Care at Home Services (South East) Limited

Care at Home Services (South East) Ltd - Thanet

Inspection report

78 High Street
Broadstairs
Kent
CT10 1JT
Tel: 01843 609533
Website: www.careathomeservices.co.uk

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 19 and 20 August 2015 and was announced. Forty eight hours' notice of the inspection was given, as this is our methodology for inspecting domiciliary care agencies.

Care at Home Services provides care and support to a wide range of people including, older people, people living with dementia, and people with physical disabilities. The support hours varied from 24 hours a day, to an hour to one to four calls a day, with some people requiring two members of staff at each call. At the time of the inspection 60 people were receiving care and support from the service.

The previous inspection of this service was carried out in 30 April and 2 May 2014. At this inspection we found that the provider was in breach of three regulations, safe care

Summary of findings

and treatment, person centred care and good governance. The provider had sent an action plan to CQC in June 2014 with timescales stating they would be compliant by September 2014.

At this inspection the plan had not been fully actioned by the provider. The three breaches of the regulations issued at the previous inspection had not been met. The service, therefore, continued to be in breach of three regulations, safe care and treatment, person centred care and good governance.

There was a registered manager in post who was on annual leave at the time of the inspection. We were supported by the operations director and regional manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Risks associated with people's care and support had been initially assessed but the assessments had not all been completed correctly to ensure that further moving and handling risk assessments were in place to make sure people were being moved safely. The guidance in place for staff was not always sufficient or clear to ensure people remained safe.

Medicines were not listed or recorded safely so it was not always clear what medicines people were taking. Staff had not always signed the medicine records to confirm people had received their prescribed medicines. Staff were applying creams to people's skin as part of personal care routines, but there were no proper records maintained to say what and when creams should be applied.

Care plans were not up to date and did not have all of the personalised information staff needed to make sure people received the care they needed. The plans did not always include people's preferred routines, their wishes and preferences, skills and abilities.

People's care plans did not always contain the guidance that staff needed to support them with their specific health care needs. Health care professionals, like district nurses and doctors, were contacted if there were any health concerns.

People were supported by staff to make their own decisions. Some people had not received a mental capacity assessment to ensure that any restrictions placed on them were in their best interests. Staff had received Mental Capacity Act 2005 training and were aware that meetings should be held involving relatives and other professionals to make decisions in people's best interests. The Mental Capacity Act provides the legal framework to assess people's capacity to make decisions, at a certain time.

Records were stored safely but were not always updated and completed accurately. Some medicine records were hand written and were not checked to make sure the correct medicines had been recorded. Care plans were not consistently updated, signed and dated by staff to confirm who had completed them. Some people who required support with their mobility did not have a full risk assessment in place to guide staff how to do this safely.

Staff had schedules to plan the delivery of care so that people received care from regular staff. However, there were mixed views from people about the consistency and experience of staff. Some people told us that they received care from regular staff while others said they sometimes did not know who was covering their calls. There was enough staff employed to give people the care and support that they needed and an ongoing recruitment drive ensured that staffing levels were maintained.

Staff had received training in how to keep people safe and demonstrated a good understanding of what constituted abuse and how to report any concerns. Accidents and incidents were reported, investigated and necessary action taken to reduce the risk of further occurrences.

New staff were recruited safely. They received induction training, which included shadowing experienced staff and there was an ongoing training programme in place. Staff had a range of training specific to their role, but there was a lack of specialised training being provided, such as dementia and diabetes training.

Some people thought that staff were well trained and knew how to care for them whilst others said that new staff lacked experience and they needed to enhance their skills to meet their needs. Staff practice was monitored

Summary of findings

during unannounced checks to ensure they had the skills and competencies to perform their role. Staff told us they felt supported and attended one to one meetings with their manager to discuss their practice.

People told us how staff supported them to remain as healthy as possible and took prompt action if they noticed any concerns with their health. They told us that staff always offered them a choice of what food and drink they wanted. Staff made flasks of drinks or left jugs of juice for people before they finished their calls.

