Care at Home Services (South East) Limited

Care at Home Services (South East) Ltd - Thanet

Inspection report

78 High Street
Broadstairs
Kent
CT10 1JT

Tel: 01843609533
Website: www.careathomeservices.co.uk

Date of inspection visit:
17 October 2016
18 October 2016
19 October 2016

Date of publication:
09 December 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17, 18 and 19 October 2016 and was announced.

Care at Home Services provides care and support to a wide range of people living in their own homes 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 call to four calls a day, with some people requiring two members of staff at each call. At the time of the inspection 65 people were receiving care and support from the service.

The previous inspection of this service was carried out on 19 and 20 August 2015 when we found breaches of some regulations. At the inspection in 2015 we found that some improvements had been made since our inspection of 2014, but the provider was still in breach of three regulations relating to safe care and treatment, person centred care and good governance. There was a lack of oversight and scrutiny to monitor, support and improve the service. The provider did have suitable systems and procedures in order to assess, monitor and drive improvement in the quality of the service and the safety of people but these were not being adhered to.

The provider had not mitigated risks relating to the health, safety and welfare of people and 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 sent an action plan to CQC in October 2015 with timescales stating they would be compliant with the regulations by February 2016. At this inspection in October 2016, the provider had not completed all the actions they told us they would make and there was a lack of any significant improvements. As a result, they were still in breach of the regulations found at the last inspection and a further two breaches of the regulations were identified.

There was a registered manager in post who was supported by a deputy 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 and associated Regulations about how the service is run. The registered manager supported our inspection with the training and development manager on the first day of inspection and operations director the second day.

The provider had systems in place to audit and monitor the quality of service, including spot checks of staff, but these checks were not carried out consistently and effectively. The shortfalls found at this inspection had not been picked up by the registered manager had not been picked up by the registered manager.

People had opportunities to provide feedback about the service provided. Quality assurance questionnaires were sent out annually and the recent survey showed that people were satisfied with the service being provided. However, feedback had not been sought from staff and from a wide range of stakeholders, visiting professionals and professional bodies, to ensure continuous improvement of the service was based on

everyone's views.

At the last inspection in 2015 care and treatment was not provided in the safest way for people because the provider did not have sufficient guidance for staff to follow to show how risks to people were kept to a minimum. At this inspection minimal improvements had been made. Not all risks associated with people's care and support had been assessed and guidance was not in place to mitigate risks to make sure people received safe care.

Medicines were not always managed safely when people were given their medicines by staff. Staff had not always signed the medicine records to confirm people had received their prescribed medicines. There was confusion about the level of support people needed with their medicines and this was not clearly explained in care plans so staff had clear guidance about how to give people their medicines safely.

People's care plans varied in the amount of guidance and information they contained. Some care plans were not up to date and did not have all of the personalised information staff needed to make sure people received the care they needed. The care plans did not always include people's preferred routines, skills and abilities so staff knew what people could do for themselves. People's care plans did not always contain the guidance that staff needed to support them with their specific health care needs. People told us staff noticed if they were not well and supported them to call the doctor or community nurse if there were any health concerns. Some of the care plans did give information about people's life history and some plans gave specific details about how people liked to receive their care and support but this was not consistent. People were supported to eat and drink enough.

People and staff told us how they always asked people for their consent before they provided care. People were supported to make their own decisions and choices about the care and support that they wanted. Some people chose to be supported by their relatives when making more complex decisions. Staff had received training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Some people's mental capacity had not been assessed to make sure that any care and support that they received was in their best interests.

People told us that they had complained at times about the service they had received. Although action had been taken to resolve individual complaints the management team had not logged these as complaints so they did not have oversight of the complaints raised to look for any patterns to try and prevent further complaints. Accidents and incidents were not always reported and recorded.

Staff practice not consistently monitored. Unannounced spot checks on staff competencies had not happened regularly to ensure they had the skills and competencies to perform their role. Not all staff had received regular support through one to one meetings and appraisals. Some people thought that staff were well trained and knew how to care for them, whilst others said that new staff lacked experience and they needed to enhance their skills to meet their needs. Staff had a range of training specific to their role and specialist training was provided. New staff were recruited safely. They received induction training, which included shadowing experienced staff and there was an on-going training programme in place.

There were mixed views from people about the consistency of staff who came to support them but on the whole people received a service from a team of regular staff and they said this had improved during the past months. Sometimes people needed to change the time of their calls to attend important appointments but said there was a lack of communication between the office staff and care staff team and people had missed their appointments.

