Nestor Primecare Services Limited

# Allied Healthcare Hythe

## Inspection report

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16 February 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| 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 15 and 16 February 2016, and was an announced inspection. The registered manager was given 48 hours' notice of the inspection. The previous inspection on 2 and 3 February 2014 found no breaches in the legal requirements.

Allied Healthcare Hythe provides care and support to people in their own homes. The service is provided to mainly older people and some younger adults and people who have a learning disability. At the time of the inspection there were approximately 236 people receiving support with their personal care. The service provides care and support visits to people in Ashford, Canterbury, Folkestone, Hythe, the Romney Marsh and surrounding areas. It provides short visits to people as well as covering shifts over a 24 hour period to support people.

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

There had been a high number of medicines errors and medicine management required improvement in most areas, to ensure people received their medicines safely and when they should. Most risks associated with people's care and support had been assessed, but staff lacked clear guidance on how to reduce these risks to keep people safe.

People did not have their needs met by sufficient number of staff resulting in a high percentage of late calls and a number of missed calls. People did not always receive care and support from regular staff that were familiar with their care and support needs. Some staff were not sufficiently trained, experienced or competent to fully meet people's needs. People were not fully protected by robust recruitment procedures.

People gave their consent for their care and support. However there was a lack records relating to the legal arrangements in relation to decision making people had in place.

Most people on the whole felt that staff were caring and respected their privacy and dignity. However people gave examples where they felt this was not the case.

People's needs had been assessed when they started to use the service and care plans were in place. However these varied in detail and all required further information to ensure people's care and support reflected their wishes and preferences. Care plans were not all up to date and some had not been reviewed for some time.

People had mixed opinions whether they were asked for feedback about the service. There had been a high number of complaints since the last inspection. People that had complained had mixed opinions about

whether when they complained things really changed.

There had been a high turnover of office staff and this had impacted on the service people received and staff morale was low. People had very mixed opinions about their communications with the office and the registered manager. Audits and systems had not been effective in ensuring people received a quality service that meet their needs.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People's medicines were not managed safely and all areas of medicine management required improvement.

People did not have their needs met by sufficient numbers of staff resulting in missed and late visits. People were not fully protected by robust recruitment procedures.

Most risks to people had been assessed, but staff lacked clear guidance about how they should manage these risks to keep people safe.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People did not receive care and support from sufficiently competent, experienced and trained staff.

People had given their consent for their care and support, but the legal arrangements they had made were not recorded to ensure they were carried out.

People were supported to maintain good health.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Most people felt most staff were caring and respected their privacy and dignity. However there were examples where this was not the case.

People felt their independence was maintained.

Some people talked about staff that went that extra mile and made a difference to their lives.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People's care plans varied in detail and did not reflect all their wishes and preferences. Some were out of date and had not been reviewed for some time.

There had been a high number of complaints and some people felt complaining did not improve the service they received.

People had mixed opinions about whether they were asked for feedback about the service.

## Is the service well-led?

**Inadequate**

The service was not well-led.

There had been a high turnover in office staff and this had impacted on service delivery.

People had mixed opinions about their communications with the office and the registered manager. Staff morale was low.

Audits and systems had not been effective in driving improvements in the service people received.

# Allied Healthcare Hythe

**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 15 and 16 February 2016 and was announced with 48 hours' notice. The inspection carried out by two inspectors.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed this and other information we held about the service, we looked at 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 we reviewed people's records and a variety of documents. These included six people's care plans and risk assessments, three staff recruitment files, staff training, supervision and appraisal records, visit and rota schedules, medicine and quality assurance records and surveys results.

Before and directly following the inspection the Commission received two letters of concern. The areas of concern including people not receiving a schedule of visits in advance, late or missed visits, staff not staying the full time allocated and poor communication with the office. These areas were examined during the inspection.

We spoke with 21people who were using the service, four of which we visited in their own homes, we spoke to nine relatives/representatives, the registered manager and 12 members of staff.

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

We sent out 50 surveys to people who were using the service, relatives and professionals involved with the

service. We received surveys feedback from 16 people, two relatives and two professionals.

Inadequate

# Is the service safe?

## Our findings

People and relatives told us they felt safe when staff were in their homes and when they provided care and support. One person said, "I do feel safe". Another person said, "All the staff that have been sent have presented as trustworthy. I have always felt safe with them". People and relatives surveyed indicated that they or their family member felt safe from abuse or harm from staff.

The registered manager told us staff handled medicines for approximately 120 people. People told us they felt they received their medicines when they should and staff handled them safely. However people were not fully protected against the risks associated with medicine management and the registered manager said there had 25 medicine errors within the last 12 months.

There was a clear medicines policy in place. Staff had received training in the management of medicines and their competency was checked by the field care supervisors. The registered manager had already identified shortfalls in medicine management and had arranged to increase the medicine management training from three yearly to annually to minimise risks and some training sessions had taken place or been arranged. However one staff member said, "We have meds training in basic and refresher training package. They arranged some additional meds training, but it didn't add to what we already knew".

