Nurse Plus and Carer Plus (UK) Limited

Nurse Plus and Carer Plus (UK) Limited - Suite 18 Ingles Manor

Inspection report

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Ratings

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

Overall summary

The inspection took place on 3 and 5 March 2015, and was an announced inspection. The registered manager was given 48 hours' notice of the inspection. The previous inspection on 4 December 2013 found there were no breaches in the legal requirements at that time.

Nurse Plus and Carer Plus Limited – Suite 18 Ingle Manor provides care and support to adults in their own homes. The service is provided mainly to older people, some younger adults and a some people who have a learning

Summary of findings

disability. At the time of this inspection there were more than 200 people receiving support with their personal care. The service provided short visits to people as well as providing a visit of up to six hours to support people.

The service is run by a registered manager, who also managers another service in Ashford owned by the same provider. 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 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 the support staff gave people with their medicines. There was a lack of systems, guidance or procedures about some areas of medicine management. Staff were leaving medicines for people to take later, but this was not clear in records. Staff were not clear about the difference between 'prompting' administering, and partial self-administration of medicines. Staff practices did not always follow good practice or the provider's policy. Some medicine records were not audited to ensure safe practices were being followed.

Risks associated with people's care had been identified, but there was not always sufficient guidance in place for staff to keep people safe.

People were involved in the initial assessment and the planning their care and support and some had chosen to involve their relatives as well. However care plans varied greatly in the level of detail and most 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. Care plans were not reviewed in line with the provider's policy.

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 had their needs met by sufficient numbers of staff. People received a service from a small team of staff. Staffing numbers were kept under constant review.

People were protected by robust recruitment procedures. Staff files contained the required information. New staff underwent a thorough induction programme, which including reading, relevant training courses and shadowing experienced senior staff, until they were competent to work on their own. Staff received training appropriate to their role.

People were happy with the service they received. One person said, "I can't complain this agency is better than any other I have ever had". People felt staff had the right skills and experience to meet their needs. Managers monitor staffs practice during unannounced checks on their practice. Staff felt well supported and attended one to one and group meetings with their manager.

People told us their consent was gained at each visit. People had also signed their care plan to confirm their consent to their care and support. 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 of Attorneys in place and some others chose to be supported by family members when making decisions. The registered manager and staff had received training on 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.

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 community nurses.

People felt staff were very caring. People said they were relaxed in staffs company and staff listened and acted on

Summary of findings

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 personal histories and preferences.

People told us that communication with the office was good and if there were any queries they called the office who responded.

People felt confident in complaining, but did not have any concerns. People had opportunities to provide feedback about the service provided. Negative feedback that had been received had been acted on. People felt the service was well-led and the registered manager adopted an open door policy.

The provider had a philosophy and vision. Staff were aware of these and felt the service listened and was caring and promoted people's independence, privacy, dignity and respect. Staff said they cared for people in a person centred way.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to 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. There was a lack of systems, guidance and procedures in some areas of medicine management. Staff did not work in line with the provider's policy.

Risks associated with people's care had been identified, but there was not always sufficient guidance about how to keep people safe.

People were protected by robust recruitment processes.

Is the service effective?

Good

The service was effective. People received care and support from trained and supported staff.

Staff knew people and their support needs. Staff encouraged people to make their own decisions and choices.

People were supported to maintain good health. Staff worked with health care professionals, such as community nurses to resolve and improve health concerns.

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.

Staff supported people to maintain and develop their independence.

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.

People felt comfortable if they needed to complain, but did not have any concerns. 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?

Good

The service was well-led. There was an established registered manager that ran the service supported by a robust management structure.

Summary of findings

People completed feedback surveys and these were used to drive improvements in the service. Staff felt well supported and listened to.

The service had systems in place to audit and monitor the quality of service people received.

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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 3 and 5 March 2015 and was announced with 48 hours' notice. The inspection was carried out by an inspector and a pharmacist 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.

We reviewed people's records and a variety of documents. These included 17 people's care plans and risk assessments, five staff recruitment files, the staff induction, training and supervision records, staff rotas, medicines records and quality and audits.

