

## Meritum Integrated Care LLP

# Meritum Integrated Care LLP (Folkestone)

### Inspection report

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Date of inspection visit: 9 and 10 September 2015  
Date of publication: 23/10/2015

### 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



### Overall summary

The inspection took place on 9 and 10 September 2015, and was an announced inspection. The registered manager was given 48 hours' notice of the inspection. This was the first inspection since the provider had registered under Meritum Integrated Care LLP.

Meritum Integrated Care LLP (Folkestone) provides care and support to adults in their own homes. The service is provided mainly to older people and some younger

adults. At the time of this inspection there were approximately 86 people receiving support with their personal care. The service provided care and support visits to people in Folkestone, Hythe and surrounding areas.

The service is run by an established registered manager, who also undertakes work at other services owned by the same provider. A registered manager is a person who has

# Summary of findings

registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they received their medicines when they should and felt their medicines were handled safely. However we found shortfalls in some areas of medicine management. Risk assessments did not always reflect the support staff gave people with their topical medicines. The system for returning medicine records to the office for auditing was not always effective. There was a lack of guidance or procedures relating to some areas of medicine management. This meant people were not fully protected against the risks of medicine management.

Most risks associated with people's care had been identified and staff were taking action to reduce such risks, but there was not always sufficient guidance in place for staff to help ensure people remained safe.

People were not fully protected by recruitment procedures. Staff files did not contain all the required information as full employment histories or gaps in employment histories had not always been recorded.

People were involved in the initial assessment and the planning their care and support and some had chosen to involve their relatives as well. However care plans varied greatly in the level of detail and most we viewed required further information to ensure people received care and support consistently and according to their wishes. People told us their independence was encouraged wherever possible, but this was not always supported by the care plan. Care plans were reviewed periodically, but not all of them were up to date and reflecting people's current needs.

There had not been any accidents since the service had registered, but there was a clear procedure for reporting and dealing with any accidents and incidents to reduce the risk of further occurrences. People felt safe using the service and when staff were in their homes. The service had safeguarding procedures in place and staff had received training in these. 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 small team of staff. Staffing numbers were kept under constant review. New staff underwent an induction programme, which included relevant training courses and shadowing experienced staff, until they were competent to work on their own. Staff received training appropriate to their role.

People were satisfied with the service they received. One person said, "As a service we find it quite all right". People felt staff had the right skills and experience to meet their needs. One person said, "We have a very qualified carer who has worked a long time with older people and does a good job". Senior staff monitored staffs practice during unannounced checks on their practice within people's homes. Staff felt well supported and attended group meetings with their manager.

People told us their consent was gained at each visit. People had also signed their care plan and an agreement to confirm their consent to their care and support. People were supported to make their own decisions and choices. No one was subject to an order of the Court of Protection. Some people had Lasting Power of Attorneys in place and some others chose to be supported by family members when making decisions. Staff had received training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager understood this process.

People were supported to maintain good health. People told us how observant staff were in spotting any concerns with their health. The service made appropriate referrals and worked jointly with health care professionals, such as community nurses and dieticians.

People felt staff were very caring. People 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 kind and caring 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

# Summary of findings

specific needs relating to their age and physical disabilities. Staff had built up relationships with people and were familiar with their personal histories and preferences.

People told us that communication with the office was good and if there were any queries they called the office who responded. People felt confident in complaining, but did not have any concerns. People had opportunities to provide feedback about the service provided. Negative feedback that had been received had been acted on. People felt the service was well-led. There had been changes in the senior staff team, but new arrangements were in place to ensure the service ran smoothly.

The provider had a set of aims and objectives. Their aim was to provide a service to meet the needs of people by promoting a standard of excellence which embraced the fundamental principles of good care practice that was witnessed and evaluated through patience, conduct and control of quality care. Staff were aware of the aims and objectives and felt they followed them through into their practice.

We found a number of 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.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

The system for returning medicine records to the office for audit was not always effective. There was a lack of guidance and procedures relating to some areas of medicine management.

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

People were not fully protected by robust recruitment processes as full employment histories or gaps with explanations had not been recorded.

There were sufficient numbers of staff to meet people's care and support needs.