Medication assessments for people were undertaken where staff were involved in the administration of tablets or topical medicines (creams/sprays). However a copy of this assessment was not kept in people's homes so staff did not have access to this information. One assessment identified the action as 'make medication available at morning and evening calls'. We asked the registered manager what this meant and they were not clear, which meant staff may also be unclear. There were Medication Administration Records (MAR) charts held on file for this person although the care plan for this person did not mention medicines or administration during the evening call, so there were no clear instructions about the management of this person's medicines for staff, leaving a risk their medicines may not be managed consistently or safely. On occasions the arrangements for topical medicines were not covered in the assessment, particularly where they were different from the arrangements for administering tablets, so staff had no guidance about if or how they should be involved with these types of medicines.

Within the each person's care plan there was a list of their prescribed medicines. However these were not always up to date and did not always reflect other medicine records, so it was unclear exactly what medicines people were prescribed, leaving a risk that people may not receive the right medicines or their medicines at the right times.

Where people were prescribed medicines on a 'when required' basis, for example, to manage constipation or skin conditions, there was a lack of clear individual guidance for staff on the circumstances in which these medicines were to be used safely and when they should seek professional advice on their continued use. For example, a person was prescribed five different creams/sprays, but there was no guidance about where these should be applied and when. This could result in people not receiving the medicine consistently or safely.

Medication Administration Records charts were in place where staff administered people's medicines. We found that a handwritten entry on one MAR chart indicated that the dosage of a medicine had been increased, but as this change was not signed or dated we were unable to ascertain exactly when this change took place. This could be important when monitoring people's health in relation to the changes and their effectiveness.

Records showed that some medicines or topical medicines (creams) were not administered according to the prescriber's instructions. For example, creams were prescribed daily, but were only administered occasionally, although no action had been taken to change the prescription to reflect people's current needs despite this being identified on one audit check. Some creams not mentioned in the care plan or on a medicines list had been applied by staff according to the daily notes they made.

One person told us what topical medicines had been administered by staff that week. However the MAR charts in place did not reflect this. Often there were long periods where no code or signature was recorded, so we were unable to ascertain what and when topical medicines had been applied.

One person had their medicines supplied in a monitored dosage system (a box of medicines separated into compartments and filled by the pharmacist). There were three tablets in both the morning and evening compartments, but the MAR chart in use stated there were eight tablets for the morning, three for tea time and three for the evening, staff had not changed the MAR or raised this with management as an issue and had signed to say all eight tablets had been administered. Staff were not required to identify what number of tablets they had administered each time, which may have reduced the risk for error. For five occasions since the start of February the code 'F' had been used, which meant the medicines were 'not available', but all the tablets that were prescribed would have been contained in the box. On three occasions there was no code or signature recorded. Another MAR chart with the right medicines recorded was contained within the folder, was dated 1 February 2016, but was not being used.

Where staff administered one person's morning and tea time medication, the MAR chart had only been signed twice at tea time and no codes entered on the other days, although all the tablets in the monitored dosage system for tea time that should have been administered had gone. On two occasions at tea time the staff member had signed the MAR chart for the evening tablets as well on the same visit. We checked the daily report notes where they had recorded the tablets for the evening had not been administered, but left out for later. According to good practice and the provider's policy a code should have been entered so as to be clear these tablets had not been actually taken by the person. For the morning tablets there was no signature or code recorded for two days since the start of February. We therefore were unable to ascertain what medicines had been administered and by who.

The system for returning 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 very old or no records. The registered manager had identified this as a concern and had recently sent out information to staff about returning MAR charts to the office monthly. However this was not yet effective.

Risks associated with people's care and support had mostly been assessed, these included people's environment, maintaining a healthy skin, nutrition, falls and moving and handling, but these in some cases lacked detail about the steps that were in place to reduce these risks. Moving and handling risk assessments did not always showed the personalised detail about how staff should move the person safely and in line with their wishes. There were charts to record the equipment staff used and service dates to ensure it remained safe to use. However these were not up to date. 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. A copy of the assessments were not kept in people's homes so in most cases the risk was identified on the summary of needs record, (which was kept in the person's home), but the action to reduce these risks were not recorded to inform staff. This left a risk that people may not receive safe and consistent care or that staff may not take the right action or act in a timely way to keep people safe and healthy.

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

People were not fully protected by recruitment processes. We viewed recruitment files of three 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 and a recent photograph. However the application form only requested that staff record five years of employment history and the regulations required a full employment history.

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.