During the inspection we spoke with 14 people who were using the service, three of which we visited in their own homes, we spoke to six relatives or representatives, the registered manager and nine members of staff. The service had recently sent out surveys to gather feedback about the service and 105 people had responded, we looked at this feedback and people's comments.

After the inspection we contacted four health and social care professionals who had had recent contact with the service and received feedback from three of these by telephone.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and this was also confirmed during people's care plan reviews, but the service was not always safe. People told us they received their medicines when they should and they felt their medicines were handled safely. However people were not protected against the risks associated with unsafe practice in medicines management.

Care plans and medicine administration records for people who were supported with medicines indicated the level of support people needed to take their medicines safely. Some records did not reflect what the staff did for the people. For example, for two people the care plan said that staff were only to assist with medicines. Although the record entered in the daily log book by the staff indicated 'medicines were given' to the person. In some care plans it stated that staff were to take medicines out of the packaging and leave this for the person to take later. Staff were signing for this in the records as though they had administered the medicine, but they had not seen the person take their medicines, there was no risk assessment to cover this practice to ensure it was safe.

Staff were not clear about the difference between 'prompting' 'administering', and 'partial self-administration' of medicines. With partial self-administration there was no procedure within the care plan to clarify the lines of responsibility, to help ensure people received their medicines when they should.

The daily log book (medicine record) had a signature against creams applied and in some cases one signature against several medicines given 'as per dossette'. The provider's new medicines policy stated that there should be a list of medicines and specifically stated it must not say 'as per dossette'. This meant staff had not been working safely in line with the new policy.

The list of medicines within the care plan held in the office was recorded on the initial assessment of the person's needs. There was no system for any changes in medicines to be updated in the care plan in the office, to ensure staff had up to date information about people's medicines.

Records of medicines administered and signed for by staff on Medication Administration Record (MAR) charts supplied by a pharmacy were not brought back to the office for auditing, to check people were receiving their medicines when they should.

In one care plan we saw that the medicines were kept 'on top of the boiler in the kitchen'. This was contrary to guidance from the Royal Pharmaceutical Society 'safe management of medicines in social care', which stated 'medicines need to be stored so that the products are not damaged by heat or dampness'.

Training for staff on medicine management was part of their induction training. The new medicines policy had been implemented, but the policy had no dates or review dates included, to help ensure it remained in line with current good practice guidance.

The provider had failed to ensure people were protected by the proper and safe management of medicines. The above is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Health and social care professionals told us that there had been problems with medicine management, but that the service had taken on board advice and guidance and were now proactive in seeking advice as and when concerns were identified.

Risks associated with people's care and support had in most cases been identified. For example, risks in relation to people's environment, falls and moving and handling people. People told us that they felt risks associated with their support were managed safely and they felt safe when staff moved people. However there were not always guidance or sufficient guidance in place to reduce these risks. For example, moving and handling risk assessments only stated the equipment to be used and the numbers of staff required. In one case the equipment recorded was not correct, as staff told us the person 'on a good day' could walk with a walking aid and a care worker each side for support. The risk assessment stated 'wheelchair' and 'stand aid hoist' only. Moving and handling risk assessments did not detail what hoist sling hooks should be used so that the person would be moved in the right

Is the service safe?

position. Another person had a history of falls and was scored on an assessment as at 'medium risk', but there was no guidance about how staff should reduce the risks of falls and keep the person safe.

The provider had failed to properly assess and mitigate risks to people. The above is a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered manager told us that any equipment used was recorded on the risk assessment together with service dates, to ensure the equipment remained safe. However this was not consistently recorded. People and staff told us that visual checks were undertaken on the equipment used at each visit. During the inspection staff reported a fault with a hoist sling and staff took immediate action speaking with health professionals and a visit to the person to resolve the issue was arranged.

The registered manager told us they had a risk assessment in place in the event of bad weather. This included measures, such as each person being assessed in relation to prioritising their visits during emergencies and this was recorded within their care plan. There was also access to a 4x4 vehicle and staff worked locally to where they lived, to ensure people would still be visited and kept safe.