**Requires improvement**



### Is the service effective?

The service was effective.

People received care and support from trained and supported staff.

People received care and support from a team of regular staff who knew people well. Staff encouraged people to make their own decisions and choices.

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

**Good**



### Is the service caring?

The service was caring.

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

People felt relaxed in the company of staff and people were listened to by staff who acted on what they said.

Staff supported people to maintain their independence wherever possible.

**Good**



### Is the service responsive?

The service was not always responsive.

Care plans varied in detail and most did not reflect people's full personal care routines or their wishes and preferences. Some care plans were not up to date with people's current care and support needs.

**Requires improvement**



# Summary of findings

People felt comfortable if they needed to complain, but did not have any concerns. People had opportunities to provide feedback about the service they received.

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

## Is the service well-led?

The service was not always well-led.

Records were not always robust. Risk assessments, care plans and medicine records required improvement.

There was an established registered manager who was supported by a senior staff team.

There was an open and positive culture within the office, which focussed on people.

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

**Requires improvement**



# Meritum Integrated Care LLP (Folkestone)

## 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 9 and 10 September 2015 and was announced with 48 hours' notice. The inspection was carried out by one inspector.

The provider was not asked to complete 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 information we held about the service, we looked at previous inspection

reports and the notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection the provider supplied information relating to the people using the service and staff employed at the service. We reviewed people's records and a variety of documents. These included nine people's care plans and risk assessments, three staff recruitment files, the staff training, supervision and appraisal records, visit schedules, accident and incident records, medicine and quality assurance records and surveys results.

We spoke with seven people who were using the service, three of which we visited in their own homes, we spoke to five relatives, the registered manager, the area manager, a director and five members of staff.

After the inspection we contacted six health and social care professionals who had had recent contact with the service and received feedback from two.

# Is the service safe?

## Our findings

People told us they felt safe when staff were in their homes and when they received care and support. One person said, “Yes, I feel safe, that’s why they have my door code”.

People we spoke with told us they handled their own medicines, but staff were applying topical medicines. It was identified during the inspection that staff did administer medicines to a few people. People told us that staff applied their topical medicines when they should and felt these were handled safely. However people were not fully protected against the risks associated with medicine management.

A medicines risk assessment had been undertaken for each person. This identified who managed the person’s medicines. However where the arrangements were different for topical medicines this was not identified within the risk assessment. One risk assessment was not up to date as it stated staff administered the medicines from a monitored dosage system (a box of medicines separated into compartments and filled by the pharmacist) and staff told us this was not the current arrangements in place. People had consented to the arrangements in place by signing their risk assessment, but this consent was not always for the most up to date arrangements and there was a risk that staff would be unclear about whether they should apply any topical creams.

The system for returning Medication Administration Record (MAR) charts to the office to be audited and to check people were receiving their medicines when they should was not effective as some people’s files contained no records for some considerable time. Where staff were administering topical medicines, medicines from a dosette box (monitored dosage system), antibiotics or eye drops there were no proper MAR charts in place. Staff were signing a record that did not identify what medicine had been administered only that it was a cream or eye drops and when it had been administered. This meant we were unable to ascertain what actual medicine had been administered to people.

Where people were prescribed medicines on a ‘when required’ basis, for example, to manage constipation or pain, there was no individual guidance for staff on the

circumstances in which these medicines were to be used safely and when they should seek professional advice on their continued use. This could result in people not receiving the medicine consistently or safely.

There was a medicines policy in place which gave staff good practice guidance on areas of managing medicines. However this did not contain a clear procedure for staff to following when administering medicines to ensure this was undertaken safely. The registered manager told us that the administration process had been made clear to staff during their medicines training, but agreed to update the policy.

