Care at Home Services (South East) Limited

Care at Home Services (South East) Ltd - Herne Bay

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 23 and 24 October 2016 and was announced.

Care at Home Services provides care and support to a wide range of people including, older people, people living with dementia, and people with physical disabilities. The support hours varied from 24 hours a day, to a half hour call and from one to four calls a day, with some people requiring two members of staff at each call. At the time of the inspection over 200 people were receiving care and support from the service.

The service is run by a registered manager, who was present on the day of the inspection visit, together with the training and development manager. The operations director was also present on the second day of the inspection. 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 and associated Regulations about how the service is run.

At the previous announced inspection of this service on 28 and 29 September 2015, three requirement notices was served due to breaches of regulations. The provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated. Medicines were not being administered safely and people were not receiving personalised care. In addition, the systems in place to monitor the quality of the service were not effective. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches. The provider sent us an action plan. We undertook this inspection to check that they had followed their plan and to confirm they now met legal requirements. At the time of this inspection some improvements had been made, however, the provider had not taken appropriate action with regard to these issues and the breaches of regulations continued.

There was still insufficient guidance for staff to follow to show how some risks were mitigated especially when moving people. Some people needed support to wash and bath. Risks to them and staff had not been assessed. Measures were not always in place to mitigate risks when supporting people with their epilepsy and diabetes. This had been identified in the previous inspection in September 2015 and remained an ongoing shortfall.

The systems to ensure people received their medicines safely had been reviewed; however, there were still shortfalls in medicines administration and recording. People were not always receiving medicines at the appropriate time as instructed by health care professionals. This had been identified in the previous inspection in September 2015 and remained an ongoing shortfall.

People and relatives told us they were involved in the assessment and planning of their care and support. However, in some care plans there was a lack of information about people's skills in relation to different tasks and what help they required from staff, to ensure their independence was maintained. Although some improvements had been made to address these shortfalls some care plans did not include this information.

Although generic information had been added to care plans with regard to people's medical conditions, the plans were not individual to people's specific needs relating to their epilepsy and diabetes. People's care plans did not always contain the guidance that staff needed to ensure that people were receiving the care they needed. Health care professionals, like community nurses and doctors, were contacted if there were any health concerns.

People were supported by staff to make their own decisions and mental capacity assessment forms were in place. However, the information in the assessments was not consistent and at times were contradictory saying that people had capacity when they actually needed support to make decisions.

Audits were carried out to monitor the quality of the service, and these had improved since the previous inspection, however, the audits in place were not effective as the shortfalls in this report had not been identified. This had been identified in the previous inspection in September 2015 and remained an ongoing shortfall.

People had opportunities to provide feedback about the service provided. Quality assurance questionnaires were sent out annually by staff at the head office. The results had been summarised but at the time of the inspection people had not been informed of the outcome. However, feedback had not been sought from a wide range of stakeholders such as staff, visiting professionals and professional bodies, to ensure continuous improvement of the service was based on everyone's views. This had been identified in the previous inspection in September 2015 and no action had been taken to address this issue.

Records were stored safely and some improvements had been made although care plans and risk assessments lacked detailed to ensure people received safe consistent care. This had been identified in the previous inspection in September 2015 and remained an ongoing shortfall.

Staff had received training in how to keep people safe. They were aware of the safeguarding procedures and reported any concerns to the registered manager. Accidents and incidents were reported, investigated and necessary action taken to reduce the risk of further occurrences. Plans were in place to ensure the service would remain running in the event of an emergency. There was also an on-call system outside of office hours for additional support for people and staff should they need it.

The office co-ordinators planned staff schedules to ensure that people received care from regular staff. Staff had permanent rotas and also covered for other staff in times of sickness and annual leave. Ongoing recruitment ensured that there was enough staff employed and all of the calls were covered. There had been no missed calls at the time of the inspection.

Safe staff recruitment processes were followed to ensure that staff were of good character and had the required knowledge and skills to support people. New staff received a three day induction training session, which included shadowing experienced staff. Staff had a range of training specific to their role, but there was a lack of specialised training being provided, such as diabetes and epilepsy awareness training.

Senior staff carried out unannounced checks on staff to monitor that they had the skills and competencies to perform their role. Staff told us they felt supported and attended one to one meetings with their manager to discuss their practice, however not all appraisals were up to date to ensure that staff had discussed their training and development needs for the future.

