Superior Care Limited

Superior Care Whitstable

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 3, 4 and 5 October 2016, and was an announced inspection. The provider was given 48 hours' notice of the inspection. The last inspection on 14 October 2013 inspected the area of medicines management, which found no breach in legislation. The inspection prior to that on 9 July 2013 also found no breaches.

Superior Care Whitstable provides care and support to people in their own homes. The service is provided mainly to younger adults and children. At the time of the inspection there were approximately 49 people receiving support with their personal care and one person was receiving nursing care. The service undertakes to provide care and support to people in Kent and at the time of the inspection this was mainly delivered in Canterbury and Thanet. Since the last inspection the domiciliary care service providing only short visits to mainly older people had transferred to another provider. It now provides staff to cover visits for as little as 1.5 hours although the majority are longer visits/shifts of up to 10 to 12 hours, which could be part of a 24 hour care package. The provider contracts with the Local Health Authority, Clinical Commissioning Groups, Disabled Childrens' Services and people that fund their own care and support including people whose care is managed by a case manager.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager's application was received following the inspection.

People told us they received their medicines when they should and felt their medicines were handled safely. However there were shortfalls in some medicine records and a lack of guidance about some areas of medicine management.

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

People and parents had been involved in the initial assessment and the planning of people's care and support and some people had chosen to involve their relatives as well. Care plans contained detailed information about clinical tasks that were required, but other areas, such as personal care lacked information to aid consistent care and support according to people's wishes. People told us their independence was encouraged wherever possible, but this was not always supported by the care plan.

There were audits and systems in place to monitor that the service ran efficiently. These had been effective in identifying most of the shortfalls highlighted during the inspection, but not all.

People felt safe using the service and when staff were in their homes. The service had safeguarding

procedures in place for both children and adults. Staff demonstrated an understanding of what constituted abuse and how to report any concerns in order to keep people safe.

People had their needs met by sufficient numbers of staff. People received a service from a team of regular staff, who had been trained in complex care tasks to match their needs. New staff underwent an induction programme and then shadowed experienced staff in people's home where they would be working and had their competencies checked.

People or their representatives had signed records to show their consent for the care and support people received in line with their care plan. People were supported to make their own decisions and choices. No one was subject to an order of the Court of Protection although people had made Lasting Power of Attorney arrangements and some people had a Do Not Attempt Resuscitation (DNAR) in place. Some parents made decisions and some other people chose to be supported by family members when making their decisions. The Mental Capacity Act provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff understood this process.

People were supported to maintain good health and they told us how observant staff were in spotting any concerns with their health and taking appropriate action.

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

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

People told us that communication with the office was now good and had improved over the last 18 months, if there were any queries they telephoned and action was taken. Most people felt confident in complaining, but did not have any concerns. People had some opportunities to provide feedback about the service provided. People felt the service was well-led and well organised. There was an open and positive atmosphere in the office and staff were committed to improving the service people received.

The provider's aim for the service was 'excellence in care' and we found this principle was followed through into practice.

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

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 were shortfalls in medicine records and a lack of guidance about some areas of medicine management.

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

People's needs were met by sufficient numbers of staff and these were kept under review.

Is the service effective?

Good

The service was effective.

People's care and support was delivered by staff that had undergone training to specifically match people's needs, to ensure it was effective.

People, parents or representatives were involved in making decisions in relation to people's care and support. Action had been taken to ensure legal arrangements for decision making were recorded.

People received care and support from a regular team of staff.

Is the service caring?

Good

The service was caring.

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

Staff supported people to maintain and develop their independence where possible.

Staff took the time to listen and interact with people and parents so that people received the care and support they needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans reflected well the clinical tasks staff were required to undertake. However in other areas, such as personal they varied in detail and did not reflect the details of people's personal care routines, their wishes and preferences or what they could do for themselves, to ensure consistent care and support.

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

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

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager for the service, which is a legal requirement.

There were audits and systems in place to monitor the quality of care people received. These had identified most of the shortfalls highlighted during the inspection, but not all.

There was an open and positive culture within the service, which was focussed on people. The provider had an aim for the service and staff followed this through into their practice.

Superior Care Whitstable

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, 4 and 5 October 2016 and was announced with 48 hours' notice. The inspection carried out by one inspector.