The registered manager told us there was an ongoing recruitment drive in place. However people did not have their needs met by sufficient numbers of staff. Forty percent of people, 50 percent of relatives and 100 percent of professionals surveyed felt staff did not arrive on time. One person commented, "I do understand that it is difficult for my carers to be with me at the set, agreed time, every time. Some days they come so late, that I have to refuse my shower, as I need to dress and be normal routine at or by a sensible time". One professional commented, "There has been a fairly long period where the service has not been reliable, calls have been late/missed and this has caused distress to people". Another professional felt that the risk of missed or late visits to some people placed them at high risk of a decline in their health due to time specific medicines. In the latest quality monitoring report available (September to November 2015), across the whole area covered by Allied Healthcare Hythe an average of 27.5 percent of visits were 45 minutes or longer outside of the agreed start time, with the worst affected area being the Canterbury area at 37.5%. One relative told us how they had waited two hours recently on two occasions for staff to arrive and in the end undertook the care and support themselves. Other people talked about recent visits that had been between 50 and 150 minutes late. Records showed that one person who received 21visits a week, which should have been undertaken by two staff, had on six occasions in one week only had one staff member arrived. Another record showed a person had a single staff member twice in a day when two should have arrived. People told us that one staff member arriving was not infrequent for their family members. Two people commented there was not sufficient travelling time allowed between people's visits on schedules and those we checked did not always allow sufficient travelling time between visits, which would make them late. This was an area also mentioned by some staff as a concern. People had mixed opinions about whether they were informed when staff were running late. One person told us, they had had a review meeting with the provider and social services, which was mainly "about timings". During the inspection we heard one member of office staff spend their whole day covering visits mainly for that day and evening, with a total of 46 visits requiring cover for that day and evening for their area. They told us this was due to staff sickness and car problems. Records and discussions showed there was a high turnover of care staff with 19 starters and 19 leavers in the last six months and in addition three staff had given notice at the time of the inspection, two had been promoted and four were on long term leave.

The provider had failed to have sufficient numbers of suitably qualified, competent and experienced staff deployed in order to meet the requirements of the service. This is a breach of Regulation 18 (1)(2) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives and most people surveyed felt staff stayed the full time and did all the tasks required, but professionals disagreed. Most people we spoke with told us staff stayed the full time or did all the tasks required and this was confirmed by records we examined during the inspection.

The registered manager told us they had a risk assessment in place in the event of bad weather and operation stack. These included measures, such as access to a 4x4 vehicle, communicating with families and staff working 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.

Requires Improvement

# Is the service effective?

## Our findings

People and their relatives we spoke with had mixed opinions about their satisfaction with the care and support they did received and the skills and abilities of the staff. Positive comments included, "All the staff seem to know what they are doing". "They are all friendly, polite and helpful, they ask what I need and get on with it". "The care is brilliant. I see that staff get supervised". "My main carers know my needs". "Normally they know what to do; they look at the care plan".

However other people were not satisfied and felt some staffs skills and abilities were not adequate. Comments included, "I don't think the recently recruited carers seem well trained. This morning's visit was fine, it was a regular carer. Last night's (carer) just stood around, I had to tell them everything. They didn't look at the book (care plan) until they were leaving". "Many carers can't cook. They also leave the bathroom in a right old state. I come here to visit (family member) and carers ask me how to do their job. They can't be properly trained. Some are too new in the job. I see it as a lack of training and supervision". "I've had to tell new staff to look at the paperwork and have asked some if they have had training, because they don't show common sense. I don't just have to remind some to use aprons; I also have to tell them why they should". "I understand the staff get quite a lot of training, but my main carer says they are one of only a few who have had training to do (specific care task). I have seen a carer being shadowed by a supervisor. But they seem to spot check staff a lot less than the agency I used to be with". People were more satisified when they received their care and support from regular staff who had built up their skills and knowledge of the person they visited and their needs and knew their preferred routine. However the service was unable to consistently provide this to people and this had impacted on the quality of care people received.

People and staff felt the level of induction training and support for new staff did not give them the skills to meet people's needs effectively. One staff member told us "There is a lot of new staff. What I see from quality of work and records, and feedback from clients, is that the level of care for many people is too basic. Clients say it's all just quickly in and out. I'm seeing that people are not being left with drinks to hand. Clients are being poorly informed". Another member of staff said, "Several staff start and finish rapidly, we lose staff faster than we get them. Most new staff are good, but I have queried the quality of some of them". An example of new staff working, but not having the right skills was raised during the inspection. One person was able to describe examples of poor practice that had happened during their visit. During discussions with staff they also raised concerns about this staff member's competency. These concerns about the staff members competency showed that the training they had received was not robust or was not being put into practice. These concerns were brought to the attention of the registered manager immediately.

Staff had completed a four day induction programme and shadowed experienced staff and also received a staff handbook. The induction was based on Skills for Care Care Certificate, which was introduced in April 2015. 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 registered manager told us there was a three month coaching/probation period to assess staff skills and performance in the role. During this time they received a one to one meeting (supervision) with a senior member of staff, observational supervision whilst working in people's homes and a first shift telephone call for support and problem solving.

One professional felt the demands on staff were high, but staff numbers (especially those with experience and training) were limited. Staff had advised them that staff that were relatively inexperienced were asked to provide hands on training for newly recruited staff and they sometimes felt out of their depth or worried about the responsibility.