Staff supported people with their health care needs when required. People told us that staff noticed when they may need to call the doctor or community nurse. Most people required minimal support with their

dietary needs. Staff encouraged people to eat and drink during their calls and when required, left drinks and snacks out for them to have later.

People told us that the staff treated them with respect and their privacy and dignity was maintained. People we visited told us the staff were polite, caring and kind. People told us they looked forward to the staff coming and they always asked if there was anything else they needed before they left.

Information on how to make a complaint was part of the care folder in each person's home. People we visited were confident to complain if necessary but did not have any concerns.

People told us that communication with the office was good. Staff told us that they were fully supported by the management team and were clear about their roles and responsibilities. They said they felt confident to approach senior staff if they needed advice or guidance.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe.

Risks to people's health and welfare had been assessed but there was a lack of sufficient guidance to show staff how to manage risks safely.

People's medicines were not always managed safely.

Staff knew how to keep people safe, when there was an emergency or if people were at risk of abuse.

People were being supported by sufficient numbers of staff and staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received Mental Capacity Act and Deprivation of Liberty Safeguards training but there was a lack of understanding of how this was applied to people's care.

People received support from trained staff.. However, some people were living with diabetes and epilepsy and staff had not received training in these conditions. Not all staff had an appraisal.

People's support was delivered by regular staff, who were familiar with people's preferred routines.

People had access to health care professionals when needed.

People were supported with their meals and encouraged to eat a healthy diet.

Is the service caring?

Good

The service was caring

People were offered choices and were encouraged to remain as independent as possible.

People and relatives told us that the staff were kind and caring. People told us they looked forward to the staff coming and they cheered them up.

People and their relatives told us that the staff encouraged and supported them to maintain and develop their independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans varied in detail, some parts were person centred whilst others did not always reflect people's full personal care routines or their wishes and preferences. The care plans were not consistently reviewed to make sure staff were aware of people's current needs.

People were supported to give feedback about the care they received. They said communication with the office was good and staff responded to their requests if their call times needed to be changed.

People and their relatives said they were confident to raise any complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a lack of leadership, oversight and scrutiny of the service and the provider had not ensured that the requirement notices from the previous inspection had been complied with.

Although the systems in place to audit and monitor the quality of service had improved, they were not always effective as they did not identify the shortfalls in this report.

Records were not suitably detailed with guidance for staff to fully meet people's needs.

People had opportunities to provide feedback about the service they received; however staff and other relevant bodies had not been included.

Care at Home Services (South East) Ltd - Herne Bay

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 24 and 25 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure we were able to speak with people who use the service and the staff who support them. We went to the service's main office and, and we visited and talked with five people in their own homes.

Two inspectors and an expert-by-experience, with a background of older people and domiciliary care, completed the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

A Provider Information Return (PIR) was submitted by the service before the inspection. 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. We looked at previous inspection reports and notifications we had received. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with 14 people who were using the service, nine of which were telephoned by the expert by experience, five of which we visited in their own homes, and two relatives. We spoke with the registered manager, operations director, the training and development manager, and six members of staff. We reviewed people's records and a variety of documents. Five care plans were looked at in people's own homes and eight care plans were looked at in the service's office. We looked at four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality

assurance surveys.

After the inspection we contacted four health care professionals for feedback about the service and no responses were received.

The previous inspection of this service was carried out in September 2015 when four breaches of the regulations were found.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe receiving care in their homes and they trusted the staff. They said, "I have used the service for over a year, they come in the morning, give me a shower, I feel safe". "Safe, absolutely, yes. The staff use the hoist, but it depends how I feel on the day about bathing". "Yes I do feel safe; I have an alarm on my wrist". "I feel safe when the carers are moving me in the hoist from the bed to the chair". "I have no qualms about the staff, so I feel safe" "I feel safe with the carers, I trust them".

At our last inspection in September 2015 the provider had not ensured that care and treatment was provided in a safe way for people as sufficient guidance was not in place for staff to follow to show how risks to people were mitigated. The provider sent us an action plan telling us how they were going to improve. At this inspection some improvements had been made but there were still shortfalls in managing risks to make sure people were as safe as possible.

Risks relating to people's care and support had not always been adequately assessed. Some people were living with potentially unstable health conditions such as diabetes. The risks associated with this condition, such as people's blood sugar levels becoming too high or too low, causing them to become unwell, had not been assessed. There was also a lack of guidance for staff to follow about what to do if people's sugar levels were too high or too low.