At the time of the inspection the registered manager was in the process of recruiting new staff. There was enough staff available to give people the care and support that they needed. Permanent staff, including the office staff, deputy manager and registered manager, covered vacant hours or calls when staff were on annual leave. Staff had received training in how to keep people safe and demonstrated a good understanding of what constituted abuse and how to report any concerns. People we spoke with said they trusted the staff.

People told us the staff were good, kind and caring. People and relatives told us how staff made sure that people's privacy and dignity were supported, and staff were polite and respectful. People we visited felt that staff understood their individual needs and they had built up relationships with them. People told us the staff were polite and kind. They told us that staff listened to what they wanted and always asked if there was anything else they needed before they left.

We found three on-going breaches and two further breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was rated requires improvement at the last inspection and remains requires improvement following this inspection.

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.

Not all risks to people's health and welfare had been assessed and there was a lack of sufficient guidance to show staff how to manage risks safely.

People's medicines were not always managed safely. Records were not completed properly or always signed correctly to confirm what medicines people had been given.

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

There was sufficient staff available to meet people's needs. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received basic and specialist training, which included induction training. Observations of their skills and competencies were not carried out regularly. Staff felt supported by the registered manager but had not all received one to one meetings or annual appraisals

Some people did not have mental capacity assessments to ensure that they were supported to make decisions about their care.

There was a lack of guidance for staff to follow to ensure people's health care needs were met.

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

Is the service caring?

Requires Improvement

The service was not always caring.

People's preferences and choices were not always recorded to

ensure they received personalised care.

People said staff were kind and caring. They said they were treated with respect and their privacy and dignity were maintained.

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 did not always detail people's preferred routines, likes and dislikes and their skills and abilities. Not all care plans had been reviewed and updated to ensure staff had current information to give the care people needed.

People and their relatives said they were confident to raise any complaints and said the management or staff would take action to resolve any issues. Some complaints had not been logged so there was no oversight of any common issues to make improvements.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had not taken appropriate steps to ensure they had oversight and scrutiny to monitor, support and improve the service.

Action plans to improve the service had not been completed within the agreed timescale to ensure compliance with the regulations.

There were continued breaches and further breaches of regulations.

Records were not suitably detailed, or accurately maintained.

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

Care at Home Services (South East) Ltd - Thanet

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 17, 18 and 19 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 are able to speak with people who use the service and the staff who support them. Two inspectors completed the inspection.

One the first day of the inspection we went to the service's main office and looked at care plans; staff files, audits and other records. On the second day we visited and talked with people in their own homes. On the third day we contacted people by telephone to get their views about the service they received.

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

We spoke with 17 people who were using the service, six of whom we visited in their own homes, and two relatives. We spoke with the registered manager, deputy manager, training and development manager, the operations director, two coordinators who organised the work for the staff and four members of staff. We reviewed people's records and a variety of documents. Six care plans were looked at in people's own homes and seven care plans were looked at 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.

We last inspected this agency on 19 and 20 August 2015 when breaches in the regulations were found.

Requires Improvement

Is the service safe?

Our findings

On the whole people felt safe receiving their care from the staff. People told us they felt safe when staff were in their homes and that they trusted the staff. People said they felt safe when they were being supported to move around. People said, "They help me move with the hoist, they are very good, they reassure me so I feel safe" and "I feel absolutely safe with the staff, they know what they are doing" and "They know how to use the equipment."

Relatives said "When they send the regular staff everything is fine and I know my relative is well looked after, but if they send new staff they sometimes don't seem to know what they have to do."

At our last inspection in August 2015 the provider had failed to make sure that risks to people, staff and others had been managed to protect people from harm and to ensure their safety. The provider did not have sufficient guidance 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 we found that little improvement had been made. Risks to some people had not been assessed and when other risks were identified there was a lack of guidance for staff on how to mitigate the risks.

Not all risks associated with people's care and support had been identified. For example, risks in relation to moving people safely and the risk of people developing pressure sores. Some people had initial assessments to identify if they were at risk of developing pressure sores. There was one pressure area risk assessment that had been completed but had not been incorrectly added up giving a false impression of the level of risk. The assessments did not go on explain and guide staff on what they had to do to keep the risk to a minimum. One person's care plan stated 'keep an eye on the integrity of skin'. It did not say what signs care staff should look for and what action they should take.