Staff attended refresher training courses relevant to their role. Most staff felt the training they received was adequate for their role and in order to meet people's needs. One member of staff felt the training was very helpful, but they were learning more on the job and still had a lot to learn from other staff. Another member of staff was "Pleased to hear the trainer talking about making the meds training more experiential". Training included moving and handling, fire safety awareness, emergency first aid, infection control and basic food hygiene. Some staff had received specialist training, such as dementia and stroke awareness. Additionally field care supervisors had identified that further training for stoma and catheter care, diabetes and epilepsy was needed and this was being planned. Staff had attended management of medication training during their induction and this training was refreshed every three years. Given the number of medicine errors the registered manager had requested that this training would be refreshed annually. However at the time of the inspection we found medicine training was not effective in enabling staff to handle medicines safely and maintain appropriate medicine records.

Two people told us that on occasions when staff arrived to do their visit they told them they had never used the type of hoist in place before. One person had two staff on each visit and they told us when one of the staff members had been before and taken the lead for the care and support it was fine, but when neither staffs members had not taken the lead previously they lacked competence and they had to tell them what to do, both these hoists were overhead tracking hoists.

The provider had failed to have sufficient numbers of suitably qualified, competent and experienced staff deployed in order to meet the requirements of the service. This is a breach of Regulation 18 (1)(2)(a) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sixteen out of the 84 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 registered manager told us staff had opportunities to discuss their learning and development through supervisions, staff meetings and an annual appraisal. During these observational supervision staff practice was checked against good practice. For example, infection control procedures. Staff were able to discuss any issues and policies and procedures were reiterated. Most staff said they felt supported; some staff said they had received good support from their field care supervisors.

People had consented to their care and support and had signed a form to confirm this. Eighty-one percent of people surveyed by the Commission indicated that they were involved in decision making about their care and support. People said their consent was achieved on each visit by staff discussing and asking about the tasks they were about to undertake and made choices available. People said staff offered them choices, such as what to have to eat or drink.

The registered manager told us that no one was subject to an order of the Court of Protection. Seven people had a Lasting Powers of Attorney in place and eight a Do Not Attempt Resuscitation (DNAR) in place; however this information was not recorded in assessments or care plan folders. The Mental Capacity Act 2005 (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 talked about a historic best interest meeting that they had been involved in regarding the future arrangements of a person's care and support and discussions demonstrated they understood the process to be followed. Mental Capacity Act (MCA) 2005 training had recently been added to the induction training, although existing staff had not received this training, so further training sessions were being planned. A professional we surveyed indicated they felt the staff and managers did not understand their responsibilities under the MCA. This is an area we have identified for improvement.

Most people and relatives told us they were satisfied with the number of staff that visited them each week as long as they were familiar with their care and support needs, which some were not. Eighty-one percent of people and 50 percent of professional's surveyed felt people received care and support from familiar and consistent staff. Although one person commented, "On certain days I am never sure who is coming if at all". Following an initial phone call where staff discussed people's needs they matched a member of staff to cover the visits. The registered manager told us the matching process was based on staff working in the geographical area, people's preferences and staff skills and experience. Some people told us when they had not been happy with a particular care worker there had been no problem with them not coming again. Although we heard during the inspection that where one person had said they 'would rather not' have a member staff if it could be helped, there were times when this staff member was allocated as no other member of staff was available to do the visit. One person told us "I won't complain (about a certain member of staff), because they will say they are the only one available". This showed there was a lack of staff available with the right skills and experience to meet people's support needs. When people had refused to have a particular staff member back in their home this was recorded on the computer system, which blocked them from being scheduled to undertake visits to that person. People felt the receiving of schedules in advance so they knew who would be visiting was a bit "hit and miss". When they did not receive a schedule in advance they did not know who would be visiting, whether there was a change if they normally had regular staff, or given the choice to change arrangements if they were not satisfied with who was visiting. When they did not receive a schedule they were unable to. The registered manager told us that schedules had not been sent out for the two previous weeks, but were being sent out again now.

Some care plans contained information about how people communicated although some information including information about hearing aids and glasses was not always brought forward into the care plan from assessments. One assessment stated that the person could slur their words when tired or unwell, but this information was not available to staff in the care plan. In another case the assessment stated 'I would like the carers to stand in front of me (when talking)", but again this was not in the care plan. This left a risk that people and staff may not be able to communicate effectively with each other particularly if people were tired or unwell.

People's needs in relation to support with eating and drinking had been assessed during the initial assessment and recorded. However some key information in these assessments was not available within the care plan, such as one person was a diabetic, so people may not get the right support they need or like. Most people required minimal support with their meals and drinks if any. The registered manager told us no one was at risk of poor nutrition or hydration and no one had needed input from a dietician recently. Although previously staff had worked with person and their relative to encourage the person to lose weight and eat a healthy diet. Staff usually prepared a meal from what people had in their home. One person used a straw and another adapted cutlery, which enabled them to eat and drink independently. People talked about how staff prepared what they asked for or looked in the cupboard or freezer and offered them a choice. Some people said staff encouraged them to drink enough and would leave a drink or drinks for later.