Some people had personalised information about what to do if their blood sugar levels become too low, such as giving them chocolate. However, other people had inaccurate or no information in their care plan for staff to follow. One person told us that they struggled to keep their blood sugar level at a normal level. Their care plan said, '[The person] has type one diabetes and is insulin dependent. If [the person] goes into a hyper or hypo give them sugar and ensure they have taken their insulin.' A 'hyper' means that someone's blood sugar levels are too high, which could cause someone to become unwell. Giving someone more sugar when their sugar levels are already high could cause their sugar levels to rise further, making them more unwell.

Risks relating to people living with epilepsy had been assessed but there was a lack of measures in place to ensure that people were receiving the care they needed. Some people had seizures and although there was some information for staff about what their seizures may look like, such as, '[the person] may clutch onto their chair and become very stiff in posture' there was a lack of information on what may trigger a seizure and what staff should do if a person had a seizure whilst they were there.

Each person had a risk assessment relating to pressure area care in their care plan. However, these had not always been accurately completed. One person was assessed as having no risk of developing pressure areas. However, their daily notes documented that they had consistently developed sore areas on three areas of their body. There was no guidance in place for staff about what action to take if this person's skin became sore.

People at risk of falling had a falls risk assessments in place, which had scores indicating the level of risk

such as moderate or high. However, there were no further guidance in place to show what measures needed to be taken to reduce the risk of people falling, such as making sure floors were clear and removing obstacles that might increase the risk of falls.

Assessments to support people with their mobility varied in detail. In some cases there were clear guidelines to guide staff how to move people safely. In other plans the assessments did not always have the full guidance for staff to follow. One person was supported to bath and the care plan noted that they were unable to step into the bath and there was no equipment involved, however further in the care plan it stated that a bath cushion was used. There was no risk assessment in place to guide staff how to support this person to get in and out of the bath safely.

Care and treatment was not provided in a safe way for people. The provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated. This was an continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems in place to ensure that people received their medicines safely were not robust to ensure that people received their medicines as per the prescriber's instructions. People did not always get their medicines at the time they needed them. One person had medicine for their epilepsy which needed to be given at the same time each day. The person's epilepsy nurse had written to the service telling staff the medication must be administered at specific times in the morning and evening, as 'their epilepsy medication needed to be at a certain level in his blood stream in order to stop seizures from happening. Seizures can lead to physical injury and ultimately seizures can be fatal.' Records showed that this person had not received their medicine at the correct time. Staff were arriving up to two and half hours early in the evening and up to an hour and a half late in the morning to administer the medicine.

Details about what individual medicines people were prescribed were not always recorded on the medicine record sheet. Some people had sealed 'dossett' boxes containing their medicines issued from the pharmacy. The contents of the box had not been recorded on the medicine records to show what medicine and dosage was being given. This was not in line with current guidance or in line with the provider's medicine policies and procedures.

Some people needed medicines on a 'when required' basis, like medicines for pain. There was no guidance or direction for staff on when to give people these medicines safely.

This is a continued breach of this regulation. There was a risk of people not receiving their medicines as prescribed. The provider had failed to ensure that people were receiving their medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had received medicine training and were able to tell us about medicine procedures. They said they were confident in giving people their medicines safely. They said, "We look at what the medicine is and give it to people in a pot. Sometimes people need you to give it to them one at a time. If that's the case then I always wear gloves. I always make sure people have a glass of water." "We write medicine on the medicine record sheet sometimes."

People told us they felt safe using the service. Staff knew how to recognise and report different types of abuse. They had received safeguarding training and information about abuse. The Kent and Medway safeguarding protocols were available in the office for all staff to refer to if needed. Staff told us they would report any concerns to their managers, and were confident it would be dealt with appropriately. One member of staff told us, "I could go to a social worker or the safeguarding team if I felt it wasn't being dealt

with though." The registered manager had made referrals to the local safeguarding team and these had been investigated and dealt with appropriately. Staff understood the whistle blowing policy and told us they would not hesitate to report any concerns or witness any bad practice. They were confident that the registered manager would take the appropriate action.

The provider had a business continuity plan to make sure they could respond to emergency situations such as adverse weather conditions, staff unavailability and a fire or flood. The plan outlined how to cover each situation so there would be minimum disruption to the care and support people received. The office staff and registered manager covered the 'on call' system to ensure that people and staff had support in an emergency outside of office hours.