Some people had bedrails on the side of their beds to reduce the risks of them falling out of bed. There were no instructions in place to make sure staff used the bedrails safely. One of the managers told us that the bed rails were provided by others and were therefore not included in the agency's assessment. However, the agency's staff were using the bed rails daily and therefore any risks should be assessed and guidance provided.

Other people were supported to mobilise using a hoist, which placed them at risk. There were moving and handling assessments but the information and guidance for staff was not sufficient to show how these risks were being managed. One person's care file had a few words on the index page stating, 'bed to shower seat-red top grey bottom' there was no further guidance for staff on how to move this person safely using a hoist. People and relatives we spoke with told us they thought the staff moved them safely; however there was no information in the care plans to confirm staff were moving people consistently and safely.

At the last inspection we asked the provider to ensure that information on medical conditions, such as diabetes and epilepsy, should be added to the care plans to give staff further understanding of the conditions so that any risks could be identified. Although some generic information was on each person's

care plan, there was still no detailed individual information and guidance for staff to help them recognise the signs that might indicate people's conditions were becoming unstable and what appropriate action they had to take. For example, some people had epilepsy and this had been identified at their initial assessment. There was no further information about this in their care plan. There was no risk assessment in place to tell staff what they should be doing to make sure risk were kept to a minimum and what action they needed to take if a person had a seizure.

The registered manager said that any accidents or incidents should be recorded in people's notes and reported to the office and an incident/accident form completed. The last recorded incident was dated October 2015. However, a person told us about an accident they had recently, while two staff were supporting them. Staff confirmed the accident had happened but they had not recorded this in the person's daily notes or completed an incident form. We suggested they do this during the inspection and they did. There was a risk that accidents and incidents were not recorded and reported by staff and that any delayed injuries may from an accident may not be linked to actual incident. The registered manager would not have accurate information to monitor for trends and patterns to reduce the risk of them re-occurring.

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 and not all potential risks had been assessed. This was an on-going breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to staff when entering people's homes were assessed. For example, if it was poorly lit or there were trip hazards. The risks were assessed and staff tried to reduce them as much as possible

There was some information in some people's care plans to tell staff about the medicines people were prescribed and when and where to apply creams to their skin. However, the support people needed to take their medicines was not up to date and so was not clear for staff. The registered manager told us some people just needed 'prompting' to take their medicines. Their care plans confirmed this, one stated 'prompt medicines in relation to the medicines administration record.' The medicine the person was taking was listed in the care plan. The list was not up to date and the person was now taking new medicines and some medicines had stopped. When we visited people they told us that they needed full assistance, not just a prompt, with the medicines. One person said "(The staff) deals with my tablets, they pop them into a pot and give them to me, they wait and make sure I have taken them and they sign the record." Another person told us "The carers do my tablets."

We checked people's medicine administration records (MAR) in their homes. Staff should sign the MAR after they have administered medicines to people. There were gaps on some people's MAR and one person's MAR had not been signed at all. Daily notes completed by staff recorded 'meds given' but as some people had no record of how many tablets they had at home we could not be sure that people had the medicines and creams they had been prescribed. Some gaps dated back to 29 September 2016 but had not been picked up by the registered manager's audits and not all the errors had been reported by other staff who had been administering medicines since then. The deputy manager explained that two of the errors had been reported by other staff but no action had been taken. The deputy manager said that the MAR were checked each month so all errors would only be picked up and acted on after this check.

There were body maps to indicate where creams should be applied on a person's body, but the application of the creams was not consistently recorded on the medicine records to show what prescribed creams had been applied. Some daily notes did indicate that creams had been applied but did not always specify what cream was being used.

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

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 an on-going breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew about different types and signs of abuse; they knew what to do if they suspected abuse. The registered manager was aware of their role in safeguarding people and there were policies and procedures for staff to refer to if they had any questions, including how staff should safeguard people's valuables and money. People told us they trusted the staff when they were in their homes.

People we spoke with were all positive about the care staff. People told us "The staff are all lovely," "They are all very good, I do not mind who comes. I could not do without (care staff name.)"

There was enough staff to cover all the calls to people's homes, although some staff said they worked over 50 hours a week. The registered manager confirmed that some staff worked lots of hours but that staff had 'zero hours' contracts and were allocated work on a weekly basis made up of some regular calls and new or random calls. The registered manager was confident that other staff, including office staff, would cover calls if a staff member was off sick.