People were supported to maintain good health. People told us staff were observant in spotting any concerns with their health. One person talked about how staff had noticed when there was a problem and always mentioned it to them and a family member. Another person talked about how the staff "liaised really well with district nurses about pressure area and catheter care. I was unwell once when my (family member) was away on a respite break. The carers realised and called 999, in hospital they told me the carers had saved my life". Records showed that when staff were concerned they took appropriate action including calling health professionals where appropriate. One relative told us how the nurse and staff worked together to enable a better outcome for their family member.

Requires Improvement

# Is the service caring?

## Our findings

Most people felt most staff were generally caring. Comments included, "They've been great". "I have the same carer six mornings a week, they are reliable and we have built an excellent working relationship. On Sundays it might be anyone and any time, but it doesn't matter, they still work well with me". "All the staff do what I want. They are all polite; they respect the privacy of my home and are attentive to hygiene. But they are so rushed; they don't always stay the full half hour. I like them to have a chat if they have finished early". "(Staff member) is my main carer. I am not at all well, she understands". "I've now had (staff member) twice a week for several months. They make me feel comfortable, ask what I would like and whether they can do any more whilst they are here. (Staff member) helps me with some paperwork; they are like a professional friend". "We have one carer most of the time and they are excellent. They are not all good, some just come in, do what has to be done and out again".

Some people told us how staff complained to them or their relatives about the organisation of the service and the work or traveling they had to do, which they felt was not professional and some people had felt under pressure by these conversations.

A social care professional told us, "There is evidence of compassion among care staff. I witnessed this first hand from a carer I met whilst visiting a client". However they also went on to say that the staff member they met had expressed "grumbles" about the conduct of some other staff and office staff and that they did not understand the impact of late or missed visits.

People and relatives surveyed felt staff treated them with dignity and respect and that staff were kind and caring. One relative commented, "They are unfailingly kindly and caring. I have full confidence in them. Clearly they have been well chosen". Professionals surveyed were not consistent about the whether people were treated with dignity and respect, one indicated they agreed people were treated with dignity and respect and the other indicated they disagreed with this statement. The professional felt that people had not received a reliable service and this had caused them distress, which demonstrated people were not treated with dignity and respect.

Most people felt they were treated with dignity and respect and had their privacy respected. However one person told us "I don't like having male carers. At lunch time I often need personal care as well as help with my meal. I have told them (the office), but I still get sent male workers. Most staff are respectful of my privacy and dignity". This demonstrated that staff had not listened to the request for not having male staff as a block should have been in place on the scheduling system. A relative said, "A male carer came; it just wasn't appropriate for (family member's) privacy or dignity. We have rung and complained. We were told a male would not be sent again and that has been accorded with". One person complained about staff that smoked and brought the smell into their house. They said they had spoken to the office, but "they haven't got the staff, what can they do".

The provider had failed to ensure that people received person centred care that meet their needs and reflected their preferences. This is a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated

Activities) Regulations 2014.

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. Most people told us they were not visited periodically to talk about their care and support and discuss any changes required or review their care plan. Records confirmed that reviews had not all been carried out annually or as needs changed, so people had not been given on-going opportunities to change or plan their own care. Most people and relatives felt care plans reflected how they wanted the care and support to be delivered.

One person talked about a negative experience with a member of staff that had visited them and they told us they had addressed the concern directly with the staff member and were now happy for them to continue visiting. Staff had received training in treating people with dignity and respect as part of their induction.

Staff were asked about how they helped promote privacy, dignity and respect during their observation supervision, to help ensure they did this. 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.

Some people talked about staff that "Went that extra mile". One person told us, "(staff member) is lovely and goes that extra mile. She is observant and never appears rushed. Nothing is too much trouble". Another person talked about the staff member that visited them most regularly, "(Staff member) is very good, she does everything and is nice and gentle and she does not rush me and she can two things at once". One person said, "Some (staff) do that extra mile and others just do their job".

Where staff visited people regularly they had built up relationships with them 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 circumstances. During the inspection staff talked about people in a caring and meaningful way.

People said their independence was encouraged wherever possible. One hundred percent of relatives and 94 percent of people surveyed felt staff helped them or their family member to be as independent as they could be. One relative commented, "The service provided is very important in keeping my (family member) independent. One person told us, "I am very independent by nature". Staff were asked about how they felt they had helped promote the person's independence during their observational supervision, to help ensure staff encouraged this.

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

The registered manager had recently signed up to be a dementia champion. Following dementia champion training they would then cascade learning to staff. Signing staff up as a dementia friend is a national government funded initiative to improve the general public's understanding of dementia.