There was sufficient staff to ensure that people received their allocated calls. People told us that when staff were not available to cover calls the co-ordinators and the managers would cover the calls. They told us that they had not experienced any missed calls and sometimes the staff may be late but they always received a phone call to let them know. People said the office staff were flexible with times of the calls and when they needed extra calls. They said, "The service is flexible when we need extra calls when my relative is away", "They can only do their best which they do".

Four office co-ordinators were responsible for organising the schedules for the staff. They told us that, as much as possible, people's calls were geographically placed to reduce travel time. However, one person told us that this was not always the case as some of the rotas showed that staff had minimal time to get from one place to another. Staff told us that the travel time was fixed on the computer system and five minutes travel time was added automatically. People and staff said this was insufficient to ensure staff were able to arrive on time. Staff said, "The times getting from A to B could be improved. I'm a walker and they expect me to get to locations which are far apart and then back again, that is just not possible." "It's never enough time as you don't know what you're going to come across. Some of my patch is quite rural so of course it will take you a while to get between people."

There were mixed comments from people and their relatives about how effective the service was delivered. Some people said the continuity of staff, their timings and duration of calls were good whilst others had experienced some issues.

People and their relatives told us that communication with the office staff was good; they said that the office staff would call them back if they needed to. They said, "The service has been very good, they organise the staff well, it is never a problem to ask for something". "The staff in the office will re-arrange the times of the calls if we have hospital appointment and I need an early call, they are flexible to our needs".

People told us that on the whole staff came on time and stayed the duration of the call unless they had finished and the people said they could leave. They told us that they could request the staff rota in advance to see what staff were covering their calls, especially in times of sickness or annual leave.

People said, "My regular carer is spot on comes at 7am". "Mostly staff arrive on time and let me know if they are going to be late". "Always on time, always let me know (if going to be late)".. "Always on time, two carers do let me know if they are going to be late". "Regular carers ring to say if they'll be late I like that. Not all staff do this, it is not consistent when they are short staffed".

"When my carer is on holiday and I get different ones every day. One time a carer didn't come, I rang the office they got me someone eventually" "When they are short staffed you have to ring them as you think they are coming at a certain time but they are late and say they will be with you at 9.30am and that's too late for

my relative to get up and dressed, it's a struggle. They are supposed to be here for an hour but sometime only here for half an hour in the mornings and 45 minutes in the evening".
"They don't often stay their full call time, but that's because we're finished. They ask if there is anything else they can do, and I say no," "I get different ones but I'm ok with that. Haven't had to stop anyone coming".

"I've never been missed completely, the office ring or I'll ring them". "It would be good if the office could ring and tell them if staff were late as sometimes this did not always happen". "There are times when the staff are late, but I understand that things happen."

The service was aware of some of these issues as the quality assurance survey had identified some of these comments. The operations director was in the process of sending the people a letter to advise them of the actions to be taken to address the issues and improve the service. The service was reviewing the rotas to improve the travel time by geographically placing calls and recruiting additional staff to improve the continuity of care.

Recruitment procedures were thorough to make sure that staff were suitable to work with people. Written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with the people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Accidents and incidents involving people were recorded. The accidents and incidents were reviewed by the management team to look for patterns and trends so that the care people received could be changed or advice sought to keep them safe.

Some people had equipment in place to aid their mobility. They said, "I get my equipment serviced to make sure it is safe". "The ceiling hoist is serviced regularly." "I have a hoist, they checked it the other day it was fine, and I have the number to phone if it breaks". Staff told us that they checked the equipment before they used it to make sure it was safe. There was a system in place to ensure the equipment was serviced according to manufacturer's guidelines, however, this information was not recorded in the office to confirm the equipment was safe to use. This was an area for improvement.

Requires Improvement

Is the service effective?

Our findings

People told us they were satisfied with the care and support they received. They told us that the staff looked after them well and supported them with their health care needs. They said, "The staff go in the ambulance to support me with my hospital appointments". "If I'm not well they phone the doctor for me." "Staff are good at noticing when I am not well". "All the carers have good people skills, they tell my relative if they think I'm unwell". A relative commented, "One member of staff mentioned a health issue which resulted in my relative attending hospital and having treatment".

People told us that staff asked for their consent before carrying out any tasks and when able people had signed their care plans to show they agreed with the support they received. One person said, "I make my own decisions about my care".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. When people live in their own homes Deprivation of Liberty Safeguards (DoLS) must be applied for via the Court of Protection. We checked whether the service was working within the principles of the MCA.