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 the registered manager was friendly and put people and their relatives at ease when they met. People and relatives were relaxed in the company of the registered manager. There was a safeguarding policy in place. Staff had received training in safeguarding adults; they were able to describe different types of abuse and knew the procedures in place to report any suspicions 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 a recent rise in safeguarding referrals reported by the service. These related mainly to the management of medicines. The registered manager had worked closely with health and social care professionals to help resolve the shortfalls. Additional and more in-depth training was being arranged, a medicines audit had been introduced and procedures had been reiterated to staff in a team meeting.

People had their needs met by sufficient numbers of staff. People told us staff 'on the whole' or 'generally' turned up when they were expected. A recent survey showed that 95% of people were satisfied with the punctuality of their visits. People told us when staff were running late the office or their care worker telephoned them to let them know. Minutes of a recent team meeting showed staff were reminded to ring the office, so they could keep people informed, this was following the results of a recent survey. People told us when they had experienced a missed call they had phoned the office and another care worker had been sent quickly, so their routine was not disrupted. The registered manager told us that a large percentage of people's visits were allocated permanently to staff rotas and these were only changed when staff were on leave. Staff usually worked in a geographical area and the registered manager kept staffing numbers under constant review. This was a large service and the registered manager told us recruitment was on-going. There was an on-call system in place. The registered manager told us at weekends the office was open from 7am to 12 noon and covered by a coordinator and a care worker, in addition two or three care workers were paid to be available 7am to 10am to pick up visits. At other times senior staff covered the on-call telephone.

People were protected by robust recruitment procedures. One person told us "They pick the right ones (staff)". Recruitment was on-going within the service. Recruitment records included all the required information. This included an application form, 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, which were also verified by telephone. Staff undertook an induction programme.

Accident and incidents were reported and details clearly recorded. Coordinators had the responsibility of investigating any incident or accidents and taking action to reduce the risk of further occurrence and keeping people safe. Incidents and accidents were also recorded on the computer system and sent to senior management, where

Requires Improvement

Is the service safe?

they were audited and analysed to ensure appropriate action had been taken and looked at in relation to 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 the medicines policy. Staff had received additional training and close supervision to reduce the risks of further mistakes and procedures had been discussed at team meetings. Longer shadowing for medicine administration was being introduced.

Good

Is the service effective?

Our findings

People and their relatives were happy with the care and support they received. A recent comment about the service included: "Your service is 100% better than my previous care provider. I would recommend your service to anyone who required it". "It is a very good service and I am hoping it will carry on". "We are delighted with the service; you have given us our life back".

People told us they received their service from a small team of regular staff and records confirmed this. One relative told us "Mum's not great with strangers and they respect this". The registered manager told us that following an initial assessment of people's needs they matched a member of staff to cover the visits. The matching process was based on staff working in the geographical area, people's preferences and staff skills and experience. People told us when they had not been happy with a particular care worker there had been no problem with changing. The registered manager said, "Not everyone can get on and we always respect this" when it has been raised by the individual. When people did not want a particular care worker this was recorded on the scheduling computer system. The registered manager told us that about 60% of people or their relatives received a schedule of visits in advance; these were sent when people had requested them. The registered manager told us the procedures for sending these out had recently been changed to improve the detail and accuracy of information people received. One person asked during the inspection for a schedule of visits and the registered manager said they would arrange this.

Staff understood their roles and responsibilities. Staff had completed a four day induction programme, which they told us included reading policies, attending training courses and they also received a staff handbook. The induction was based on the Skills for Care common induction standards, which are the standards people working in adult social care need to meet before they can safely work unsupervised. In addition staff also undertook shadowing of experienced senior staff until they were signed off as competent in a variety of tasks. The registered manager told us staff received induction training and this was refreshed every year with a further two days of training. Training included enablement, stoma and catheter care, nutrition and hydration, health and safety, moving and handling, fire safety awareness, emergency first aid, infection control and basic food hygiene. Staff received some specialist training, such as dementia care including dealing with challenging behaviour, mental health, end of life, epilepsy and Parkinson's and stroke.

The service had 148 staff and 60 had achieved or were undertaking 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 felt the training they received was adequate for their role and enabled them to meet people's needs. People felt staff had the skills and experience to meet their needs. One person said, "Yes they are very good".