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. Prior to the inspection we reviewed this and other information we held about the service, we looked at the previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we reviewed people's records and a variety of documents. These included eight people's care plans and risk assessments, three staff recruitment files, staff training, supervision and appraisal records, visit schedules, medicine and quality assurance records.

We spoke with five people who were using the service, who we visited in their own homes, we spoke with three relatives, the chief executive, a director, both lead nurses, senior coordinator and coordinator, recruitment officer, training manager and seven members of staff.

After the inspection we received feedback from one health care professional that had had contact with the service, which was positive.

We sent out 52 surveys to people who were using the service, relatives and professionals involved with the service and 60 surveys to staff. We received survey feedback from 17 people, four relatives, and one professional and 18 staff.

Requires Improvement

Is the service safe?

Our findings

People and parents told us they felt safe when staff were in their homes and when they provided care and support.

People told us they felt they received their medicines when they should and staff handled them safely. However people were not fully protected against the risks associated with medicine management.

There was a clear medicines policy and procedure in place. Staff had received training in the management of medicines and their competency was checked by lead nurses during observations of their practice.

Where people were prescribed medicines on a 'when required' or 'as directed' basis, for example, to manage constipation or pain relief or skin conditions, there was a lack of clear individual guidance for staff on the circumstances in which these medicines were to be used safely, where (for topical medicines) and when they should seek advice on their continued use. For example, people were prescribed different creams/sprays, but there was not always guidance about where or when these should be used. Another person was prescribed a medicine to help with constipation, but there was no guidance about when this should be given and when or if further doses could be administered. This could result in people not receiving the medicine consistently or safely.

People had Medication Administration Records (MAR) charts in place where staff were involved with the administration of people's medicines. Daily reports by staff showed they were using a topical medicine, but this was not listed on the MAR chart. MAR charts examined in some cases showed a lack of codes or signatures so we were unable to ascertain whether people had always received their medicines. In some cases staff told us that a relative might have given the medicines, but there was no code in place for staff to use so that it was clear the medicine had been administered. Some MAR charts had handwritten changes, but these had not been signed or dated so we could ascertain who had made the changes and when.

Risks associated with people's care and support had been identified. For example, risks in relation to people's environment, falls, skin integrity, behaviour, medicines and moving and handling people. People told us that they felt risks associated with their support were managed safely and people said they felt safe when staff used equipment, such as to move them in the hoist. However although staff had received training in moving and handling there was not always sufficient guidance in place to reduce these risks as far as possible and ensure people remained safe. For example, some moving and handling risk assessments did not always detail how the person preferred to be moved or how it should be done safely, such as detailing what hoist sling hooks should be used, so that the person would be moved in the right position, but stated that staff should use 'good moving and handling techniques'. Where people had a catheter in place staff monitored the output of urine including the colour, but assessments did not always detail this and disposing of clinical waste was also not always included in the risk assessments. Where people had diabetes this was recorded, but the signs and symptoms if they were to become unwell due to their diabetes was not always recorded or what action staff should take to ensure people remained healthy.

The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. The provider had failed to have proper and safe management of medicines. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected by safe recruitment procedures. We looked at three recruitment files of staff that had been recruited this year. Recruitment records included the required pre-employment checks to make sure staff were suitable and of good character.

People had their needs met by sufficient numbers of staff. Most people told us that staff arrived when they were expected and stayed the full length of time. One person told us of an incident when a staff member did not arrive on time, but the staff supporting them at the time stayed until another arrived to take over. One relative told us due to sickness the provider had been unable to cover a wake night during the summer. One person said the covering of their care and support at weekends was covered by another provider. Records showed that appropriately trained staff had not been available for one shift over previous three weekends for this person and this had been covered by another provider. The provider told us they worked in partnership with this service on occasions to ensure people received a service from appropriately trained staff. Another person told us things had improved and that "Recently (last 18 months) it has been much better organised and I have never been left without a care worker when I'm expecting one". Most staff felt there was sufficient staff to meet people's needs. People said staff did all the tasks that they required. Previously the provider had recruited staff directly for a person's package of care, but this had now changed so staff worked across more than one package to aid staff availability in times of sickness and leave in order to cover people's care and support. The provider had an ongoing recruitment programme in place and kept the staffing numbers under review. At the time of the inspection staff told us there were ten prospective staff waiting for their recruitment checks and training to be completed.

