Kent Social Care Professionals Limited

Kent Social Care Professionals Domiciliary Service

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 23, 24 and 25 February 2016. The inspection was announced. The provider was given two working days' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available at the locations office to see us.

Kent Social Care Professionals domiciliary care agency provides care and support for people in their own homes. Care is provided for a range of people including older people and people with dementia. The agency operates in areas including Tonbridge, Tunbridge Wells, Paddock Wood, Sittingbourne, Medway, Dartford and Gravesham. At the time of our inspection they were supporting approximately 700 people.

There was a registered manager in place. 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.

Recruitment practices were safe and checks were carried out to make sure staff were suitable to work with people who needed care and support.

People were treated with dignity and respect by staff who also maintained people's privacy.

People experienced a service that was safe. They received support and assistance from enough staff to fulfil their expected care packages and meet their assessed needs. Staff and the management team had received training about protecting people from abuse, and they knew what action to take if they suspected abuse. Risks to people's safety had been assessed and recorded with measures put into place to manage any hazards identified.

Where staff were involved in assisting to managing people's medicines, they did so safely. Policies and procedures were in place for the safe administration of medicines and staff had been trained to administer medicines safely.

Staff had received the training they required to meet people's needs. Staff had a clear understanding of their roles and people's needs. Staff were supported in their role from the management team.

People's needs had been assessed to identify the care and support they required. Care and support was planned with people and reviewed to make sure people continued to have the support they needed. People were encouraged to be as independent as possible. Detailed guidance was provided to staff within people's homes about how to provide all areas of the care and support people needed. People, if required were supported to eat and drink enough to maintain good health.

Systems were in place for monitoring the quality and safety of the service and assessing people's

experiences. These included telephone reviews, face to face reviews and spot checks.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Recruitment practices were safe and followed current guidance.

Staff understood the importance of protecting people from abuse and the action to take if they suspected abuse.

There were enough trained staff to meet people's assessed needs.

Risks to the safety of people and staff were appropriately assessed and managed.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice. Staff understood the importance of gaining consent from people before they delivered any care.

Staff were trained and supported to have the knowledge and skills to meet people's assessed needs.

Where it was part of people's care package, staff understood the importance of ensuring people had enough to eat and drink to meet their needs.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring. People's privacy and dignity were maintained whilst promoting people's independence.

People were involved in the development of their care plans. People's personal preferences were recorded.

Staff had access to people's likes, dislikes and personal histories.

Is the service responsive?

Good

The service was responsive.

The complaints procedure was available and in an accessible format to people using the service.

People's needs were assessed recorded and reviewed.

Systems were in place to ensure staff were responding to people's needs.

People were included in decisions about their care.

Is the service well-led?

Good

The service was well-led.

There were effective systems for assessing, monitoring and developing the quality of the service being provided to people.

Records were maintained appropriately and were up to date.

The registered managers and local managers understood their role and responsibility to provide quality care and support to people.

Kent Social Care Professionals Domiciliary Service

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 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 23, 24 and 25 February 2016 and was announced. The inspection team consisted of four inspectors. The provider was given 48 hours' notice because the service provides a domiciliary care service; we needed to be sure that the registered manager was available and someone would be in.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We also looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law.

We spoke with 14 people about their experience of the service. We spoke with 10 staff, the registered manager, the managing director, the training co-ordinator and the care and quality manager to gain their views.

We sent people using the service, staff and external professionals a questionnaire about their experiences and received 50 responses back from people using the service and 55 back from staff.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring

systems, internal audits and the quality assurance system. We looked at 19 people's care files, 10 staff record files, the staff training programme, the staff rota and online recording system for all calls.

A previous inspection took place on 23 August 2013; the service had met the standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Good

Is the service safe?

Our findings

People we spoke with and feedback from the questionnaires showed that people felt safe with the staff that supported them. Their comments included, "I am very happy with the service, staff are usually on time and I feel safe in the hands of the staff." And There aren't any (staff) I don't feel safe with."