People were treated with respect and their privacy and dignity was maintained. People we visited told us the staff were polite and kind. They told us that staff listened to what they wanted and always asked if there was anything else they needed before they left.

People felt confident they would complain to the staff if necessary but did not have any concerns. Systems were in place to record, and investigate complaints but there had been no complaints recorded this year.

There was a lack of oversight and scrutiny to monitor, support and improve the service. The timescales within the action plan to improve the service had not been met, and the provider remained in breach of three regulations.

The provider was open and transparent and acknowledged that the action plan had not been completed; therefore not all of the required improvements had been achieved in the agreed timescales.

The service had systems in place to audit and monitor the quality of service but there was a lack of evidence to show how and when the results of these checks had been actioned to continuously improve the service.

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

We found three ongoing breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version 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?

Requires improvement

The service was not consistently safe as there was an ongoing breach of regulation with regard to safe care and treatment.

Risks to people's health and welfare had been assessed but there was a lack of sufficient guidance to show staff how to manage risks safely.

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

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

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

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff had received basic training, which included induction training and observations of their skills and competencies. However, staff had not received training in line with people's specialist needs, such as dementia and diabetes training.

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

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

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

Is the service caring?

Requires improvement

The service was not always caring.

People's preferences and choices were not always recorded to ensure they received personalised care.

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

People and their relatives told us that the staff encouraged and supported them to maintain and develop their independence.

Is the service responsive?

Requires improvement

The service was not consistently responsive as there was an ongoing breach of regulation with regard to person centred care.

Summary of findings

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

There had been no complaints recorded this year. People and their relatives said they were confident to raise any complaints and said the management or staff would take action to resolve any issues.

Is the service well-led?

Requires improvement

The service was not well-led as there was an ongoing breach of regulation with regard to good governance.

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

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

Records were not suitably detailed, or accurately maintained.

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

Care at Home Services (South East) Ltd - Thanet

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 20 August 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure we are able to speak with people who use the service and the staff who support them. We went to the service's main office and looked at care plans; staff files, audits and other records and we visited and talked with people in their own homes.

Two inspectors and an expert-by-experience, with a background of older people and domiciliary care, completed the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider was unable to complete a Provider Information Return (PIR) because they did not receive the information from CQC prior to the inspection. 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. We looked at previous inspection reports and notifications we had received. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with 15 people who were using the service, three of which we visited in their own homes, and two relatives. We spoke with the operations director, the regional manager, two co-ordinators who organised the work for the staff and two members of staff. We reviewed people's records and a variety of documents. Three care plans were looked at in people's own homes and seven care plans were looked at the service's office. We looked at four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys.

After the inspection we contacted four members of staff by telephone to gain their views and feedback on the service. We also contacted four health care professionals for feedback about the service but no responses were received at the time of this report.

The previous inspection of this service was carried out in May 2014. At this inspection we found that the provider was still in breach of three regulations.

Requires improvement

Is the service safe?

Our findings

The majority of people we spoke with told us they felt safe being supported by the staff. People said: "I feel very safe with the carers". "I think they are all very honest and reliable, I feel quite safe with them". "I am happy that the carer is well trained in using the hoist, and I feel very safe". One person was concerned with the number of different staff who attended their calls. They said: "There has been so many new staff it has made me feel uncomfortable and unhappy".

At the last inspection in May 2014 we asked the provider to take action to protect people from the risk of inappropriate and unsafe care, including the administration of medicine and record keeping. Following the inspection the provider sent us an action plan to tell us of the improvements they were going to make by September 2014. However, this plan had not been fully implemented to comply with the regulations.