Risks associated with people’s care and support had mostly been assessed, these included people’s environment, maintain a healthy skin, nutrition, falls, mobility and moving and handling, but these records lacked detail about the steps that were in place to reduce these risks. Many risks identified had ‘Care workers to monitor, record and report any relevant changes in (person’s) well-being’ as the only guidance about how staff should manage and mitigate risks. Moving and handling risk assessment showed the number of staff required and the equipment used, but there was no personalised detail about how staff should move the person safely and in line with their wishes. Some people had health conditions, such as epilepsy and diabetes, but risk assessments did not identify the signs and symptoms a person may display when they became unwell due to these conditions or what action staff should take to keep the person safe. Staff had received training in these health conditions and discussions identified they knew what to do in such circumstances. However to help ensure the person remains safe guidance should be in place. In other circumstances staff were taking steps to help ensure people remained safe either by their practices or by using equipment and this must be detailed in the risk assessment records to ensure people always receive safe and consistent care.

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.

Staffs medicine administration competency was checked following training and then annually by senior staff to ensure they followed good practice and people received their medicines safely.

## Is the service safe?

People were not fully protected by recruitment processes. We viewed recruitment files of staff that had recently been recruited. These contained evidence of a Disclosure and Barring Service (DBS) check having been undertaken (these checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people), proof of the person's identity, a recent photograph and evidence of their conduct in previous employments. There was a completed application form on each file. The application forms examined did not require the prospective employee to record dates of their employment so it was not possible to always ascertain whether a full employment history had been recorded. However it was evident that in possibly two cases that a full employment history had not been recorded and gaps in employment history had not been explained, as required by legislation.

The provider had failed to ensure that all the required information in respect of a person employed was in place. This is a breach of Regulation 19 and Schedule 3 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us that visual checks were undertaken on the equipment used at each visit to ensure it was safe. One person told us their hoist had recently been serviced. The area manager told us that the plan was to record any equipment that was used by staff on the risk assessment together with service dates and set a calendar reminder, to ensure the equipment was serviced regularly and remained safe. During the inspection staff told us about a situation where a faulty hoist sling was reported, staff took immediate action speaking with health professionals and a new sling was obtained.

The area manager told us and records confirmed the provider had plans in place in the event of emergencies, such as bad weather or operation stack on the M20 motorway. This included measures, such as global texts sent to staff to keep them up to date on conditions, each person had been assessed in relation to prioritising their

visits during emergencies and this was recorded. There was also access to 4x4 vehicles and staff worked locally to where they lived, to ensure people would still be visited and kept safe.

People told us they felt safe whilst staff were in their home and would feel comfortable in saying if they did not feel safe. There was a safeguarding policy in place. Staff had received training in safeguarding adults; they were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. The registered manager was familiar with the process to follow if any abuse was suspected; and knew the local Kent and Medway safeguarding protocols and how to contact the Kent County Council's safeguarding team.

People had their needs met by sufficient numbers of staff. People told us, "The majority of the time" and "Within reason" staff turned up on time and when they were expected. Minutes of a recent team meeting showed staff were reminded about the importance of arriving on time for people's visits. People told us when they had experienced a late call they sometimes had phoned the office or on call, but their care worker had arrive soon after, so their routine had not been too disrupted. The last quality assurance survey showed that people felt staff stayed the allocated time. One person told us, "They don't rush me". The area manager told us that 92% of people's visits were allocated permanently to staff rotas and these were only changed when staff were on leave. Staff usually worked in a geographical area and the registered and area manager kept staffing numbers under constant review. There was an on-call system in place, should people need it, for outside of office hours. The area manager told us that the office was open from 9am to 5pm Monday to Friday and covered by the coordinators. In the evenings and at weekends the on call phone was held by senior staff.

Accident and incidents had been previously reported and recorded. There had been no accidents since the service had registered. There was a clear written accident procedure in place and staff demonstrated in discussions that they knew what action to take should an accident occur, in order to keep people safe.



# Is the service effective?

## Our findings

People and their relatives were satisfied with the care and support they did receive. Comments included, “We get satisfaction and good care”. “The carers are usually very good”. “They are so on the ball and very very good; they make us feel at ease”.

A social care professional told us that they had recently undertaken a review with their client and they were “Happy with the service care they received from Meritum carers”.