There was an out of office hour's service covered by an out of hour's team. This operated Monday to Friday 6am to 9am and 5pm to 11pm and at weekends 6am to 11pm. This was supported by the coordinators for their background knowledge about people and their care and support needs.

People told us they felt safe from abuse and harm. There was a clear safeguarding policy in place. Staff had received training in safeguarding adults and children; they were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. There had been a safeguarding alert in the last 12 months and the management team were familiar with the correct process to follow when any abuse was suspected; and knew the local Kent and Medway safeguarding protocols and how to contact the Kent County Council's safeguarding team.

Good

Is the service effective?

Our findings

People, parents and relatives were satisfied with the care and support people received. Comments included, "I am happy, I certainly wouldn't go to another agency. I love them all here". "It's the only agency that always give regular staff and do not complain when I don't want a certain carer".

Care plans contained information about how a person communicated and what support was required to enable good communication, such as 'staff to speak slowly, using short sentences and questions with a yes/no answer and give them time to speak. Thumbs up can indicate yes and a thumbs down no'. Another care plan showed how a person may show they were unwell, such as 'placing their arm over their head for prolonged time'. The care plan advised staff to use signs and gestures to explain things, such as counting down when the television was going off. Staff told us another person used eye coordination with a computer screen to communicate. The provider had also used the services of a translator for review meetings.

People, parents and relatives felt staff had the right skills, training and knowledge to provide care and support that met people's needs. One person said, "They're very good".

People or parents had signed a consent statement 'I can confirm that I have contributed to the paperwork of the following care planning tasks, seen a copy of the finished documents and approved the care planning documentation listed below', as evidence of their consent to receive care and support according to the care plan. People and parents said their consent was also achieved by staff discussing and asking about the tasks they were about to undertake. People said staff offered them choices, such as what to have to eat or drink. In the provider's recent (2016) quality assurance survey everyone agreed that they were able to say how they wanted their care to be provided.

Staff were trained in Mental Capacity Act (MCA) 2005. Staff told us no one was subject to an order of the Court of Protection although 12 people did have Lasting Powers of Attorney arrangements in place and three people had a Do Not Attempt Resuscitation (DNAR) order. The needs assessment tool used to gather information about people captured this information to ensure people's wishes would be followed and staff acted legally. 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. Staff told us about a best interest decision they had been involved in regarding the future arrangements of one person's care and demonstrated they understood the process that was followed.

People and parents told us they received their care and support from a team of regular staff and were happy with the number of staff that visited them. Records showed people received continuity of staff. Staff were recruited and trained to provide care and support to a small number of people. Records and discussions with people showed that when people were not happy with a particular staff member there had been no problem with them not visiting them again. People said they usually knew who was coming because they received a schedule, although one person said at times this could include 'blanks'. Staff told us if this was the case people were telephoned once the shift/visit was scheduled. Most people told us they usually met

staff prior to them providing any care and support.

Staff understood their roles and responsibilities. Staff completed an induction training course, which was based on the Skills for Care Care Certificate. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. This included emergency life support, health and safety including fire safety, infection control including food hygiene, safeguarding adults and children, mental capacity, equality diversity and inclusion, moving and positioning and the management of medicines. In addition staff received a staff handbook.

Following this staff attended a 'complex care training' course delivered by one of the lead nurses, which included clinical subjects that had been identified as required, in order to support the individual people staff would provide care and support for, such as enteral feeding and medications, epilepsy awareness and administration of emergency medications, ileostomy/stoma care, nebulisers, oral suction, oxygen therapy, tracheostomy care including BLS and suction via tracheostomy. Following the training staff had their competency checked for eternal feeding and medications and tracheostomy care including BLS and suction via tracheostomy by the lead nurses. Staff then shadowed an experienced member of staff in the person's home where they would provide care and support.

Training was periodically updated. Some staff had also received training in dementia, autistic spectrum and acquired brain injury where this was appropriate. Staff felt the training they received was adequate for their role and enabled them to meet people's needs. One staff member told us, "Have worked for this company for many years and have always been happy with my job and support I receive from the office staff. My training has always been relevant to my job role. Brilliant to work for". Another said, "They are very good at ensuring you do the training, you can't work if you haven't got the training".