Staff did not have the guidance and information to make sure people received the care and support that they needed, in the way that was safest for them. Some people were moved using special equipment like hoists and slings, but some risk assessments did not tell staff how to do this safely. Staff had assessed three people as 'high risk' due to their complex mobility issues, but had not completed a further risk assessment to manage and lower the risks. One person told us that they had a risk of falling and had to remind some staff to make sure that the wheelchair was in the right place, the brakes were on and it was in the right position before they felt safe to move. They told us that they had concerns that some new staff did not have the experience to make them feel confident they were being moved safely. Another person said: "New care staff do not know me. They do not know that I can transfer myself, so I just tell them what to do". There was no moving and handling risk assessment in this person's care plan to inform staff how to care and support them in a way that kept them as safe as possible and keep any risks to a minimum.

One person had suffered a stroke and their moving and handling risk assessment stated that they did not get out of bed, however staff told us that this person was supported to sit in the chair 'on good days' and the hoist was used, but there was no explanation of how staff would know 'what a good day' meant. There was no guidance of how to support this person to move safely taking into account their medical condition.

Staff told us that they did not always rely on the risk assessments but knew how to move people safely; they told us that they had received moving and handling training and shadowed experienced staff to be shown how people were to be moved. There was therefore a risk that staff may not be moving people in line with their personalised risk assessments, to ensure they were being moved consistently and safely.

We visited people in their homes and all three people needed staff support to move about. Two of the three did not have a moving and handling risk assessment in place to give staff guidance about how to move them safely. When people were at risk of falling, a risk assessment had identified this but there was no further risk assessment in place to tell staff how to keep this risk to a minimum, like making sure the person had their walking aid close by or keeping the area free from clutter, or obstacles that might increase the risk of falls.

Some people needed support with their behaviour as they might get anxious or angry. There was no behaviour care plan in place to guide staff how to manage such events. There was no information with regard to any known triggers to the behaviour and strategies were not in place to minimise the likelihood of incidents.

Some people were at risk of developing sore skin. One person's care plan stated 'carer's to monitor my pressure areas', but there was no information or risk assessment about what staff should do to monitor this person's skin, what signs to look for and what action to take if there were any concerns.

At the last inspection in May 2014 we asked the provider to ensure that information on medical conditions, such as diabetes, should be added to the care plans to give staff further understanding of the condition. Although some information was on each person's care plan, there was still no detailed information and guidance for staff to help them recognise the signs that might indicate people's conditions, such as diabetes, was becoming unstable and what appropriate action they had to take.

Care and treatment was not provided in a safe way for people because the provider did not have sufficient

guidance for staff to follow to show how risks to people were mitigated. This was an ongoing breach of Regulation 12 (1) (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines when they should. There were some shortfalls in the management of medicines. Details about what medicines people were prescribed were not always up to date in the care plan. The medicine policy had been reviewed to include the use of controlled drugs; however, this information was not clear to ensure that staff understood the guidance. For example the medication policy stated that two staff should be present to ensure that the measurement of controlled liquid medication is overseen and witnessed, and both staff must sign the medication sheet. However in the section 'unauthorised duties' it clearly states that staff must not carry out the administration of controlled drugs unless they have been trained. This information was not clear to ensure that staff followed the correct procedures when administering controlled drug medicines.

Some Medicine Administration Records (MAR) charts were pre-printed by the supplying pharmacist and in others they were handwritten by staff. MAR charts viewed showed staff had not always recorded a signature when administering people's medicines, or a code to indicate why medicines had not been given. Some people needed medicines on a 'when required' basis, like medicines for pain. There was no guidance or direction for staff on when to give these medicines safely. One person had pain relief medicine prescribed to be taken four times a day, the dosage of the medicine was not recorded and over a period of 31 days there were 16 entries of refusal, three entries had been initialled by staff, and for five days a '1' had been entered, the remaining days had been left blank. Therefore we were unable to ascertain whether this person had received the correct dose or had been given their medicine correctly on these occasions

Some people had sealed 'dosette' boxes containing their medicines issued from the pharmacy. The contents of the box had not been recorded on the medicine records to show what medicine and dosage was being given. When the dosage of a medicine varied, the name of the medicine had been recorded but not the various dosages. Therefore, we could not be sure that the person had received their prescribed medicine as the staff had not consistently signed to confirm what dosage of the medicine they had given the person.