People told us they received their service from a small team of regular staff and records confirmed this. Staff told us that following an initial phone call where they discussed people’s needs they match a member of staff to cover the visits. The matching process was based on gaps within staff schedules, staff working in the geographical area, people’s preferences and staff skills and experience. People told us when they had not been happy with a particular care worker there had been no problem with changing. When people did not want a particular care worker this was recorded on the computer system, which blocked them from being scheduled to undertake visits to that person. Staff told us that some people received a schedule of visits in advance; these were sent when people had requested them. One person asked during the inspection for a schedule of visits and this was feedback to the office staff.

People felt staff had the right skills and experience to meet their needs. Comments about staffs skills and experience included, “We’ve had reasonable and very good girls”. “They are very caring and practical as well”. “I have one main carer and they are very professional”. “The majority are good, but new ones can get flustered”. “Some are better than others, but they have all been trained”. Staff understood their roles and responsibilities. Staff had completed a five day induction programme, which included shadowing experienced staff, attending training courses and staff also received a staff handbook. The induction was based on the Skills for Care common induction standards, which are the standards people working in adult social care need to meet before they can safely work unsupervised. The provider told us they were working towards matching the existing induction training to the new Care Certificate, which was introduced in April 2015 by Skills for Care. These are an identified set of 15

standards that social care workers complete during their induction and adhere to in their daily working life. The area manager told us there was a three month probation period to assess staff skills and performance in the role.

Staff attended training courses relevant to their role, which were refreshed. Training included enablement, care principles, nutrition and hydration, health and safety, moving and handling, fire safety awareness, emergency first aid, infection control and basic food hygiene. Staff received some specialist training, such as stoma and catheter care, care of the elderly, diabetes awareness, dementia care, and stroke awareness, end of life and epilepsy awareness. Staff felt the training they received was adequate for their role and in order to meet people’s needs. Twenty-two of the 24 staff had obtained or were working towards a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

The area manager told us staff had opportunities to discuss their learning and development through team meetings, unannounced community supervisions and an annual appraisal. A new appraisal scheme had recently been introduced where staff would receive an appraisal after three months and then annually. Unannounced community supervision were undertaken by the senior staff, these were unannounced, whilst staff were undertaking visits to people. During these observations staff practice was checked against good practice, such as communication with the person, infection control and respect and offering choices to people. Team meetings for staff were held. Staff were able to discuss any issues and policies and procedures were reiterated. Staff said they felt supported.

People had signed their care and support plans and an agreement form to confirm their consent and they told us their consent was gained at each visit. People said consent was achieved by staff discussing and asking about the tasks they were about to undertake. People said staff offered them choices, such as what to have to eat or drink or what to wear. The registered manager told us that no one was subject to an order of the Court of Protection; two people had a Lasting Powers of Attorney in place. Sometimes

## Is the service effective?

people chose to be supported by family members. Staff had received training in the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager told us that the service had not been involved in any best interest meetings, but they understood the process, which had to be followed when one was required.

People's needs in relation to support with eating and drinking had been assessed during the initial assessment and recorded. Although most people required minimal support with their meals and drinks if any, staff told us two people were at risk of poor nutrition or hydration. Staff told us how they worked closely with the dieticians who had been involved in these cases and their recommendations were followed into practice. Staff said, both people were on a fortified diet, which was supplemented with meal replacement drinks and they were weighed regularly. Staff told us other people had special diets, such as high fibre and high fat/sugar diets. People talked about how staff

prepared what they asked for or looked in the cupboard and offered them a choice. People said staff encouraged them to drink enough and would leave a drink or drinks for later if they did not have relatives around.

People were supported to maintain good health. People told us how observant staff were in spotting any concerns with their health or if they were "Not themselves". One person said, "They are attentive and aware". People and relatives told us how staff always commented when they noticed any changes and sometimes suggested calling the doctor. One person told us about how a staff member had called an ambulance when they thought something was wrong with their foot and they were admitted to hospital. The area manager told us about a recent incident when someone had become unwell due to their diabetes and staff had recognised the signs and called an ambulance, although the person had refused to go to hospital another ambulance was called later when the person was admitted to hospital. Where people were at risk of pressure sores staff were observant and reported any concerns if they were worried about an area and then worked with the community nurses to improve people's health. Information about people's health conditions diabetes, warfarin awareness and prevention of pressure ulcers had been obtained and was given to staff.