People's capacity had not always been accurately assessed. Some people had capacity assessments in place that said they lacked capacity. These were generic and did outline why the capacity assessment had been completed, or what decision the person lacked the capacity to make. One person's relative told us that their loved one refused to speak to staff they did not like, indicating they were able to make a choice regarding this, yet they had been assessed as having no capacity.

Another person had made an advanced decision that they did not wish to be resuscitated. There was a copy of this document on file in the office. The registered manager told us the original document was in the person's file at their home and this was a high quality colour copy of the original. An original 'do not resuscitate document' clearly states 'do not copy' to reduce the risk of the wrong document being in place. Health care professionals, including ambulance staff, can only act on the original documents; therefore the service needs to implement clear guidelines of how they record this information in line with current practice.

The provider had failed to ensure that people's capacity was assessed in line with the Mental Capacity Act 2005. This is in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not made any applications to the Court of Protection, as people's liberty was

not restricted. Staff had received Mental Capacity Act training and were aware of the importance to support people to make decisions. They said, "People have to be assessed if they have capacity. The care manager, family members and us [carers] could be involved." "I know one of our clients has a 'do not resuscitate' form in place." "Clients know us which helps, you explain things to them. They might give you a yes or no answer; if they refuse our help then we call the office. We can't make them do anything, but we do explain why we want to help."

There was a lack of guidance in some people's care plans around their health care needs. Some people needed support with their catheter care. A catheter is a tube that it is inserted into the bladder so that urine can drain freely. There was no guidance in the care plan to support staff about how to empty the bag and clean the area. There was nothing in the care plan to show staff how this should be done safely to reduce the risk of infection. There was no guidance for staff about what to look for that might indicate an infection.

Staff contacted the appropriate health care professionals when people needed additional support. Occupational therapists had also been contacted when people's mobility had changed and they needed to be re-assessed.

People told us the staff were well trained and knew what they were doing. They were aware that new staff had a three day training session before they started work and ongoing training was provided. People said, "The carers are good, they have pretty good training". "The staff seem to know what they are doing, they are well trained". One relative commented, The staff know my relatives' needs they are well trained". Staff told us that there was an ongoing training programme to ensure their skills and competencies were updated.

The provider had appointed a training and development manager to review the training. As a result, new staff underwent three days of induction training sessions, linked to the Care Certificate, a nationally agreed set of care standards which must be met to ensure safe and effective care is delivered. The staff records showed this process was structured and allowed staff to familiarise themselves with the policies, protocols and working practices. All of the required basic training was covered. In addition there were sessions on dementia awareness, pressure area care, and an overview of medical conditions such as diabetes and epilepsy. New staff shadowed more experienced staff and were given an opportunity to get to know people. Staff told us they were supported well during their induction training. One staff member said, "I went out with [staff member] and learnt how to use the hoist." There were systems in place to ensure that new staff were monitored and observed by senior staff before they were signed off as being competent.

Some staff had completed vocational qualifications in health and social care or were in the process of being registered to complete the award. These are work based awards that are achieved through assessment and training. To achieve vocational qualifications candidates must prove that they have the competence to carry out their job to the required standard.

Staff had regular one to one meetings with the management team to discuss any issues that had arisen and any development needs. Staff received regular, unannounced 'spot checks' from their manager when they were providing care in people's homes. Two staff members told us, "There are 'spot checks', we have just had ours!" During the 'spot checks' staff were questioned on their level of knowledge of the people they were caring for and the rationale for the care they were providing. This was to make sure staff were providing the care and support that people needed. Staff were also assessed on their appearance and communication skills and were given feedback about their performance.

The programme to ensure that staff received an annual appraisal to discuss their training and development needs was not up to date. The registered manager said that these would be scheduled in over the next few

months. This was an area of improvement.

People's needs in relation to support with eating and drinking had been assessed and were recorded. Most people required minimal support with their meals and drinks, or were assisted with this by family members. One person said, "My relative makes sure I have plenty of food in, I do my own food and the carers do what I ask of them".

When people did receive support, their preferences about what they liked to eat and drink were clearly outlined in their care plans. One person's care plan told staff to help them make 'two slices of toast with peanut butter' and another person's care plan said they liked their coffee 'black, two thirds hot water, one third cold water.' People told us that staff left drinks or snacks out for them if they needed to eat later.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were kind and caring. They said, "I can't fault the staff, they are very good". "The staff are all brilliant". "The carers are kind and caring and make me laugh". "The carers are good listeners and they do what I want. I'm looked after well". "I can talk to my carers about anything I've got a cheerful one". "The staff are gentle, I feel so well cared for". "I was in hospital a few weeks ago they phoned and visited me. Like a friend and family. They do whatever I ask them". "The younger members of staff are as good as gold. They do my washing and housework". "The carers do everything I want them to do".