Two staff were trained in Makaton (a language programme using signs and symbols to help people to communicate) and had recently been trained as trained trainers so they could cascade this training to other staff. It was planned that a person using the service who used Makaton would also be involved in delivering the training to staff.

Staff felt well supported and received opportunities for support and supervision. A lot of the support staff received was achieved in an informal way. Staff felt the director, lead nurses and office staff were always available and approachable and used this to telephone or come into the office to discuss any concerns or issues. Some staff told us they received spot checks on their practice. The lead nurses regularly visited people's homes to support staff and check things were running smoothly, this was more frequent when there were any concerns with staff or their practice. During the inspection one lead nurse visited a person's home to support staff with a clinical procedure. Staff received an annual appraisal and they told us they had had opportunities to discuss their learning and development.

People's needs in relation to nutrition had been assessed and were recorded. Some people required minimal support with their meals and drinks and staff prepared a meal from what people had in their home. Staff told us where people were at risk of poor hydration or nutrition measures were in place to reduce these risks, such as food and fluid charts to monitor their intake. Special diets were supported including diabetes. Some people received their food and fluid via a percutaneous endoscopic gastrostomy (PEG). This is a tube that feeds directly into a person's stomach. Another had their fluids thickened to reduce the risk of choking. Care plans contained information about risks associated with people's nutrition, such as ensure food is cut into small pieces. One person told us, "I like cake, cake and more cake, but they (staff) do encourage me to eat healthily".

People were supported to maintain good health. People had complex health needs and told us staff were observant in spotting any concerns and took any appropriate action when they were concerned. During the inspection staff discussed with one person their current health and encouraged them to contact the doctor to arrange a visit, which they did the following morning. Records showed that when one person had a problem with the flow of their catheter staff contacted the district nurse to visit. When people were at risk of poor skin integrity there was a repositioning chart in place and people said they were repositioned regularly. Staff liaised with health professional, such as occupation therapists to ensure people had the right equipment to support their health needs, community matrons and district nurses.

Good

Is the service caring?

Our findings

People and parents told us staff were caring and listened to them and acted on what they said. People and parents were relaxed in the company of staff and they and relatives were complimentary about the staff. Comments included, "My care worker has the patience of a saint. A lovely girl with a lovey disposition". "Some carers are better than others. Ninety percent are very good". "The care and support I get from Superior Care is 100% and always has been. They are very caring and loving people and should be thanked for all the hard work that they do". "The staff are wonderful and go out of their way to help (family member)". "They (staff) spoil me".

People, parents and relatives felt staff always treated people with dignity and respect and that the staff were kind.

The service had received a number of compliments. Some people talked about staff that "Went that extra mile". One person talked about some staff that visited them saying "There is a group of carers I call them my musketeers". A relative talked about a member of staff who returned to their family member on an unscheduled visit as they were worried about their health and they knew the doctor had been due to visit. Further discussions were had with the doctor who then prescribed antibiotics and another member of staff collected these to ensure they could be started directly. A district nurse visited the next day and confirmed antibiotics had been necessary.

During the inspection staff took the time to listen to feedback and answer people's questions. When people raised concerns or wanted to make changes to better suit them, senior staff listened, made suggestions to contact appropriate health professionals or updated them on feedback from health professionals and where this involved timing of visits/shifts reported to coordinators in the office to address.

People told us they received person centred care that was individual to them. People and parents felt staff understood people's specific needs, such as health and physical disabilities. Staff had built up relationships with people, their relatives and parents and were familiar with people's life histories and preferences. Assessment of needs and care plans contained some details about people, such as information about their personal histories, although in some care plan folders there was a different type of support plan, which contained more detailed information about the person, their preferred name, their history and preferences. During the inspection staff talked about people in a caring and meaningful way.

People and parents told us people's independence was encouraged and developed wherever possible. One person talked about how they washed their top half and another person told us staff encouraged them to eat what they could themselves before being assisted.

People and parents told us they were involved in the initial assessments of people's care and support needs and planning their care. Some people had chosen to involve their relatives. Most people and parents told us that senior staff visited periodically to talk about people's care and support and discuss any changes required and reviewed the care plan. People and parents felt care plans reflected how they wanted the care

and support to be delivered.

