded.

Health and social professionals felt the service was "generally well-led". However it appeared from their more recent contact that the senior team were under high levels of pressure due to the difficulty with recruitment and retention of staff including more senior staff and the consequent difficulties covering shifts. They felt the high levels of new staff was likely to have an impact on the quality of the service provided even if for an interim period. Another professional told us that the registered manager was an "Excellent manager and her enthusiasm and dedication rubs off on the team she leads". They went on to say that she had an excellent relationship with their client and family and communicates well with professionals.

Records were stored securely and there were minutes of meetings held so that staff would be aware of issues within the service.

There was an established registered manager in post who was supported by senior staff, coordinators and an administrator. The registered manager worked four days one week and five days the next (Monday to Friday). They worked both within the office and also undertook a support shift each week. The supported living service had two service managers who oversaw the day to day running of the service. The registered manager told us these staff were matched to manage the part of the service where their skills and experience matched the people they supported. At the time of the inspection one of these posts was vacant. One staff member told us their senior staff member had left and they were not sure now who was managing this part of the service. The domiciliary care service was overseen by a team leader who was fairly new in post. Senior staff were responsible for undertaking the initial assessments of people's care and support needs, developing the care plans and then reviewing, quality monitoring visits and staff supervision. All senior staff also undertook a support shift each week for people that they had management responsibility for. Only a few people had had any contact with the registered manager. Other people were familiar with the senior staff that oversaw their service. One person told us that their senior was fairly new, but had already started to turn things round for the better. Other comments about the management team included, "(The registered manager) and CNCA work hard to create a good team". "The best agency we've had. (Member of senior staff) is on the ball, any problems and she will deal with it".

During the inspection there was an open and positive culture within the office, which focussed on people. The registered manager told us they adopted an open door policy regarding communication and often worked in the open plan part of the office. Staff felt the senior team motivated them and other staff. Staff felt the senior team listened to their views and ideas. However one staff member told us, there had been a lot of changeover of staff in the office.

Staff said they understood their role and responsibilities and felt they were supported. However they felt team meetings had previously been more frequent than they were now. Some staff could not remember having received a spot check on their practice. Staff did tell us that senior staff were available by telephone should they have any concerns or queries. Staff in the office also used a daily handover to keep up to date. The daily handover was attended by both the registered manager and the chief executive officer this helped them to monitor the service and also keep up to date with what was happening. Electronic communication was used to keep other staff up to date.

Within the service the provider displayed their aims and objectives. The registered manager told us these were linked to staff supervision and annual appraisals. Staff were not sure what the aims and objectives were when we asked them, but felt they would include respect, dignity, ensuring

Good

Is the service well-led?

people lived a fulfilled life, empowering people and covering calls and being reliable. The aims and objectives included to provide a first class service, to meet people's needs and maximise their independence.

The service had signed up to the Social Care Commitment. **The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services.** It is a Department of Health initiative that has been developed by the sector, so it is fit for purpose and makes a real difference to those who sign up. Made up of seven statements, with associated 'I will' tasks that address the minimum standards required when working in care, the commitment aims to both increase public confidence in the care sector and raise workforce quality in adult social care. The chief executive told us signing up to the social care commitment had impacted on care practice and interviews as they now used value based questions, and toolkit to recruit and retain kind and compassionate staff. The seven statements were the basis for the service action plan. The service was also an autistic ambassador. They had links with the Kent Autistic Trust, followed and cascade media stories and undertook joint working with Foxwood School and South Kent College when working people that used both services. The service had also undertaken some joint working with Kent County Council around planning for future services. These memberships, the use of the internet, and attending managers' meeting within the service and meetings with other stakeholders, such as social services was how the registered manager and chief executive remained up-to-date with changes and best practice.

The service had forged links with the local community. The chief executive told us about a luncheon club for people with dementia that was held close by every two weeks. This was organised by the local Admiral Nurse and staff from the service volunteered to help. In return it was planned that the Admiral Nurse would organise a dementia master class training session linked to Skills for Care.

Audits were carried out to monitor the quality of the service and to identify how the service could be improved. Within the supported living service this included a monthly visit by senior staff to each house. Audits looked at records that were kept to monitor the care and support people received, such as personal finances, medicines, records of food and menus and daily reports made by support staff. Checks also included visual checks on whether staff were supporting people to maintain a clean and tidy environment. This audit had recently been expanded and senior staff now had to check and record how many accidents or incidents there had been since the last audit so these could be closely monitored. Audits within the office included the number of hours delivered, accident and incidents, care reviews due and completed, permanently scheduled or unscheduled visits, missed calls and supervisions due and completed. A system to ensure people received their visits was in place. Staff texted to report they had arrived at a person's visit, if a text was not received this sent an alarm call to the office or on call phone. This helped monitor the timing of visits and reduced the likelihood of any missed calls.

People, their relatives, staff and health and social care professionals had been sent online quality assurance questionnaires to give feedback about the services provided. If people did not have access to a computer the registered manager told us they were sent a postal survey. There was one negative comment and action had been taken to resolve this.

Staff had access to policies and procedures via the provider's computer system or a folder was held within the service. These were reviewed and kept up to date by the provider. In addition the registered manager had created flow charts for a quick overview of what to do in different situations and these were available to senior staff online. For example, accident reporting and complaint handling. The registered manager told us she had seen the senior staff using these, which were tied in with induction standards for the Learning Quality Framework by Skills for Care, which senior staff were working towards. The leadership qualities framework is about leadership at all levels and care workers leading from the front line. It provides clear guidelines enabling organisations to introduce training to help their leaders deliver higher quality and better care. The service had produced 'welcome' information for people when they started to use the service. This included an easy to read version using pictures for people receiving the supported living service.

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 fully assess risks and do all that was reasonably practical to mitigate any such risks. The provider had failed to ensure the proper and safe management of medicines. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of staff to meet the care and support needs of people. Regulation 18(1)