Relatives said, "The staff are very caring, they make sure that my relative has the right support. These are reasons why we stay with the service. The staff make my relative smile, they are very aware of her needs. The care is about her and what she needs and they [the staff] are very good with confidentiality". "There are three members of staff who are special people to my relative. They are superb, they can polish their halo. It makes things better for me because my relative is happy."

Each person's care plan had a background about their lives so that staff could chat about things that were important to them. People told us the staff understood their daily routines, choices and preferences, such as what they preferred to be called and how they liked to receive their personal care. They said, "The staff are good and attentive and know what I need". "My carers are 'on the ball' they know all about me". "The care is about me and my needs". A relative said, "The staff are very pleasant, they know my relative likes music and they sign along with them". "The staff are very polite and encourage my relative, they cheer them up and dance along the hallway".

People said they were involved in planning their care and were able to make their own decisions. They told us they had been consulted to agree with their care plan and if they would prefer a male or female member of staff. One person said, I was asked if I preferred care from a male or female member of staff so I was able to make the choice". Another person said, "Once I had a male carer he was very nice, couldn't fault him but I preferred a lady so they changed it for me".

People and relatives told us that the staff maintained their privacy and dignity. Staff talked about people in a respectful and caring way. Dignity training was part of the induction training for all staff and staff gave us examples of how they supported people to receive their personal care in private, such as closing doors and curtains.

People said, "The staff know what I need, I have been with them for a long time. They are all good. I can undress myself so they go into another room to respect my privacy. I'm looked after well". "The staff always knock when I am in the bath". "The carers are understanding". "They treat me with dignity and respect and keep me covered when giving me personal care". "Some staff are more caring than others, they respect my privacy and dignity". "If I've got company and I need to use the commode the carers take me into another room".

Relatives said, when staff supported their relative to wash, they always covered the half they were not washing to maintain their dignity. They talked them through the tasks, saying, "Is it ok, is that ok if we need to do this. We're going to lift the bed now". They said "They're superb couldn't praise them enough".

People were encouraged to remain as independent as they could. Staff gave examples of how they encouraged people to help with their personal care or supporting people to dress. People said, "They encourage me to do things for myself". A relative said, "They prompt my relative to do things for themselves and encourage him to be independent as possible, even if it is just to hold a towel or flannel".

Staff understood the importance of keeping people's confidentially and how not to discuss any private information in front of other people. One person said, "The staff never gossip, I can hear them. We all get on, they discuss any important decisions with my family as they have power of attorney to support me with my decisions."

Staff told us that most people did not require support to help them make decisions about their care, and those who did were supported by their relatives. No one at the time of the inspection was being supported by an advocate. (An advocate helps people to make informed choices).

Requires Improvement

Is the service responsive?

Our findings

People said the service was responsive to their needs, and people felt confident that the staff listened and acted on what they said. People said, "I am confident that if I talk to staff and ask them to do something they will do it". "I've had a couple of visits to check everything's in order- a review. I can speak to the office, they're approachable".

Staff told us they tried to be responsive to people's needs, they said, "We will report anything straight away to the office and then [the registered manager] tells us what to do." "If I have any problems then I'll ring the office. If there has been an accident or if someone has passed away for example I will write it in the book and inform the office so the next person will know what I have done." "I always ask if there is anything else you need me to do. One person I go into, their relative had an accident and I helped them. You have to think on your feet and help people where you can."

People had their needs assessed before they started using the service. The initial assessment of people's care needs was usually completed by the registered manager or co-ordinators from the office. People told us they were involved in the assessment process and in planning their care. They said, "When I started a lady and gentleman came to assess me". "I am included in all assessments. They involve me with everything". "I know about my care plan and have signed to agree with the care".

At our last inspection in September 2015 the provider had not ensured that care and treatment people received was person centred and that treatment that appropriate, met their needs and reflected their personal preferences. The provider sent us an action plan telling us how they were going to improve. At this inspection some improvements had been made but there were still shortfalls in some care plans as they did not contain step by step guidance to support people on each visit, including their preferences, what they could do for themselves and what support they required from staff.