Staff told us at the time of the inspection most adults did not require support to help them with decisions about their care and support, but if they did or chose were supported by their families or their care manager, and no one had needed to access any advocacy services. Details about how to contact an advocate were available within the service.

People and parents told us people had their privacy respected. People and parents 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. Information within the service user guide confirmed to people that information about them would 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.

Requires Improvement

Is the service responsive?

Our findings

People and parents told us they were involved in the initial assessment of the care and support needs and in planning the care. Some people had also chosen to have their relatives involved in these discussions. One person told us "(Member of staff) and (member of staff) came out and introduced themselves and we discussed things". People and parents told us they felt their care plans reflected the care and support staff undertook.

Care needs assessments included areas, such as personal care, continence, medical, nutrition, mental health, mobility, culture/spiritual needs, social interaction, community, education employment and day activities and communication.

Care plans were developed from discussions with people and parents, observations and the care needs assessments. Since the last inspection the provider had changed the format of the care plans, which were now based more on clinical interventions. In these areas the care plans contained clear guidance about what support was required by staff. However in other areas the care plans varied in detail and nearly all required further detail to ensure that people received care and support consistently, according to their wishes and staff promoted and developed people's independence. For example, one care plan stated 'ensure oral hygiene is given daily and sore areas around mouth are treated as required'. The care plan did not inform staff how the person liked this to be done, if there were any parts they could undertake themselves and what parts staff were required to do.

Care plans did not state where people had their personal care, some people were being cared for in bed, but we were unable to tell this from the care plan. One care plan did not detail whether the person had a strip wash or a shower, although staff told us they had both depending on what the person was doing that day, but this was not recorded.

A care plan stated that the person wore incontinence pads, but there was no information about how frequently they liked these changed or the personal care that would accompany changing the pad. One care plan stated 'change continence aids promptly as needed' with no other guidance. One staff member talked about a complex toileting routine for a person, but none of the detail was included in the care plan.

One person's care plan stated they had a nebuliser, but staff told us this was no longer the case, although the care plan had not been updated.

In another care plan there was good detail about oral care that showed what the person could do for themselves and what support staff were required to provide. However the care plan went onto toileting needs and it mainly talked about moving and handling arrangements and not how the person's toileting needs would be met.

People did have preferred routines, such as when and where their personal care took place and staff talked about these in detail, but none of this information was included in the care plan. Staff did shadow other staff

within the person's home, but the complex nature of people's routines would not be remembered. Daily reports showed people had things done by staff which were not in the care plan, such as rolling cigarettes and domestic tasks. This meant that following the shadow shift people would have to explain their preferred routine to new staff that visited or would not receive consistent care in line with their preferences.

One person's home contain lots of lists and instructions for staff, but this information should have been contained within the care plan as it was part of their preferences for the delivery of their care and support to ensure all their needs were met.

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 and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People said senior staff came and reviewed their care plans periodically and records confirmed care plans were reviewed at least annually.

People were not socially isolated. Staff told us they supported some people to ensure they were ready in time for daycentre transport. A relative told us staff provided a sitting service so they could go out. Some people said they looked forward to the staff visits each day and told us this in itself sometimes ensured they were not lonely. One person said, "They always cheer me up". Others had visitors, used the internet to stay in contact with friends or were able to get out and about in the community and talked about groups they attended.

People told us they felt confident in complaining, but did not have any concerns. Most people said they knew how to make a complaint and if they had complained previously most felt the service had responded to the concerns raised. One person told us, "If I did (have a complaint) I would phone the office and tell them, so it's a problem that gets solved". The complaints procedure was contained within the service user guide, which was given to everyone when they started to use the service. Records showed there had been a number of complaints in the last 12 months, which had been investigated and responded to appropriately.

People did have some opportunities to provide feedback about the service provided. People could be visited by the lead nurses as part of staff's observational supervision and had the opportunity to raise any concerns, as they did during their care plan review visit. The provider had sent out some questionnaires earlier this year to people and parents to gain their feedback about the service and an action plan was put in place to address any negative feedback and make improvements.

Requires Improvement

Is the service well-led?

Our findings

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager cancelled their registration in May 2015 and the service has not had a registered manager since that time, despite communication from the Commission to reiterate this legal requirement.