There was a safeguarding policy in place, staff were aware of how to protect people and the action to take if they suspected abuse. Staff received training in equality and diversity and how to safeguard vulnerable adults. Staff were able to describe the potential signs of abuse and what they would do if they had any concerns such as contacting the registered office, police or the Care Quality Commission (CQC). Staff were able to describe how they kept people safe and how they would report any concerns that they had. One member of staff said "I would call the office immediately if I was worried about anything". Another said "If there is anything I'm not sure of I will call the office". Safeguarding concerns had been raised by the registered manager to the local authority safeguarding team and CQC when necessary. A process was in place to monitor and record any actions taken following a safeguarding.

Accidents and incidents were recorded with the details of the accident, description, additional comments or information, details of the person completing the form and any action taken. For example, a member of staff had called a person's doctor and family member following a witnessed fall. These were monitored by a member of the management team.

Staffing levels were assessed in line with the assessments of needs completed for the people who used the service. The service took into consideration the number of staff required to assist each person and the frequency of visits to each person. The registered manager said that they were constantly recruiting in order to fulfil new contracts and also where they picked up new contracts from other care agencies, if the service user wanted to, they would employ the carer from the other agency to ensure continuity.

Staff said that on the whole there were enough staff. One staff member said "It can't be helped if someone goes sick but we all pull together and fit in some extra calls so that we don't let people down". Another member of staff said "They do try and cover sickness. We're short staffed just like everybody is short staffed but they do their best to cover".

Feedback from questionnaires showed people had received a large number of late calls. As a result the organisation used an electronic system for tracking that staff were in the right place at the right time. Each member of staff had a company phone which contained all the information they needed such as their rota for the day, if they were working as part of a team for example where people needed to carers to support them with moving and handling and an application which they used to connect with a device in people's homes to allow them the log in and log out so that staff were aware of when people were arriving and leaving people's homes. Staff at the registered office were able to see in real time where staff were and if they were attending people at the correct time. People we spoke with told us that usually they would receive a call from the office if their carer was running late.

Recruitment practices were safe and checks were carried out to make sure staff were suitable to work with people who needed care and support. Each staff file we viewed had a workflow document at the front which documented the information received as part of the recruitment process such as the documentation required, references, Disclose and Baring Service (DBS) background check and health and medical fitness. Details about each stage of the process were recorded such as the type of identification documentation reviewed, what stage of the process they were at and if any outstanding items were overdue. Comments such as "Completed, waiting for completed form" and "Satisfactory reference" were included on the form.

A compliance checklist was in place which covered the application form and DBS, interview notes, identification and eligibility to work in the UK, acknowledgements and training. This had been ticked off by one of the recruitment team once each stage was complete. Potential staff's references had been signed by the recruitment team to confirm that they had been verified and were satisfactory. People could be assured that the staff supporting them were safe to work with them.

There was a disciplinary procedure which outlined the requirements for managers and employees to follow, where staff were not performing their role to an acceptable standard, in line with the requirements of the company and the policies and procedures in place. The policy clearly set out what constituted misconduct and how this would be managed. The registered manager confirmed that there were no staff going through the disciplinary process at this time.

Potential risks to people in their everyday lives had been assessed and recorded on an individual basis. For example, risks relating to personal care, medicines, management of health conditions and mobility. Each risk had been assessed to identify any potential hazards which were then followed by detailed control measures to inform staff how to reduce the risk. The risk assessment informed staff what people were able to do for themselves and what specific support they required from staff. For example, 'Glasses need to be worn as (the person's) mobility can be unsteady at times.'

Medicines were managed safely if people required support with this. There were up to date policies and procedures in place to support staff and to ensure that medicines were managed in accordance with current guidance. Staff completed training in the administration of medicines during their induction. People had assessments completed with regards to their levels of capacity and whether they were able to administer their medicines independently or needed support. Guidance was available with a risk assessment detailing the support staff were required to give people with their medicines.

Good

Is the service effective?