In some cases the care plans had been personalised such as what clothing people liked to wear, how people liked their porridge, and tea, and how they used their walking aids, but others lacked detail. One plan stated that the person was reliant on care staff to perform all tasks such as personal care, preparing food and drinks, but there was no further information on what the person may be able to do for themselves or about their daily routines.

Care plans were not always clear to ensure staff had the right guidance to make sure people received the care they needed. One person living with epilepsy had some information from their placing authority in their care plan that said 'offer them something to eat and drink after a seizure as they may be experiencing low blood sugar or low blood pressure or both'. This information had not been included in the person's risk assessment or care plan to show that these instructions were being carried out and the person was receiving the care they needed.

Another person was living with diabetes and was supported with their insulin medicine from the community nurse. The care plan stated that the nurse called every morning to do this, however the plan also said that,

at times, the person may still be in bed and would need to be supported to get out of bed. The plan stated that "at times, when I am not downstairs, I would like the carer to come upstairs and wake me". There was no further information in the care plan to confirm if the person had their insulin before or after their breakfast to maintain their sugar levels.

People's medical conditions were recorded in their care plans but there was no other guidance for staff to follow to show how they were being supported. For example, one person's care plan stated that they had autism but there was no further information to say how staff should support this person with this condition. This person was also living with depression and anxiety but there were no specific care plans of how they were being supported to manage these conditions. Another person was living with dementia. Their care plan did not contain sufficient detail to ensure they received the care and support they needed. This person became anxious at times and there was no specific plan in place to support them with their anxiety or about how staff should manage their dementia.

Care plans had been reviewed but some did not always accurately represent people's needs or tell staff how to support them effectively. One person's care plan had not been reviewed since June 2015. Staff told us the person now remained in bed, however their care plan said they were able to move around their flat using mobility aids. We met one person who required assistance to communicate verbally. Their relative told us they usually communicated by saying yes or no, and sometimes became confused due to their dementia. Their care plan said they were able to hold a clear conversation with staff.

People told us that the staff supported them to maintain healthy skin by applying creams to reduce the risk of developing pressure areas. The risk of developing pressure areas had been risk assessed but there was no plan to show staff how to manage people's pressure areas to minimise the risk of further outbreaks. The care plans did not contain information to inform staff on how to give care to people whose skin may be at risk of breaking down. There was no information about what signs to look for in case sores were developing and what action they should take, like contacting the doctor or community nurse. There was no information about how people should be positioned or what equipment may be needed to prevent their skin from deteriorating further. When people did have pressure sores, they were receiving support from the local community nurses.

The registered manager told us that a new care plan about skin health was in the process of being implemented and pressure care training had been added to the induction training programme.

The provider has failed to make sure that people received person centred care and treatment that was appropriate, met their needs and reflected their personal preferences. This was an continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they looked forward to visits from the staff. They said, "I really like my carers, they are a good laugh, I look forward to them coming. I enjoy their company". "My regular carer tries to cheer me up, we discuss things, and as a rule they are very helpful, we are on the same wave length and have a banter". A relative said, "The staff discuss things with me about my relative's care. It's a life line, it means I can nip out to the shops and do a few jobs. People were contacted by the service regularly by telephone and some people had received surveys to ask for their opinion and feedback about the service. They said they were also asked for their views at their care plan reviews.

The service had a complaints policy which staff were aware of and knew the process for. People and their relatives told us they would contact the office if they had any concerns. They said, "The staff are really good,

I have no complaints at all".

Two people told us that they had complained about certain members of staff, there were two staff whose first language was not English and they were speaking in front of the person in their own language. The registered manager took appropriate action and replaced the staff. Another person told us that they complained as a member of staff was not wearing their gloves, they said, "If you complain they sort it out straight away". Each person's care plan contained information about who to contact if there were any issues.

Complaints were logged and responded to. The registered manager or the training and development manager investigated any issues that were raised. There was no process in place for analysing complaints and identifying whether themes and trends were emerging.

We recommend that the provider reviews the practice of recording and monitoring all complaints.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us that they were satisfied with the care being provided. They said, "I am satisfied with the service, it has improved". "Overall I am satisfied with the service". "I would recommend the service". "I am 100% happy and satisfied with the service".

Staff told us that they felt supported by the management team and thought the office was well run. They said, "I don't have any problems raising things as they are a friendly bunch. I don't have any issues with the management team at all."

The service was currently being run by a registered manager (who is also the registered manager for the organisation's location in Broadstairs) and four co-ordinators. The registered manager was based in the office and routinely covered direct care calls twice a week in the community as part of their duties.