People told us they generally knew which care staff would be supporting them because it would be one of a team of care staff. They said that during the week they knew which staff would be coming. At weekends they did not always know. People said "Monday to Thursday I am totally satisfied but at weekends it's hectic. I know they will always come but sometimes they are late or early" and "Every time it seems there is someone different, I don't really mind."

People told us that on the whole, staff arrived on time and they always stayed for the allotted time. People said if staff were delayed more than about ten minutes the office staff would telephone them to let them know, but this was not very often. People said staff did what they were there to do and always asked if there was anything else to do. There had been no calls to people that had been missed.

New staff were checked before they started to work on their own. Prospective staff completed an application form, answered some written questions and attended an interview. Any gaps in employment history were questioned and references obtained. Criminal background checks were carried out to make sure staff were safe to work with people in vulnerable circumstances. The registered manager said they tried to match staff to people who might have the same interests. In the past some people had been involved in interviewing staff so they had a say about who might support them.

Systems were in place to manage unforeseen emergency situations. The business continuity plan described in detail the provider's response to a number of emergency situations. These included a loss of power at offices, adverse weather conditions, flooding, fire and the loss of key staff. The provider had plans in place to cover these situations so there would be minimum disruption to the care and support people received. The plan was reviewed yearly and was signed as read by key staff members.

Requires Improvement

Is the service effective?

Our findings

.Some people told us they thought staff were trained and the right skills to support them. One person said "I think they are well trained, they noticed when I was unwell and reported it." Staff told us they thought the training was sufficient and that they felt supported by the office staff and that communication with the office was good. Other people said the established staff knew what they were doing but new staff did struggle. One person told us, "They sent two new staff to help me neither of them knew what to do. I reported it to the office and it hasn't happened again".

The registered manager said that the provider's policy was for staff to have regular spot checks of their practice, to have a one to one meeting with a line manager every six months and to have a yearly appraisal. This policy was not followed consistently. Of the four staff files we checked, only one of the four had an appraisal this year, only one of the four had a one to one (supervision) meeting this year, only one of the four had a spot check by senior staff this year. One of the staff had not had a supervision meeting since 2013. There had not been a whole staff meeting this year so staff had limited opportunities to give their views and ideas and have coaching and mentoring and talk about their career development.

The provider did not ensure staff had received appropriate support, professional development and supervision as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Some staff did not show a clear understanding of their responsibilities in relation to the MCA. Other staff understood their responsibilities and said they had received training in this area and had a basic understanding of how to support people to make decisions. Some staff told us that they did not think it was their responsibility to complete the mental capacity assessments and that this should be done by care managers or doctors.

The care plans were not clear about people's level of capacity. Some people's care plans did not contain any details about how to support people to make decisions. There were mental capacity assessments in place but these had not all been fully completed. On some mental capacity assessments staff had written on the top of the assessment 'has capacity' but when we visited people it was evident that some people did not have mental capacity or that it could fluctuate. Some people were confused and disorientated so it was important to assess if they were able to make a decision and give consent or not and to keep this under review. Their relatives said that they would be unable to make any complex decisions themselves but there was lack of guidance for staff about what support the person would need. There was limited information to

show that people's mental capacity had been considered, what ability they had or what support they may need to make decisions.

One person had been into hospital after being unwell and told us they would not like to go back into hospital even if they really needed to. Their mental capacity assessment stated that the person had capacity so staff would need to respect their decision. However, when we met the person it appeared that they were confused and this may impact on their capacity to make this sort of decision. In this case, staff would have to act in the person's best interests, without clear guidance and an up to date accurate assessment of the person's capacity they were at risk of not having the support they needed.

Staff asked for consent from people before undertaking tasks. Some people were able to make decisions, such as what they wanted to eat or drink but needed the support of others to make decisions on more complex matters.

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. For people receiving care in their own homes an application must be made to the Court of Protection. No applications had been made to the Court of Protection because none were needed.

The provider was not ensuring where people were not able to give consent that they were working within the MCA. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A training and development manager was employed who gave staff face to face training in a variety of subjects. Specialist training was provided when necessary by other agencies including the Kent Fire and Rescue service.

New staff attended training over three days as part of their induction. A variety of subjects was covered over the three days so some subjects were covered in just over an hour including mental capacity, safeguarding and medicines. Some staff said although this gave them a basic overview it was not really enough time to cover the subjects in much detail. New staff, with no experience, worked towards the care certificate, which is an identified set of standards that social care workers work through based on their competency. They then completed 15 hours of shadowing experienced staff and were observed until they were signed off as competent to work on their own.