Our findings

People we spoke with told us they received the support they required from staff when they needed it. Their comments included, "The staff do know how to care for me, I have to say the staff all seem very capable." "The care is good." And "I am very impressed by KSCP."

People's needs were assessed and recorded with them and a member of the management team. People told us that they usually had regular care staff who worked well with them. However some people said they had requested regular care staff but this request had not always been met. The registered manager told us that the coordinating staff tried to ensure requests were met but this was not always possible.

Staff were provided with an induction when they joined the service. This occurred before staff were able to work with people. The induction process included classroom based training with the companies training manager who worked through mandatory training courses and completed assessments with staff to ensure that they meet the required level of knowledge and skill to undertake the role. The training manager said that she was able to assess people's level of knowledge and if she felt that staff were struggling or needed additional assistance, she offered them one to one time to discuss where they needed additional support. They also said that if she felt that someone wasn't meeting the required standards, then she would inform recruitment and the registered manger to decide whether the person was suitable for the role or whether additional support was required. Staff were also given an employee handbook which contained information about important policies that they may need to refer to whilst carrying out their roles.

Staff were trained and supported to have the right skills, knowledge and qualifications necessary to give people the right support. Training was broken down into three areas which were; induction training, which staff were required to attend before they began working, role specific training which was dependent on the needs of the people they were supporting and refresher training which was training that needed to be refreshed on a regular basis. New staff worked alongside more experienced staff within the within the community to meet people and get to know them before working unsupervised. A shadowing competency checklist was completed to confirm that new members of staff were able to undertake the tasks required of them safely and in line with company procedures. Records of shadowing competencies were kept in staff files.

Staff were offered the opportunity to complete a formal qualification during their employment. For example, QCF in Health and Social Care, this is an accredited qualification. Staff said that they were encouraged to develop their skills and progress in their careers. Staff also said that if they required additional training or support, they were able to ask for it.

Staff received support and supervision in different formats which included face to face supervisions, spot checks and observations with a line manager in line with the provider's policy. The care delivery team were responsible for carrying out face to face supervisions, telephone supervisions and spot checks. Face to face supervision covered whether any issues needed to be raised either by the staff member or the manager any training and development requirements, punctuality and reliability. Staff raised issues such as "Calls being

added to rota's without letting me know" and "Office don't return calls".

Telephone supervisions covered the same areas as face to face supervisions and staff were able to discuss concerns with their personal welfare whilst working for example, "X has severe dementia and can be violent". The manager said that when staff raised concerns such as these they were reflected in updates and reviews to people's care plans.

Spot check supervisions included checking staff appearance and that they were wearing the appropriate identity badge, record keeping, time keeping, how tasks were completed on the call and notes or concerns. Some of the items raised included "Concerns raised about time keeping" and actions were set in place to monitor performance such as "Arranged to meet for a face to face in two month's time".

The company policy for performance appraisals and training review stated that each care worker would undergo a review of work performance every six months and the outcome of the review would be recorded on a performance appraisal record form which would be kept in staff files. Records were not always kept in staff files however there was an overall record of the supervision and appraisal that staff had received. There was a structure for who was responsible for carrying out appraisals for each staff group and was team based. As the organisation was in a period of transition, there were new development and appraisal systems being introduced.
A whistle blowing policy was in place which staff were aware of, if they needed to raise concerns that they felt were not being addressed internally. Staff told us they had not needed to follow the procedures but felt confident to use the process if they needed to.

The registered managers and staff were aware of their responsibilities under the Mental Capacity Act (MCA) 2005. Staff had been trained to understand and use these in practice for example, how they applied it to their work such as through capacity assessments, offering choices and asking people if they were happy to proceed before carrying out any care. One member of staff said "I always ask people how they are and what they would like me to do". Another member of staff said "It is all about communicating with people. If I think that someone isn't themselves, I can call the office and ask someone to come out and assess them again".