# Is the service caring?

## Our findings

People told us staff were caring and listened to them and acted on what they said. People and their relatives told us this sometimes included the use of appropriate banter and good humour. People were complimentary about the staff. Comments included, “They are very kind and helpful”. “They are very pleasant and chatty”. “Caring – very”. “I have two regulars, they appear to be friends, I am relaxed in their company and they are very friendly”. “They have a nice way about them”. The last quality assurance survey showed that 100% of people felt staff were friendly and caring. The service had received a number of compliments from people and relatives. One had said, “Thank you for all your help and kindness shown to Mum”.

Some people talked about staff that “Went that extra mile”. One person talked about a member of staff who was observant and notices any little change in their well-being. Another person talked about a time when they couldn’t get out of their chair to open the door, but the staff member persisted and when they couldn’t gain entry went and summoned the housing manager to assist with a master key. One person said, “I like (staff member), she’s good. It makes all the difference to my day when she comes”.

Senior staff talked about a fairly new member of staff who again they felt went beyond the call of duty. They told us about an incident where a person was crying and extremely upset. The staff member sat and talked to the person for an hour, calming them with a kind and caring approach.

People told us they received person centred care that was individual to them. They felt staff understood their specific needs relating to their age and physical disabilities. Staff demonstrating a person centred approach and understanding people’s specific needs was checked during community supervision. Staff had built up relationships with people and were familiar with their life histories and preferences. Care plans contained some details of people’s preferences, such as their preferred name and some information about their personal histories. During the inspection staff talked about people in a caring and meaningful way.

People said their independence was encouraged wherever possible. One person said, “I am very independent. I do as much as I can and they do the rest”. Another person said, “They encourage and push me (in a nice way) to help myself”. Another person talked about how staff started to take off their t-shirt and then they could manage getting it off on their own. People were asked if staff helped them maintain their independence during community supervisions undertaken in their home to ensure staff encouraged this.

People told us they were involved in the initial assessments of their care and support needs and planning their care. Some people had also involved their relatives. People had mixed views about whether senior staff visited periodically to talk about their care and support and discuss any changes required or review their care plan. People and relatives felt care plans reflected how they wanted the care and support to be delivered. The registered manager told us at the time of the inspection most people that needed support to help them with decisions about their care and support 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 told us they were treated with dignity and respect and had their privacy respected. One care plan identified that the person wished to be left in the bath until they were ready. People were asked during visits by senior staff if staff respected their dignity and privacy. Staff had received training in treating people with dignity and respect as part of their induction and had their practice observed in relation to this during community supervision. Information given to people confirmed that information about them would be treated confidentially. People told us staff did not speak about other people they visited and they trusted that staff did not speak about them outside of their home.

The registered manager and a director were both dementia friends. Signing staff up as a dementia friend is a national government funded initiative to improve the general public’s understanding of dementia.

# Is the service responsive?

## Our findings

People told us they were involved in the initial assessment of their care and support needs and in planning their care. One person said, “They came out and discussed things”. Another person said, “Everything was discussed and they go through things all again each year”. Some people told us their relatives had also been involved in these discussions. People had signed forms showing their consent for care and support to be delivered in line with their assessments and care plan. Assessments were undertaken by senior staff. In addition when contracting with the local authority the service had obtained some information from health and social care professionals involved in people’s care and support, to make sure they had the most up to date information on the person.

Care plans were developed from discussions with people during the assessment visit. Care plans should have contained a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. However they varied greatly in detail and most we viewed required further detail to ensure that people received care and support consistently, according to their wishes and staff promoted people’s independence. For example, one person told us they washed themselves as much as they could, but this was not evident in the care plan.

One care plan simply stated ‘AM visit - assist with catheter, washing and dressing, apply creams to legs and sacrum and check for any pressure areas, breakfast and hot drink’. Another person had a catheter in place, but this was not mentioned within the care plan tasks although staff were emptying and changing the catheter bags. One care plan was not up to date with the visits the person received. The care plan stated that the individual had a visit each morning, but staff told us and other records confirmed they only received a visit three mornings a week.