There were mixed views from people about the continuity of care from regular staff who knew them well. People said this had improved over recent months. Most people and relatives told us they were satisfied with the staff that visited them each week as long as they were familiar with their care and support needs. Most people received care and support from familiar and consistent staff during the week and they were happy with this arrangement. However, some people did say that at weekends they did not know who would be coming. People commented, "On Saturdays and Sundays I am never sure who is going to turn up. It can be very erratic and its takes twice as long to get everything done as I have to explain how to do things". Some people told us when they had not been happy with a particular care staff. They had contacted the office and there had been no problem with them not coming again.

Most of the people or their relatives told us they arranged their own healthcare. However, they said they were confident that the care staff would assist them with this if required. The care staff had a good understanding of the different types of healthcare professionals who could be contacted to help people maintain good health. These included opticians, district nurses and GP,s. In some people's care records

staff had recorded that they had contacted a GP when they had been concerned about the person's health.

People's health care needs were not always detailed in their care plans. One person had an allergy and it was important that staff knew about it. The allergy was not recorded in the person's care plan. Some people had catheters to help them pass urine. There were no guidelines in place for people receiving catheter care for staff to follow, such as how to change the catheter bags or what signs and symptoms staff should look for to reduce the risk of infection and when to request medical advice.

Some people were at risk of developing pressure sores and so had special mattresses and cushions to sit on. However, there was no information in the care plans to guide staff about the signs to look for of developing pressure sores to enable them to take action to ensure people's skin was as healthy as possible. People, their relatives and staff told us that the community nurses visited people to help to maintain their skin integrity and they liaised with these professionals to ensure that the recommendations made were being applied. One relative said, "The staff always tell me if there are any changes to (my relative's) skin. I then contact the district nurse and they come and have a look and let me know what to tell the carers'. People did not always have the same staff supporting them and community nurses did not visit people every day so it was important that staff had guidance to follow about keeping people's skin healthy and what to look out for.

People's needs relating to eating and drinking had been identified when they first started receiving care. People told us that part of their care package was that care staff prepared their food and drinks to their liking. One person told us, "They ask what I like and then I choose and they cook it." Another person said, "They cook my meal in the microwave. It is hot and quick to do." A relative whose family member needed support with meals and drinks was happy with the way in which the staff made the meals. Some people were prescribed special supplement drinks to help them maintain their weight. Staff made sure people got these drinks and recorded that they had been taken.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us the staff who visited their homes were caring, kind and respectful. People said, "They do everything I want and absolutely treat me with respect". "I am a bit slow in the morning and they are so kind and patient. I have two regular carers, they are both fantastic. I would be lost without those two".

Relatives said "The care staff are always happy and cheerful. They sing with (my relative) and that really cheers them up in the mornings". "The staff always explain to (my relative) what they are going to do. They are great. I am happy with the staff who come", "I get on well with them. They are all very nice and helpful. If I want anything else done they will do it".

Some people told us that they had regular staff and had built up relationships with them. They said the staff were familiar with their life histories and knew their family. They understood their daily routines, choices and preferences, such as what they preferred to be called and how they liked to receive their personal care. Parts of people's care plans contained information about people and their preferences but this was inconsistent and some plans lacked this detail so staff may not be aware of people's personal histories, personal preferences and people and events that were important to them. People were asked if they preferred male or female staff to support them or if they did not mind. One care plan contained detailed guidance about how a person preferred to have pillows placed in bed to make sure they were as comfortable as possible. When we visited the person we found that staff had accurately followed this guidance.

Some people said that they were involved in planning their care and were able to make their own decisions. Others said that they had not been involved but were able to tell staff what they needed. Some people would not have been able to tell staff about the care that they needed. Care plans lacked information to show that people were encouraged and supported to be involved in the care planning and how they made decisions about their care. Relatives told us that they were involved in the care of their relative but this information was not recorded in the care plans.

We recommend that the provider reviews their procedure to ensure that everyone is involved in planning their care.

Staff told us when they provided care to the same people this made a big difference. They said this helped them to get to know the person they were caring for and to understand their individual needs. Staff said they had been able to build good relationships with people. They all said this was an important part in providing good care. We observed one staff member visiting people in their homes. There was an obvious affection from people to the member of staff with warm and humorous conversations and laughter. The staff member knew people well and talked enthusiastically to people about their families and hobbies.