People's capacity to consent to care and support had been assessed and recorded within their care plans. Staff completed daily logs for people which included recording if the person they were supporting had capacity. The log also included staff recording whether the person had given consent to their personal care. A policy and procedure was in place to advise staff on any action they needed to take regarding a person's capacity. Records showed that these had been followed in relation to assessing people's capacity to make certain decisions. For example, people understanding prescribed medicines and consent to care and treatment.

People using the service were living within their own homes and receiving support from staff. People had guidelines in place for eating and drinking support if they required it. People told us the staff supported them with their meals and always ensured they left a drink available. They said "The staff make my breakfast and other meals, they always leave me a drink", and "The staff always make me something to eat and always leave me a drink before they go". One relative fed back that the lunchtime care staff will always fine extra tasks to complete to ensure they use the full allocated support time. People's food and drink was recorded by staff within their daily event folder.

People if required, were supported to maintain good health. Guidelines were in place to inform staff of the specific support the person required during their call and any equipment staff were required to use. For example, the summary of care form detailed the use of the stair lift and to encourage the person to use the

grab rails. Staff had recorded within people's daily logs if they were concerned about people's health and the action they had taken. For example, contacting the person's doctor and next of kin. One member of staff said "If I am worried about someone, I sometimes give their relatives a quick call just to keep them aware that someone isn't themselves that day". One person said "The staff seem to notice the way I am and when I am in more pain. Staff support me in my hospital visits if I can get them on the day she (staff) works".

Good

Is the service caring?

Our findings

People we spoke with told us the staff were kind, caring and treated them with respect. People's comments included, "The staff are lovely very kind and they do respect me, I do feel that". Another said "The staff are very respectful, they are very nice girls." And "The care given has been exemplary so far".

Staff were given training in protecting people's privacy and dignity. The training manager said that she encouraged this as part of the training she did in all areas and encouraged staff in the group to discuss examples of how privacy and dignity is promoted. Staff spoken with gave examples of how they maintained people's privacy and dignity which included making sure that people's curtains were closed and people were appropriately covered when delivering personal care. One staff member said "I have one gentleman who I take to the toilet every morning and I always make sure that I give him a few moments of privacy".

Staff were able to talk about some of the people they supported and explained people's likes and dislikes. They gave examples of how people liked to have their personal care delivered in different ways such as, some people had certain routines they followed and other people preferred a bath to a shower.

Information about people's personal histories was recorded in people's care plans. One member of staff said "When you go into people's houses, you can read about them in their care plans, but personally I prefer to talk to people and ask them how they like things to be done". Staff said that they sometimes found it sad when they had worked with people for a while and built up a rapport and then had to work with other people. However they also said that what they most enjoyed about the job was getting to know people and being able to help them.

People were able to provide feedback and express their views about the service they received through their reviews. These included telephone reviews and annual face to face reviews. A sample of telephone reviews were viewed which showed that some people had said they did not know how to make a complaint or compliment. Action was then taken by the member of staff who completed the reviews, which recorded that they had explained to people who were unaware how to make a complaint or compliment.

People were involved in the development of their care plans, which were specific to each individual. People's independence had been maintained throughout the care files. For example, plans informed the staff what the person can do for themselves and the specific support they require. People were supported to remain as independent as possible. One person said "I was asked when they started coming what I wanted done, they do what I want them to." Staff said that they always asked people before delivering any care if they were happy with them carrying out the tasks that they were there to support people with.

Records we saw were up to date and were located quickly when needed. People's records were held securely within a locked room within the recruitment office. Only people who were able to have access to this information knew the door entry code.

Good

Is the service responsive?

Our findings

People told us that they had a care plan within their home which the care staff wrote in and referred to. People said they usually had the same consistent staff who knew them well. However, they said the office had now always informed them if there were changes due to sickness or holidays. One person said "I have an excellent regular carer but when they go on holiday or are ill I am given any old carer or none at all." Other comments included "Sometimes we do not always get consistent carers, maybe ongoing to sickness and holidays", and "There is a lack of communication if the carer is running late." People told us that since the provider had recently introduced an electronic clocking in system and things had improved.