Requires Improvement

# Is the service responsive?

## Our findings

People did not have a personalised care plan in order that they could receive care and support in line with their wishes and preferences. One care plan stated 'I need you to support me with a strip wash' and 'I need help with washing and dressing'. The assessment contained information about what the person could do for themselves and what support was required from staff, but this information was not followed through into the care plan in the person's home, so staff would not have this information despite the person saying "I like to be as independent as possible". This meant the person would have to explain their routine and what help they needed on each visit when it was not a familiar member of staff.

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 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.

Another care plan stated 'Assist me with personal care, apply creams and change pad' and 'assist me with brushing my teeth, assist me into my nightwear and check bottom area and apply cream'. This person had a catheter in place and this was not mentioned in the care plan. Assessments described changing water and flannels, but again this had not been followed through into the care plan. Other care plans continued in the same line 'I would like the carer to assist me to dress'. One care plan did contain better detail about the personal care routine, but there was no information about the preferences of where the person undertook their personal care or what if any toiletries were used. Another person had their continence pads and catheter bag changed, but this information was not included in the care plan.

Most people felt their care plan had not been reviewed. One person said, "A supervisor came on Thursday to sort out my folder and wrote down exactly how my (specific area of care) has to be managed, it was very out of date". Another commented, "I've been a user for three years, the care plan hasn't been reviewed in all that time". One person said, "The care plan is fine and the carers look at it. Continuing Care have been to check it with me, but Allied don't come out". According to the provider's policy care plans should be reviewed at least annually or when changes occurred. However records also showed not everyone had received a review in the last 12 months. One care plan had not been reviewed since 2013 and it was evident from the daily reports that the staff were providing more support as the person's health had deteriorated, which meant the care plan did not describe what staff needed to do to make sure the person received personalised care and support.

People only felt they got the care and support they wanted that reflect their preferences and wishes when their regular staff member visited and at other times they had to explain their preferred routine in order to achieve this or they may not receive consistent and safe care. Some people told us staff did not read the care plan when they arrive and one person said a staff member had arrived and asked "What do you want me to do". One staff member told us, "Care plans don't always show how the person wants care, it's easier to read what was done last time and ask the person what they want, to reflect their choice".

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(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.
People talked positively about the initial assessment of their care and support needs and in planning their care. Some people told us their relatives had also been involved in these discussions. People had signed a form showing their consent for care and support to be delivered in line with their assessments and care plan. Assessments were undertaken by the field care supervisors. 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 about the person.

People felt confident in complaining, or felt a relative would complain on their behalf, but had mixed opinions about whether when they complained things really changed. The complaints procedure was incorporated into people's welcome pack, contained within the folders kept in their own homes, although not everyone we spoke with was aware of this and only sixty-two percent of people surveyed said they knew how to complain. Relatives surveyed felt complaints were responded to well. Eighty-seven percent of people felt care staff responded well to their concerns, but this reduced seventy-three percent when dealing with office. The registered manager told us there had been a high number of complaints in the last 12 months. Complaints were recorded onto the computer system and an action plan developed to address any shortfalls. This was then allocated to the most appropriate senior member of staff to investigate and resolve. One person told us how they had complained last year, but felt they had never really had any feedback about the outcome or felt supported when they had complained. Another person told us, "Last night, a new carer came, they did not appear wholesome, their hair wasn't tied back. They didn't use an apron; there are two or three who don't. I shall be ringing to complain". One person told us they had complained to head office "about no-shows and things improved". Records showed that complaints had identified themes that reflected the shortfalls found during the inspection, such as medicine management, reliability of visits and communication, so although some management action had been taken and some people had told us things had improved for them following their complaint, this could not be said for everyone and changes to practices across the service were still required.

People had mixed views about whether they had yet had opportunities to provide feedback about the service provided. Sixty percent of people and 50 percent of relatives we surveyed felt they had been asked for feedback about the service. Some people told us they had completed questionnaires, but were not sure they had been asked at any other time for feedback or had a review meeting; others told us they received a phone call or had a visit from a field care supervisor. The registered manager was aware that reviews were behind and that some reviews had identified concerns. They told us they intended to visit each person who had concerns to try to resolve these. Questionnaires were sent directly from the organisation and results were collated by them. The registered manager received a copy of the analysis and any negative feedback that may require action.

Some people were supported by staff in the mornings to ensure they were ready to go out, so they were not socially isolated. One person told us the staff visiting made a "hugh difference" to their quality of life and with most staff they "have a laugh". Another person said, "(Staff member) and all the other carers when they are away, are lovely, they all work in a similar way and help me feel less lonely".

Inadequate

# Is the service well-led?

## Our findings

Eighty-nine percent of people and 50 percent of relatives we surveyed said they would recommend this service to a friend, but two professionals we surveyed would not recommend this service to a friend.

Eighty- one percent of people and 100 percent of relatives we surveyed indicated they knew who to contact at the service if they need to and 88 percent felt the information they received from the service was clear and easy to understand. People we spoke with had mixed opinions about their communication with the office staff and the effectiveness of the office staff. Some people felt they were polite and responded to their call. However others felt the office was not "running well, I never seem to get a straight answer. I don't think the office staff know what care entails, or know the geography of the area. I think the carers find it difficult putting across to the office what the difficulties are". One person talked about a difficult telephone call they had had with staff member and had now "reached a point where I think it is best to have no contact with the office".