People felt they got the care and support they wanted that did reflect their preferences and wishes. Although this meant that people would have to explain their preferred routine to any new staff that visited or may not receive consistent and safe care particularly when their regular staff member did not visit. Staff were knowledgeable about people’s preferred routines that they visited.

The provider had failed to maintain an accurate and complete record in respect of care and support provided to people and the decisions taken in relation to that care and support. The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not socially isolated. Some people were supported to be ready to attend local centres or clubs; others were supported to access the community for shopping or social activities. Staff told us a few people were supported for a period of time to give a main carer (usually a family member) a break and enable them to access the community. People told us they looked forward to the staff visits and this helped break up their day. One person said, “I am a bit anti-social, but they are chatty and I enjoy their visits”. Another person said, “They always make time to chat about what I did yesterday and what I am going to do, they are very friendly”.

People felt confident in complaining, or felt a relative would complain on their behalf, although people did not have any concerns when we asked them. People had information about how to complain within the folder kept in their home, so they would know how to complain. This included the timescales in which they would receive a response. People had signed an initial visit form to indicate that the complaints procedure had been explained to them and their understanding of how to complain was checked during visits made by senior staff. Records showed complaints were recorded together with investigations and outcomes. Complaints were monitored at senior staff meetings and used to improve the service.

People had mixed views about whether they had yet had opportunities to provide feedback about the service provided. People and sometimes relatives had the opportunity to feedback during review visits. People confirmed that senior staff sometimes visited them to carry out their care and support, so during this time, people were able to feed back about the service they received. Some people told us they or their relatives had completed questionnaires to give their feedback about the service provided. Telephone calls to check the quality of the service provided were also undertaken by senior staff. The responses of both these were held in the office and were

## Is the service responsive?

mainly positive. Where one person indicated they were not happy a review meeting was held between the person, staff and their care manager to review and address the concerns.

# Is the service well-led?

## Our findings

People and relatives felt the service was well-led and well organised. Comments included “There are no problems, we are very happy”. “It’s very very good”.

Records and systems were not always robust. Some records were not up to date. For example, some care plans had not been updated when people’s visits had changed and a risk assessment had not been updated when the arrangements for managing a person’s medicines had changed. The system for returning MAR charts and daily records made by staff was not always effective, resulting in these records not being available within the office. There was not always clear information about which medicine or topical cream should be administered/applied where and when. There was a lack of guidance for staff on medicines prescribed ‘as required’. Risk assessments lacked detail about the systems and practices that were in place to keep people safe. Care plans should have contained a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. These varied in detail and some required further information to ensure that they really reflected people wishes and to ensure staff promoted people’s independence.

The provider had failed to maintain an accurate and complete record of the care and support provided and decisions taken in relation to people’s care and support. This is a breach of Regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were stored securely and there were minutes of meetings held so that staff would be aware of issues within the service. Where records had been returned from people’s homes these had been audited for legibility and content. The area manager told us any shortfalls and action to address these were identified and picked up with staff during supervision.

Staff had access to policies and procedures via the office or their staff handbook. The provider was in the process of introducing a new set of policies and procedures, which had been written to ensure any new legislation and good practice was included. However these lacked a clear procedure for administering medicines. The registered manager contacted the company that had supplied the policies to address this during the inspection.

A new Service User Guide had been developed. This is an information folder that each person was given at the start of using the service. It contained information about what people can expect from the service. The provider had developed the new information and then asked a selection of people to give their feedback on the contents. Feedback was positive, but people raised one area for further improvement relating to the on call telephone numbers and changes had been made to make this clearer.

There was an established registered manager in post who was supported by coordinators and an area manager. The registered manager was registered for the Folkestone service, but also worked in other branches own by the same provider. They worked Monday to Friday each week and their time spent in the Folkestone varied from week to week depending on the needs of the service. Coordinators worked in the office Monday to Friday 9am to 5pm unless it was covered by the registered or area manager whilst the coordinators were out on assessments or review visits. There had been a period of unsettledness within the service due to changes in the coordinator arrangements due to long term sickness. However this had been resolved at the time of the inspection. Only a few people had had any contact with the registered manager. Other people were familiar with the coordinators that oversaw the service. People felt communication with the office was good and staff responded well and were polite. One person said, “They are very nice”. The last quality assurance survey showed that people who responded felt the office staff were “Polite and helpful”.