Staff treated people with dignity and respect and understood the need to maintain confidentiality. People told us care staff respected and ensured their privacy and dignity. One person told us that a staff member had not treated them with respect. They had contacted the staff at the office and the member of staff did

not return to support them again. People said their independence was promoted and staff supported them to do as much as possible for themselves. However, people's personal hygiene care plans did not detail what people could do for themselves and the areas where they needed support. A relative told us, "They help to keep (my relative) independent by letting them wash as much as they can when showering". Another relative said, "They treat (my relative) with dignity and respect and have time for me too. It's good to have people to talk to who understand what you are going through".

Advocacy services were available but there was no one using this service at the time of the inspection. (Advocates are individuals who supports a person so that their views are heard and their rights are upheld).

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in August 2015 the provider had failed to make sure that people received person centred care and treatment that was appropriate, met their needs and reflected their personal preferences. At this inspection we found that there was a lack of significant improvements.

Each person had a care plan, with copies held at both the branch office and in their homes. Care plans should contain a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. However, they varied greatly in detail and all we viewed required further detail to ensure that people received care and support consistently, according to their wishes and that staff promoted people's independence.

One care plan stated 'I require assistance showering and dressing. Confidence building with mobility and also getting dressed to encouraged.' Another care plan stated. 'Epileptic. Risk of aspiration. Support with full wash. Bedrails –make sure they are up.' There was no further guidance for staff about how this care and support should be given. There was no information to let staff know what the person could do for themselves and when they needed support. There was no guidance for staff on how to give the care and support safely and in a way that suited the person best.

Some people had catheters in place. A catheter is a tube that it is inserted into the bladder so that urine can drain freely. There was no plan to give staff the guidance or instruction 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 about what staff should look for that might indicate a problem, like an infection, and what they should do about it.

On another person's assessment it stated a person was 'epileptic'. There was no other information in the care plan about this condition and what staff should do to monitor and support the person and what staff should be doing to make sure the person's condition remained as stable as possible. There was no information about what staff should do if the person had a seizure?

Some people had medical conditions like diabetes. There was generic information in their care plans about diabetes that had been printed from the internet. There was no information in people's care plan about how this condition specifically affected people, personally and what staff should be doing to support them. There was no information about how the individual may present if their condition became unstable and what action the staff should take.

The care plans showed that people had not been involved in the development and review of their care plans in a meaningful way. People's care needs were not reassessed regularly and this resulted in their care plan being out of date and not reflecting their current needs. When one person had been reviewed by a care manager from the local authority it was noted that there had been changes to how the person received their medicines. This information had not been transferred to their care plan and there was therefore a risk that the person may not receive their medicines safely.

Some staff said that they had been out to support people without any information about the person. They said this was not good and was embarrassing having to ask the person about what support they needed. The registered manager confirmed that there had been occasions when people's needs and risks had not been assessed before they sent a member of staff to support people.

People and their relatives said that staff rarely referred to the care plans. They said they just looked at the record of what the staff before did and did the same and wrote the same.

The provider had failed to ensure that care plans reflected people's assessed needs, preferences and remained up to date. The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff carried out an initial assessment of each person's needs before providing them with a service. Where relevant, an assessment from the funding authority had also been obtained. The registered and deputy managers used this information to make sure they could provide the service people wanted.

People had information about how to complain within the care plan folder kept in their home. This information explained how the registered manager would respond and act on any complaints that they received. The registered manager said this was not currently produced in any other format, for example, in an easy read style. People felt confident in complaining, or felt a relative would complain on their behalf. They said that when they had complained action had been taken and the issue had been resolved.

The last recorded complaint was dated September 2015. This had been investigated and resolved. The registered manager said there had been no other complaints since then. However, people told us they had made complaints. They told us the complaints had been looked into and sorted out but without a record of these complaints and the themes and outcomes there was a risk that the registered manager would not be aware of them and therefore, not use this to improve the service.

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

Inadequate

Is the service well-led?

Our findings

People told us that the service they received had 'got better' over the past few months.
People said, "The manager is very approachable and good" and "This is the best agency we have had. You know that they will always turn up. If they are going to be late more than 15 minutes you usually get a call". "Staff from the office visited a few times in the beginning so that helps, I feel like I am talking to someone I know. We are very happy with the service".