At our last inspection in September 2015 the provider had not ensured that the procedures in place to assess, monitor and drive improvement in the quality and safety of people were effective. People were not protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records. The provider sent us an action plan telling us how they were going to improve. The provider's timescale for completing their action plan was February 2016, which had not been met. At this inspection some improvements had been made but the audits to monitor the quality of the service had failed to identify the shortfalls noted in this report. Although record keeping had improved there were still areas that needed further improvement including the lack of detail in care plans and risk assessments to give staff the guidance they needed to meet people's needs safely.

The continued breaches in the regulations indicates there was a lack of leadership, oversight and scrutiny of the service to make sure that effective planning and improvements were made to become fully compliant with the regulations.

Staff had completed audits of the care plans and medicines records but these were not effective. For example, medicine administration records (MARs), people's daily notes and call logs had been checked and signed off by the registered manager. However, the audits had not identified that one person was not getting their medicine at the time required or that some staff were writing 'dossett box' instead of writing out individual medicines. There were no further checks to ensure that the actions to address the shortfalls had taken place to ensure continuous improvement of the service.

People told us that they had been asked about the quality of the service. Some people said this was carried out when their care was reviewed and others said they had received a survey or telephone call from the office. A survey was sent to people annually, directly from the head office. The outcomes had been summarised and the operations director was in the process of sending a letter to people explaining what improvements were to be made. These included improving the continuity of care by reviewing staff rotas and staff reading the care plans. Overall the outcome of the survey was positive with over 96% of people saying that the staff treated them with privacy and dignity and they felt safe using the service.

Although feedback had been requested and received from some people, the provider had not actively encouraged feedback about the quality of care from a wide range of stakeholders, such as staff, visiting professionals and professional bodies to ensure continuous improvement of the service.

Staff meetings were held to give staff an opportunity to raise any issues with the service. Staff were able to contribute to the meeting and to make suggestions of importance to them. However, the minutes did not contain a review of the minutes of the previous meeting. In addition, the minutes did not contain a plan to decide what action would be taken as a result of the issues raised, by when and by whom. Therefore, it was not possible to judge the effectiveness of staff meetings or to know if staff's concerns or requests had been dealt with. This was noted as an area for improvement at the previous inspection and remained outstanding at this inspection.

Records were not always completed with the full details needed to ensure people received the right care and support. The care plans lacked detail of personalised care, including how to manage and reduce the risks to ensure people received safe care. Although there was generalised information about people's medical conditions, guidance was still not in place to show staff what to do in case of deterioration in people's health and when to seek medical advice.

The systems and procedures in place in order to assess, monitor and drive improvement in the quality and safety of people were not effective. The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records. The provider had failed to seek feedback about the quality of care from a wide range of stakeholders, such as staff, visiting professionals and professional bodies to ensure continuous improvement of the service. This was a continued of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The senior management team met each quarter to discuss best practice and implement any changes to the service. In addition the service had to submit quarterly returns to the local authority to enable them to measure the quality of service provided.

Staff said they understood their role and responsibilities. There were systems in place to monitor that staff received up to date training, spot checks, and supervision meetings. This gave staff the opportunity to raise any concerns and be kept informed about the service.

Staff talked about the visions and values of the organisation. They said they treated people with respect and dignity and ensured they received the care they needed. They said, "When I leave them I know I have done a good job and I look forward to going in and seeing people the next day". "We aim to be the best, treat people equally, and provide good consistent care". They told us that they worked hard as a team to ensure people received personalised care and said they would recommend the service to a family member if they needed support.

The managers attended conferences to improve their practice, and regularly met with the local authority to share good practice and were members of the Kent Community Care Association. The service was also a member of the local chamber of commerce and had been involved in participating in events to support the local community.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. This meant we could check that appropriate action had been taken. We had received notifications from the service in the last 12 months to advise us of events that affected people in the community.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider has failed to do to make sure that people received person centred care and treatment that was appropriate, meet their needs and reflected their personal preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that people's capacity was assessed in line with the Mental Capacity Act 2005.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people because the provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated. There was a risk of people not receiving their medicines as prescribed. The provider had failed to ensure that people were receiving their medicines safely.

The enforcement action we took:

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Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to ensure that suitable systems and procedures were in place in order to assess, monitor and drive improvement in the quality and safety of people. The provider has failed to mitigate risks relating to health, safety and welfare of service users. The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records.

The enforcement action we took:

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