The registered manager told us they had recently introduced increased support for staff over and above the timescales within the provider's policy. This meant, once fully implemented staff would receive either an unannounced check on their practice or have a one to one meeting or attend a team meeting each month. Staff told us they had spot checks of their practice, supervision meetings and that they attended team meetings. Spot checks were undertaken unannounced whilst staff were undertaking visits to people. During these observations staff practice was checked against good practice, such as their approach and communication skills with people, and ensuring staff offered people choices and medicine administration. Staff told us they had an annual appraisal when there was the opportunity to discuss their learning and development. Staff were also asked at a recent team meeting whether there was any additional training they would like to attend. Staff said they felt well supported.

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. One person said, "They don't boss me about". People had signed their care plan to confirm their consent to their care and support. People said staff offered them choices, such as what to have to eat or drink. The registered manager told us that some people had a Lasting Powers of Attorney in place and others chose to make decisions with the support of family members and no one was subject to an order of the Court of Protection. The registered manager had raised a concern about a possible Court of Protection with the local authority. This had resulted in them being

Good

Is the service effective?

involved in a best interest decision, where the future of a person's care and support was discussed, so they understood the process, which had to be followed. The registered manager and staff had received training on 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.

People's needs in relation to support with eating and drinking had been assessed during the initial assessment. Most people required minimal support with their meals and drinks if any. Staff usually prepared a meal from what people had in their home. One person said, "They tell me what I have got and I tell them what I am going to have". People told us how staff encouraged them to eat and drink sufficiently and left a stock of cold drinks or food for in between visits. When there was a risk of poor nutrition health professionals had been involved and their recommendations were followed through into the care plan. Measures were in place to reduce these risks, for example, a meal supplement was prescribed by the doctor or thickeners were used in liquids. One person used a straw to help them drink and another person was fed through a percutaneous endoscopic gastrostomy (PEG). This is a tube that feeds directly into a person's stomach and staff had received training in how to do this effectively.

People were supported to maintain good health. People and relatives told us staff were good in spotting any concerns with their health. One person told us how "Carers are well on the ball and can tell (when not well)" and talked about how staff had called an ambulance and telephoned their family following a fall they had and they were taken to hospital. Daily notes showed how staff were concerned about one person having an infection so took a sample to the local surgery to get it tested. Information and guidance about supporting people's health care needs were contained within their care plans, such as managing diabetes. However in one person's assessment and care plan it was not clear they had diabetes although there was information about managing the condition. Staff told us the person was a diabetic. When people were at risk of pressure sores staff were observant and called in the district nurses as soon as they were worried about an area. The registered manager told us this resulted in joint working with nurses for a period of time with good outcomes for people. Social care professionals told us that the service "on the whole" worked well with them and kept them informed about people's health and wellbeing.

Good

Is the service caring?

Our findings

People told us staff listened to them and acted on what they said. During the inspection the registered manager took the time to listen to feedback and answer people's questions. People were relaxed in the company of the registered manager. Relatives were very complimentary about the staff. Comments about staff included, "(Care worker) is a lovely girl". "They are all very good and very pleasant". "I have never had anyone I feel uncomfortable with". "They are very good; I would give them 10 out of 10". "They are very good, they have very caring ways". "They all know me that come and understand what I want". "They are very good carers, excellent team that I have". "Everything they do for me is centred around me". "They are polite, lovely girls".

One person talked about when they had had a fall and staff found them and stayed with them until the ambulance came giving them reassurance and phoning their daughter. They told us "They wouldn't all do that; some would have to rush off to the next one".

Staff talked about one member of staff who 'went the extra mile with people'. They told us how this staff member had spent time with an individual teaching them words and hand gestures to expand their communication. They had also ensured staff understood these so they were consistently used. Staff also used other forms of communication to ensure people were able to make their needs known. For example, staff verbally communicated with one person and they used their computer to reply to staff, another person used eye movements.

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 personal histories and preferences. One relative said, "They have started to shower Mum now, which has taken it off me". Care plans contained details of some people's preferences and could have better reflected details of people's personal histories.

People said their independence was encouraged wherever possible. One person talked about how their independence had increased since using the service. They told us how they could now walk round their flat when previously they were unable to. A relative also talked about how their family member was encouraged by staff to walk and use their computer to communicate.