Although we received positive feedback from people and their relatives and some improvements had been made since the last inspection there were continued breaches of the same regulations. The provider had failed to fully implement the action plan to improve the service sent to CQC in October 2015 following our last inspection. The service continued to be in breach of the regulations relating to safe care and treatment, person centred care and good governance. There continued to be a lack of detailed, personalised care planning, including risk assessments. Care plans had not all been regularly reviewed or updated when a person's needs changed. Although there was some 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 recording and management of medicines was not safe. Some records were not accurate or completed properly.

The provider's timescale for completing their action plan was February 2016, which had not been met. There were continued breaches of regulations and breaches of other regulations were identified at this inspection. This included, staff not receiving appropriate support and professional development. The provider was not ensuring where people were not able to give consent that they were working within the Mental Capacity Act.

There was a lack of leadership, oversight and scrutiny to make sure that effective planning and improvements were made to become fully compliant with the regulations. The registered manager and deputy manager both audited aspects of care monthly. People were at risk of receiving unsafe care and support because the audits had not identified the shortfalls that were found at the inspection. Audits had not identified that care plans and risk assessments did not contain the information needed to make sure people received safe personalised care and support.

The registered manager said they checked that staff were providing good care by way of spot checks on staff and telephone calls and surveys to people. However, not all staff had regular spot checks of their practice. Of the four staff we looked at only one had been spot checked this year. A survey had been sent to people in June this year and 18 had been returned. Most of the responses were positive. At the last inspection staff and other stakeholders, including district nurses and care managers, were not being surveyed or asked for their views. This was still the case, staff and stakeholders had not been surveyed and there had been no all staff meeting this year. Some staff had not been offered the opportunity to meet on a one to one basis with a line manager to give their views and suggestions for improving the service.

The registered manager told us that staff should meet with a line manager for supervision twice a year and have an annual appraisal to discuss their performance and development for the year ahead. This was not

happening consistently. Of four staff we looked at two had no supervision meetings at all and one had not had supervision since 2013. Only one of the four had had an appraisal in the last two years.

Staff in the office carried out checks of people's daily records and medicines records each month. Any errors should be picked up at these checks, including gaps on medicines administration records (MAR). We found some errors in records and MAR that had not been picked up, either the error had not been noticed or there were some days to go until the monthly check. For example, some care plans were not up to date stating that people needed only prompting with their medicines when they actually required full assistance. Gaps we found on MAR had not been picked up and with another two weeks until they would be checked by the office staff, there would be a delay in taking any required action.

Records were not always accurate and completed. Care plans and risk assessments completed by the staff did not contain the information to make sure people received the care and support that they needed that kept them as safe as possible. In some cases, there were no personalised care details in place, or moving and handling risk assessments. A pressure risk assessment had been completed incorrectly giving a false result and did not accurately identify the level of risk. Medicine records were not accurate or completed properly. Some medicine records had not been signed by staff to show who was accountable for completing the information. Mental capacity assessments had not been completed.

The provider failed to ensure that systems were established and operated effectively to ensure compliance with the regulations. The systems and procedures in place 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.

This was an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had experience in supporting people in their own homes and had been the registered manager for five years. The registered manager was working towards a management qualification. They split their time between the Broadstairs office and the Herne Bay office and were supported by a deputy manager. The registered manager said they tended to spend more time at the Herne Bay office as there were more people to support there. The registered manager said that the vision of Care at Home was to 'try to keep people safe in their own homes for as long as possible'.

Staff knew about the visions and values of the organisation and told us how they cared for people in a way that they wanted, and helped to keep them as safe as possible. Our discussions with people, relatives and staff showed that there was an open and positive culture between people, staff and the management. Staff understood about their responsibilities to the people and to the management team. They told us they felt supported by the management team.
The registered manager said they attended local provider groups and forums to share best practice and ideas with other providers.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines. All records were stored securely and safely. Records were held securely and computers were password protected.

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 had failed to make sure that people received person centred care and treatment that was appropriate, meet their needs and reflected their personal preferences. This was an on-going breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring where people were not able to give consent that they were working within the MCA. This is a breach of Regulation 11 of the HSCA Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff had received appropriate support, professional development and supervision as was necessary to enable them to carry out the duties they were employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. 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. This was an on-going breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have suitable systems and procedures in place in order to assess, monitor and drive improvement in the quality and safety of people. They had failed to mitigate risks relating to health, safety and welfare of people. People were not protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records. This was an on going in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Issued a warning notice.