During the last 12 months there had been a high turnover in both field care supervisors and coordinators and this had impacted on the quality of service people received. We asked people if they felt the service was well-led and well-organised. Comments included, "It's the organisation (of the service) that's irregular". "Changes of coordinators hasn't helped, they say they will ring back but they don't. I complained to the office (about an incident) about the coordinator's behaviour, I wanted them disciplined, but I never heard back". They talked about how one coordinator started and then left and about the lack of skills of the coordinators. "No-one from the office comes. I ring them, but as with care staff, they are new and don't know what they are doing".

One person told us they had learnt to telephone in the afternoons when they could speak to a certain member of staff and they were confident then things would be sorted out for them. One person commented on a survey, "Agency, please listen to clients more" and a relative commented, "I do have some concerns on the office management of the carers rounds, which leads to problems of timeliness on rather too many occasions and my (family member) not always being kept advised of delays".

Another person told us they had complained about the timing of the visits being irregular. They had then complained to the local authority who advised them to write to the provider, which they did and there was some improvement. They talked about how their family member had had to go to bed at 6pm for nine months as this was the only visit time that could be offered and was agreed with the provider prior to the start of the service. After this they worked with the local authority and the provider to get an agreed later time of 8pm, but this had not happened so they have written again. They were monitoring all their visits, which were approximately 30 minutes late. They spoke about contacting the out-of-hours who they felt "did not seem to know what this office were doing".

One person talked about the office sending staff when their main staff member was on leave who had an illness and allergies, so was entirely unsuitable to visit their particular home. They had to send them away and it was sometime later they sent someone suitable. They complained, but felt this was stressful for them.

Both of the professionals surveyed felt they had not been asked to give feedback on the service people received. They felt the service was not well-managed and was not working hard to try continuously to improve the quality of care and support they provided to people. The other two professionals we received feedback from had mixed opinions about the management of the service. One, although their contact with the service was limited, felt their contact with the office staff had been positive. The other who had had more contact felt that when there were concerns the service did not learn from these and requests for information and agreed action within an action plan were either not acted on or not so in a timely way. Professionals felt in their experience staff morale was low and they were stretched in terms of hours they work to cover visits.

Staff had mixed opinions about whether the service was well-organised. One staff member told us "The supervisors do a good job considering they cover calls as well. They respond well to new information we provide and review care plans. It's not surprising they burn out". Another staff member felt supervision was "not wonderful, about 10 minutes. I think supervision is done as a box ticking exercise just to show it's done. My experience doesn't suggest they (field care supervisors) are trained in supervision skills". Other comments included, "There have been a lot of staff changes, especially in the office. I don't have a lot of confidence in the office. They only care about covering calls; they don't have care experience and have no clue about meeting individual needs with the right person or making the job achievable for carers". This staff member talked about being asked to "just go to (another area)" to work, but felt the office staff did not understand the journey or time it would take. They felt there had been changes to schedules although the out of hour's service had not been informed. Staff felt under pressure from the out of hour's service about missed calls and late calls. "I have worked here (long time), rota planning is the worst it's ever been. There's too much inexperience in the office and communications are poor. Us older staff are spoon-feeding the office". Another fairly new staff member talked about the poor performance of coordinators and how schedules were inaccurate. They had also been asked to work in another area. They felt the office staff did not understand care or the practicalities, or what it meant to people and relatives to have changes of staff. They felt they got a "poor response on the phone from office staff".

Records and systems were not always robust. The system for returning MAR charts and daily records made by staff was not always effective, resulting in no or only a few records held on files and these records being audited some seven months later. Folders in people's home lacked detail about the systems and practices that were in place to keep them safe following assessment.

There were audits and monitoring of the service to help ensure the service ran effectively and people remained safe. However audits were not all effective or showed what action had been taken as a result of shortfalls. For example, an audit on daily reports identified there was too little information in parts and no information about a person's meals, but the space for action to address shortfalls was blank, so we were unable to ascertain if any action had been taken. An audit on MAR charts identified shortfalls that one type of tablet should have been two tablets, a cream had been added to the chart, there were gaps in signatures or codes, but again there was nothing recorded about what if any action had been taken. Another MAR chart identified a topical medicine prescribed daily had not been administered every day and the assessor had written 'there are gaps in the rota, but all medication is given when requested – action taken was NA (non-applicable). This shows a lack of understanding by the assessor that prescription instructions must be up to date. On a customer quality review form negative comments had been noted, but nothing about any action taken and there was no further review on file.

A call monitoring system was in place to ensure people received their visits on time and reduce the risk of missed calls. The coordinators monitored this computer system all day. Call monitoring showed when a staff member logged in to a person's home using their telephone at the start of their visit and when they logged out at the end of their visit. If a call had not been logged into within 30 minutes of the start time the

system then notified the coordinator. This system was also used by the central out of office hour's team. However people and records showed that some calls continued to be delivered outside of this timescale with one person telling us they had waited two hours for someone to arrive on two occasions recently.