This was discussed during the inspection and the chief executive had recently received their DBS check back and a registered manager's application was submitted following the inspection.

There were systems and processes in place to ensure the service operated effectively. However the evidence to support this was not easily available or not sufficiently detailed to evidence the quality of what had been undertaken. This is an area we have identified as requiring improvement.

There was a system to monitor that staff received observation supervision and an appraisal. The provider's policy stated that staff should receive one observation supervision a year and an annual appraisal. Supervision monitoring records showed that although staff felt very well supported there was slippage on them receiving observation supervision. However when we looked at other records, such as the events log we saw that the lead nurses had visited people's homes and completed competency checks with staff and supported staff in clinical procedures, but these had not been recorded as a supervision, but an event. The provider had identified the slippage and was discussing supervision arrangements and recording with staff.

Senior staff told us observation supervision would general last approximately one to two hours in a person's home. During this time as well as the observation of staff practice and discussions with them, the lead nurse would talk to the person or their parents and gain their feedback about the staff and service that was provided, but again this was only recorded as a supervision and not a visit to the person unless anything negative arose when it was then logged as an event, but not a quality monitoring visit to the person.

When lead nurses visited people's homes to check how the package was going and obtain feedback on the staff, an event was logged to identify this with any negative issues detailed, but the positive feedback was not recorded.

There were very few accidents and incidents, but these were reported and recorded. These were reviewed and discussed on a day to day basis regarding action taken and lessons learned.

There were monthly quality and governance meetings held to monitor the service. These meetings looked at areas, such as staffing levels and vacancies, new people using the service, recruitment and training, staff supervision and appraisals, staffing concerns, care plans and risk assessments and reviews, compliments comments and complaints, quality assurance and training.

The provider was looking at improving ways in which people could feedback their views of the service and had started to develop questionnaires for future use. They were looking at sending out a survey soon after a person started to use the service and then at six months and then annually. They were also looking to widen the range of feedback by sending surveys to professionals.

The service was run by a team of staff, which included the chief executive, a director, two lead nurses (who were trained in paediatrics), a training manager, senior coordinator and other coordinating and recruitment staff. The lead nurses undertook assessments, care planning and observation supervision as well as delivering clinical training. The coordinators ensured people's visits/shifts were scheduled. The training manager undertook induction and refresher training and moving and handling assessments.

The provider was a member of the Kent Integrated Care Alliance and also subscribed to the Quality Compliance System, these and the internet kept them up to date with good practice and changes in legislation.

During the inspection there was an open and very positive culture within the office, which focussed on people. Staff demonstrated a strong commitment to learning and driving improvements to the service people received. It was evident during the inspection that staff worked hard as a team to ensure the service ran smoothly. There was close working between coordinators and recruitment staff to ensure the right people with the right skills were recruited to match people's needs.

People, parents and relatives spoke positively about the management team. People felt comfortable in approaching and speaking with them. People felt communication with the office was now good and staff were always polite and courteous. Office staff adopted an open door policy regarding communication and we saw a number of staff came in to discuss their work and schedules with coordinators. Surveys returned as part of the inspection from staff indicated that communication with the office, management and staff had not always been good. During the inspection staff told us that communication between the office, lead nurses and them was good. One said, "Its (communication) is getting a lot better from the office". The provider told us there had been some issues and changes had been made to resolve things, such as a 'ring round' to check staffs schedules with them and coordinator staff acting as back up for the out of hours service.

Most people felt the service was well-led and well organised. Comments included, "Superior Care are an excellent firm and very caring and understanding". "There is a marked improvement in the last eighteen months or so". "The office staff also go out of their way to provide a service, which is flexible and which can meet their (family member's) needs which sometimes change very rapidly". "On the whole it is well managed, although there could be improvements". Most people said they would recommend this service to another person.

The provider's aim was 'excellence in care'. In discussions staff were not always aware of the actual aim, but told us their role was to "Continually look after people to a high standard ". "Provide excellent care, respecting people as individuals". "Meet people's needs".

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 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
Nursing care 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. Regulation 9(3)(b)

Regulated activity	Regulation
Nursing care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. The provider had failed to have proper and safe management of medicines. Regulation 12(1)(2)(b)(g)