During the inspection there was an open and positive culture within the office, which focussed on people. The registered manager told us it was a “Team approach here”, but they adopted an open door policy regarding communication and even when not working in the Folkestone branch could be contacted directly. Staff felt the senior team motivated them and other staff and listened to their views and ideas. For example, better clustering of visits through a reschedule and clearer arrangements for claiming travel time.

Social care professionals felt the service was well-led. One person told us, their experience of meeting with the management team was that they appeared be positive and



## Is the service well-led?

proactive in responding to actions. Professionals told us that the registered manager was positive and appeared to portray an outcome focussed approach to ensure the well-being and safety of people the company supported.

The provider's aims and objectives were included in the service user guide and staff handbook. Staff were also aware of the aims and objectives of the service through induction and training. They told us the service these were to provide a quality service and promote peoples independence.

The service had signed up to the Social Care Commitment. However there had been a considerable delay in the service receiving their information pack and poster and told us this would be chased following the inspection. **The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services.** It is a Department of Health initiative that has been developed by the sector, so it is fit for purpose and makes a real difference to those who sign up. Made up of seven statements, with associated 'I will' tasks that address the minimum standards required when working in care, the commitment aims to both increase public confidence in the care sector and raise workforce quality in adult social care.

The provider was a member of the United Kingdom of Home Care Association and Kent Community Care Association. The management team had undertaken some joint working with Kent County Council looking at developing policies relating to adults at risk. The management team also networked with other local service providers had monthly meetings with the local authority and attended forums. This all helped in order to share good practice and keep up to date with changes. The management team was keen to promote innovative new ideas to help people remain healthy and safe. They were currently piloting a scheme called 'EDAYBOOK'. Edaybook is a new concept in social care technology. The idea is to work with people and help them to take ownership of their own health issues. It's also really helpful as an early warning of health issues arising and being given the time to consult professionals in order to put things right instead of reacting to them after they have happened. Staff carry tablet computers and can communicate with senior staff and write daily notes directly onto a system, which can be accessed by all senior staff.

There were audits and monitoring of the service to help ensure the service ran effectively and people remained safe. These included the number of hours delivered, care reviews due and completed, permanently scheduled or unscheduled visits, missed calls and community supervisions due and completed and staff sickness. The area manager told us that learning from incidents helped to drive improvements. For example, a recent case had identified that when taking on a complex package of care, good communication with people and relatives that were involved in the care and support arrangements and possibly a pre-delivery meeting helped resolved early issues. The initial referral form had been updated to ask questions about the previous care and support arrangements of people to help identify where there might be a problem.

Staff said they understood their role and responsibilities and felt they were well supported. There were systems in place to monitor that staff received up to date training, had regular team meetings, community supervision and appraisals, when they could raise any concerns and were kept informed about the service, people's changing needs and any risks or concerns. For example, we saw that new better quality disposable gloves had been introduced following feedback from staff.

People and/or their relatives completed quality assurance questionnaires to give feedback about the services provided. During October 2014 people responded to surveys sent out by the provider. A high majority of those showed people were "Very satisfied" or "Satisfied" with the overall service received. Negative comments were used to drive improvements to the service and a letter relating to the action taken was about to be sent out to people. However the time delay in people receiving feedback was quite considerable. The area manager told us that they were planning to introduce a new system for gaining feedback. In future questionnaires would be sent out every January starting from 2016 and we saw a plan which showed people would receive feedback relating to the results within a six week period. A newsletter to keep people up to date was also about to be introduced. This would include information about how to keep safe in hot or cold weather, introducing the new service user guide, information about staff changes and useful contact information.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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

Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The lack of detail in care plans, medicine records and risk assessments meant the provider did not have an accurate and complete record of the care and treatment including decisions taken in regard to people.</p> <p>Regulation 17(2)(c)</p>

Regulated activity	Regulation
Personal care	<p>Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed</p> <p>The provider had failed to ensure that all the required information in respect of a person employed was in place.</p> <p>Regulation 19(3)(a)</p>