During the inspection staff talked about people in a caring and meaningful way. When the registered manager thought that people had not fully understood a question or they had forgotten an event they quietly intervened and reminded the person, so they did not become distressed.

People told us they were involved in the initial assessments of their care and support needs and planning their care. In some cases relatives had also been involved. People said a senior member of staff visited periodically to review the care plan and discuss any changes required. People felt the care plan reflected how they wanted their care and support to be delivered. People told us that communication with the office was good and if there were any queries they called the office or the registered manager and they responded. The registered manager told us at the time of the inspection most people that needed support were supported by their families or their care manager no one had needed to access any advocacy services.

People told us they were "always" or "definitely" treated with dignity and respect and had their privacy respected. Staff had received training in treating people with dignity and respect as part of their induction and their practice was checked in relation to this during the spot check visits. At care plan reviews senior staff confirmed that people were treated with dignity and respect. Information within the service user guide confirms to people that information about them will be treated confidentially. The service user guide was a booklet that was given to each person at the start of using the service, so they knew what to expect. 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. Health and social care professionals felt people's privacy and dignity was respected and their independence was promoted.

The registered manager told us they were a dignity champion, which is someone who should challenge poor care practice, acts as a role model and educates and informs staff working with them. They were also a

Good

Is the service caring?

dementia friends champion; this is a national government funded initiative to improve the general public's understanding of dementia. They were encouraging all staff to register as a dementia friend.

Requires Improvement

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. Some people told us their relatives had also been involved in these discussions. The registered manager or senior staff undertook the initial assessments. In addition when contracting with the local authority or the health authority they 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.

Care plans were developed from discussions with people, observations and the assessments. 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 care plan only stated 'please encourage me to do as much for myself (time allowing)', but there was no detail about what they could do for themselves.

One 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 they should be undertaken. 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, 'wash and dry hair' or 'help me to get dressed'. Daily notes by staff talked about connecting a catheter leg bag or changing a catheter, but there was no detail in the care plan about the person having a catheter and about what to do. Daily notes talked about a full days support and taking a person out, but this was not included in the care plan.

Care plans were reviewed periodically by senior staff to ensure that any changes could be identified and reflected the discussions people had with senior staff during visits. Other changes, such as an increase in support that were required were discussed with health or social care professionals and the changes agreed. However during the inspection care plans had not all been updated to reflect the current care and support that was being delivered. One person no longer spent their day in their lounge, but went back to bed and this was not reflected in the care plan. Another person told us they no longer wore their lifeline around their neck, but had other arrangements for it, but again the care plan had not been updated. The providers service user guide stated that care plans would be reviewed at least six monthly, care plans were not reviewed in line with this policy.

This meant that people would have to explain their preferred routine to any new staff that visited or would not receive consistent and safe care particularly when their regular staff member did not visit.

The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. The above is a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 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 groups, so they were not late or socially isolated. Other people were supported whilst their carer (family member) had a break and this visit was used to spend time with the person on a one to one basis to socialise and chat. At care plan reviews senior staff discussed involvement in the local community and whether the service could do anything to aid this. People said they looked forward to the staff visits and told us this in itself ensured they were not lonely.

People felt confident in complaining, but did not have any concerns. People told us when they had "raised things the office responded and resolved things". The complaints procedure was contained within people's service user guide, so people knew how to complain. Complaints including any small 'niggles' were all recorded on the computer system. The last complaint had been about the conduct of a care worker. This had been investigated thoroughly and action was taken to help reduce the risk of further occurrence. The service had responded to the complainant explaining what action they had taken. Health and social care professionals told us that the service responded to any concerns.

Requires Improvement

Is the service responsive?

People had opportunities to provide feedback about the service provided. People were asked informally for their feedback during their care plan review visit and also during staff spot check visits. Quality assurance questionnaires had been sent out during January 2015.

Good

Is the service well-led?

Our findings

The service was run by a registered manager who also managed another service in Ashford owned by the same provider. The registered manager had managed this service for eight years. The registered manager worked in the office, attended meetings and was also out and about undertaking assessments. They were supported by a deputy manager, five coordinators, three field supervisors, two administrators, a trainer and 12 senior care workers. Coordinators, field supervisors and care workers all worked in geographical areas to aid consistency and effective working. People and relatives spoke highly of the registered manager. They felt comfortable in approaching and speaking with them. Staff felt the registered manager and office team motivated them.