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. The provider had failed to have systems and processes established and operated to ensure compliance with requirements. The above is a breach of Regulation 17 (1)(2)(a)(b)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was an established registered manager in post who was supported by field care supervisors and coordinators. The area covered by the service was split into three zones, Canterbury and coastal, Ashford and South Kent coastal (Folkestone to Romney Marsh). Canterbury and coastal and South Kent coastal each had two field care supervisors and two coordinators. Ashford was a smaller area and had one field care supervisor and one coordinator. The coordinators were office based and scheduled the visits and field care supervisors were out and about undertaking assessments, supervisions and care plan reviews. In addition there were two administrators who dealt with payroll, training and invoicing and support from head office. The registered manager and coordinators worked Monday to Friday and both them and the field care supervisors covered a backup system for the organisations central out of office hour's service. No one we spoke with had had any contact with the registered manager. One person told us, "As far as I know (registered manager) is the manager, but everything is put in the way to stop you speaking to them, I never have". A social care professional also felt the registered manager was not as accessible as they should be.

The registered manager told us the new field care supervisors had undertaken care planning training and had been observed by experienced field care supervisors for support. The three new coordinators were having weekly supervision to reduce the risk of errors when scheduling visits.

The registered manager told us they were developing a spreadsheet, which office staff would all be able to access. This would show the date the MAR charts were sent out from the office and confirmation that staff had returned it to the office. This would help track that MAR charts were returned and audits could be carried out in a timely way. The service had been involved in a local authority project with occupation therapists to look at people that required two staff to visit. These details had been given to the occupation therapist that then reviewed these cases with field care supervisors to see if changes could be made so that one member of staff could undertake the visit.

The organisation had recently carried out a consultation with staff and changed their terms and conditions of employment, although all staff were now paid travel time between visits and a mileage payment. The registered manager told us this change had led to some staff leaving, but a planned review of schedules should help to ensure staff were working and travelling more effectively. The registered manager told us they were involved in a project with other providers in the Canterbury area and the local authority to look at where visits were in a particular area and see if more effective working/travelling could be achieved. One social care professional told us the office staff had been helpful and engaged in this process. In addition the registered manager had implemented a form which coordinators used each day to confirm what visits they had covered, by who and how that had been arranged. This was to reduce the risk of coordinators missing visits that required cover. A hospital admission/discharge form had also been developed to help ensure that all appropriate people were informed and visits were not missed.

During the inspection the Commission received some negative anonymous survey feedback from people, relatives and professionals. This was discussed during the inspection to ensure that any improvements that were being planned were included in discussions. In addition a medicines concerns was picked up on the

visits, which was feedback to the registered manager, who sent out a field care supervisor the next day to investigate further and agreed to let us know the outcome. Some concerns were identified when speaking with people over the telephone, one was an area of staff competency and again this was relayed to the registered manager who told us extra support would be provided to the individual member of staff.

There had been a high number of complaints within the last 12 months. The registered manager told us the themes had been medication, visits where two staff are required and communication. Although the above and other action had been taken we found that at the time of the inspection all three areas remained a concern for people.

The organisation sent out quality assurance surveys to people after the first eight weeks of receiving a service and on the anniversary of the date they started to use the service. The last results available within the branch were dated May 2015, but contained results of surveys from July 2013 to May 2015, which did not give a view on the current service people received, to help drive the improvements that were required.

The provider's mission was displayed within the office. Staff were also aware of the aims and objectives of the service through induction and training. One staff member told us the work is about helping people maintain what independence they can by working reliably to professional standards. However another staff member felt there was "no customer focus or loyalty to staff".

There were systems in place to monitor that staff received up to date training, had regular team meetings, observational supervisions and appraisals, when they could raise any concerns and were kept informed about the service and any risks or concerns. Staff felt the training was well-organised. The provider had introduced a 'carer of the month' branch award. This was nominated by staff and was awarded every two months for staff. In addition one staff member was nominator for the organisation's annual 'Shining Star' award.

Staff had access to policies and procedures via the office or their staff handbook. These were reviewed and kept up to date. Records were stored securely and there were minutes of meetings held so that staff would be aware of issues within the service.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider had failed to ensure that all the required information in respect of a person employed was in place. |

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure that care plans reflected people's assessed needs, preferences and remained up to date.<br><br>The provider had failed to ensure people received person centred care that meet their needs and reflected their preferences. |

**The enforcement action we took:**

Warning Notice

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>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. |

**The enforcement action we took:**

Warning Notice

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>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. The provider had failed to have systems and processes established and operated to ensure compliance with requirements. |

**The enforcement action we took:**

Warning Notice

| Regulated activity | Regulation |
|---|---|

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to have sufficient numbers of suitably competent, skills and experienced staff in order to meet people's needs.

**The enforcement action we took:**

Warning Notice