The provider used a road runner system for staff which was on their phone and logged the time they arrived and left. The system logged if someone wasn't home for example on the day of our inspection a gentleman wasn't in for his morning call. This was logged onto the system, a call was then made to the next of kin who informed the service an earlier call was required. This was flagged up onto the system to show staff this gentleman required an earlier call.

A system was in place to monitor and record any missed calls. A missed call would be flagged up onto the system which is then investigated by a designated member of staff within the office. If a call had not been logged onto the system by the staff member's phone the office staff would then call the person or the staff member to confirm the call had taken place. One person said "Care has greatly improved with the addition of rota information with dates, times and the name of the carer listed."

People's care plans had been developed with them and their families from the initial assessments carried out by the provider. Care plans were individualised and contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's needs. They included guidance about people's daily routines, health condition support, communication and life histories. People's care plans and guidelines were person centred, they detailed what people could do for themselves and what support they required from staff.

Systems were in place to ensure people's care plans were reviewed with them on a regular basis. The provider had a database in place which alerted a member of the management team when a review was due. The reviews were completed on a rolling programme which included' a telephone review, six monthly care plan review, reassessment at nine months and a yearly review which included people's representatives. Records showed people had been involved in the development and review of their care plans.

The complaints procedure was available to people and was written in a format that people could understand. Staff told us they would talk to their manager or any of the office staff if they had any concerns or issues, and would support people to complain if they wished to. The provider had a complaints policy and procedure in place which was available to people and their relatives within their service user guide. This included the procedure people could follow if they were not happy with the complaint response. People told us if they had any concerns they would contact a member of staff in the office.

Feedback from the 2015 service user questionnaire showed that 12% of people said they did not know how to make a complaint. As a result a newsletter was produced and sent to people using the service. The newsletter provided feedback to people following the questionnaire and what action the provider had taken as a result. It also included information on how people could make a complaint or compliment. Records showed the procedure had been followed by the registered manager following three complaints we saw.

The service also kept compliments that they had received. Compliments from relatives spoke about how they were pleased with the standard of care their relative had received. It read "Thank you for the carers that come to both my mum and my father. I am really pleased with the standard of care given." Another said "The member of staff was brilliant, she introduced herself, friendly, reassuring and confident."

Good

Is the service well-led?

Our findings

There was a registered manager in post who had managed the service for a number of years. The registered manager was supported by local field care supervisors who managed the care staff. Staff we spoke with understood the management structure, who they were accountable to, and their role and responsibility in providing care for people. People were able to approach the registered manager or local care supervisors when they saw them within the office. During our inspection the registered manager knew the people they were supporting and were observed talking to staff who had come into the office.

The registered managers had a good understanding of their role and responsibility to provide quality care and support to people. They understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, if a person had died or had an accident. There had not been any notifiable incidents since the last inspection. The registered manager told us they felt supported by the provider and the director who was her manager.

People and their representatives were involved in the development of the service being provided to people. Systems were in place to regularly monitor the quality of the service that was provided. People and their representative's views about the service were sought through annual service user questionnaires. These were written in a way people could understand with a score of 1 to 3 being given for each question. The results were collated into a newsletter which was sent out to people. Results showed that a high proportion of people rated the service they received as "Good" with over 97% of people saying they were treated with dignity and respect, and that they were supported to maintain their independence. People and those acting on their behalf had their comments and complaints listened to and acted on.

The provider had an audit schedule in place which included audits by the field care supervisors to discuss people's experience of using the service. When shortfalls were identified either through the audits or questionnaires these were discussed with staff and action taken. Reports following the audits detailed any actions that were required.

The registered manager was based within the main office to have an overview of what was going on, on a daily basis. People told us that at times they do not get an answer when they call the office but if they leave a message someone will always call back.

The company had recently changed provider to City and County Healthcare Group. We spoke to the Managing Director who had a clear action plan of how the service would be gradually transitioned over to City and County. A clinical governance board was in place as well as a head of quality. The registered manager would be supported to understand and embed any new ways of working as well as new policies and procedures.