The registered manager told us they adopted an open door policy regarding communication. People felt communication with the office was good. One relative said, "We had a meeting with (the registered manager) and the coordinator to iron things out. We are due a review in March".

Health and social care professionals told us that there was good communication with the registered manager who was "proactive".

Staff told us, the registered manager was "firm but fair", "prepared to do calls" and "on the ball and sorted things out". The registered manager was nominated by a staff member and was a finalist in the British Care Awards for the category of Home Care Manager 2014.

People and relatives felt the service was well-led. One person said, "I'm impressed, it is not easy". The service was large and one key challenge had been that they had grown quite quickly in recent months and this had in its self had caused problems. However this had been recognised by the registered manager and senior management and as a result a deputy manager had been appointed and the number of coordinators in the senior team had been increased from three to five. There was also a plan to increase the field supervisors from three to four or five and the registered manager had a budget meeting to confirm this in the week following the inspection. The changes had allowed the registered manager to spend more time with the trainer and field supervisors to address some of the shortfalls. The registered manager also planned to introduce a key worker scheme. Staff felt the service was "generally" well-led. One staff member said, "Things do not always run smoothly, but they try their best".

Senior management received reports from the registered manager regarding accidents, incidents, assessments, spot checks, care plan reviews, recruitment, training, supervisions, team meetings and appraisals. The manager undertook quarterly visits to the service to carry out audits on files and their contents. A report was then produced based on a traffic light system, when the service had not reached green, action was required and an action plan put together, which was monitored until the next audit. We saw that some shortfalls identified within our inspection had already been picked up and were being addressed.

The service were members of the Kent Community Care Association, Contractors Health & Safety Scheme (CHAS), Recruitment and Employment Confederation (REC), National Skills Academy Social Care and Social Care Commitment in Kent. These memberships, the internet 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.

The provider's philosophy and vision were included in the service user guide and staff handbook. Staff were aware of the aims and objectives of the service through team meetings and training. They told us the service promoted person centred care, independence, privacy, dignity and respect.

Staff felt the service always listened to their opinions. In team meetings staff were asked if they had any issues or concerns. Minutes of a meeting held in January 2015 confirmed they did not. Recent survey comments showed staff were concerned about the induction training, in particular watching a DVD, these had been passed to the trainer and the registered manager had allocated time to spend resolve this with the trainer. A new company had been sourced as staff were concerned about the length of time it had taken to complete their Diploma in Health and Social Care. This showed the service listened to staff and valued their opinions.

Staff said they understood their role and responsibilities and felt they were well supported. There were systems in place to monitor that staff received up to date training, had

Good

Is the service well-led?

regular team meetings, spot checks, supervision meetings and appraisals, when they could raise any concerns and were kept informed about the service, people's changing needs and any risks or concerns.

People and/or their relatives completed quality assurance questionnaires to give feedback about the services provided. During January 2015 105 people responded to surveys sent out by the provider. A high majority of those showed people were satisfied with the service received. An overview of positive and negative comments including what action the service was taking had been fed back to people. The registered manager told us they used any negative feedback to drive improvements required to the service. One of the areas identified for improvement by people was communication with the office staff. The registered manager felt that the appointment of the deputy manager who had a full time presence in the office had started to address this. During the inspection all comments about the office staff and their conduct were positive. Another area was the information or lack of within schedules people received about who would be undertaking their visits for the coming week. The registered manager had changed the day they were sent out in order for them to be completed fully before they were sent out.

Staff had access to policies and procedures via the office or their staff handbook. These were reviewed and kept up to date. Records were stored securely and there were minutes of meetings held so that staff would be aware of up to date issues within the 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 failed to properly assess the risks to people and mitigate such risks. There was insufficient guidance in risk assessments to ensure the welfare and safety of service users. The provider did not have proper and safe arrangements for recording and handling, safe keeping and safe administration of medicines used for the purposes of the regulated activity. Regulation 12(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. The level of detail in care plans did not fully protect people against the risk of receiving inappropriate or unsafe care and support. Regulation 9(2)(b)