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

Staff told us that they had received medicine training and were able to tell us about medicine procedures, but records did not confirm that this was being done as safely as possible.

There was a risk of people not receiving their medicines as prescribed. The provider had failed to ensure that people were receiving their medicines safely. This was an ongoing breach of Regulation 12 (1)(2)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had completed training about how to support people safely and recognise the signs of and how to report abuse. They knew the actions to take, such as reporting issues to their manager and other agencies, including the local authority safeguarding team. Staff told us about the whistle blowing process and said they would not hesitate to report other staff if they had concerns.

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

There were sufficient staff on duty to cover the scheduled calls in the community. However, people told us that there was a lot of new staff and the retention of staff was not very good. Records confirmed that 15 of the 34 staff members of staff employed had joined the service in 2015 and 12 staff members had left in the same period. There were mixed views with regard to the people receiving care from the same staff each week. Some people told us they had the same people each time but one person said they had many

Requires improvement

Is the service safe?

different carers which were inexperienced and felt that they were not as good as the experienced staff. People said that when necessary the office staff would cover the calls in times of sickness or annual leave.

The regional manager told us that they had some very experienced members of staff who had been with the organisation for several years and that recruiting staff in the local area was a challenge therefore there was an ongoing recruitment drive to further improve the continuity of care.

Staff were recruited safely to make sure they were suitable to work with people who needed care and support. Appropriate checks were undertaken before staff began work. Recruitment records included all the required information, including an application form, evidence of a Disclosure and Barring Service (DBS) check, proof of the person's identity and evidence of their conduct in previous employments. All new staff undertook an induction programme, and were on probation before becoming permanent staff.

Accidents and incidents involving people were recorded. The accidents and incidents were reviewed by the management team to look for patterns and trends so that the care people received could be changed or advice sought to keep them safe.

Some people had equipment in place to aid their mobility. Staff told us that they checked the equipment before they used it to make sure it was safe. There was a system in place to ensure the equipment was serviced according to manufacturer's guidelines.

Requires improvement

Is the service effective?

Our findings

Some people told us they were satisfied with the care and support they received. They told us that the staff were well trained and knew their daily routines. However, other people said that there was a lot of new staff who lacked the experience, and felt that they needed further training to fully meet their needs.

People told us that the staff supported them with their health care needs. They said that staff were good at recognising when they did not feel well and would suggest if they needed to see a doctor. One person told us the staff acted promptly when they noticed an issue with their skin which had resulted in ongoing medical treatment being required.

Some people had catheters in place. A catheter is a tube that it is inserted into the bladder so that urine can drain freely. One care plan stated: "Contact the district nurse if the catheter by passes or blocks". There was no plan to give staff the guidance or instruction about how to empty the bag and clean the area. There was nothing in the care plan to show staff how this should be done safely to reduce the risk of infection. One person told us that on one occasion a staff member had not managed the catheter correctly as they left the drainage tap open by mistake.

Records showed that when staff reported to the office that people needed support from their doctor or district nurse, action had been taken to contact the appropriate health care professional. Occupational therapists had also been contacted when people's mobility had changed and needed to be re-assessed.

People told us, and we observed, that staff asked for consent from people before undertaking tasks. Some people were able to make decisions, such as what they wanted to eat or drink but needed the support of others to make decisions on more complex matters. The care plans were not clear when recording people's capacity. Some people did not have mental capacity assessments completed so there were no details of what decisions people could make. One care plan stated that the person could be forgetful at times, then it was recorded that they became confused and had short term memory loss, but there was no mental capacity assessment completed to assess what, if any, further support may be needed. Staff had received training in the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make decisions, at a certain time. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who knew the person well and other professionals, where relevant. The management team were aware of the process for this framework but at the time of the inspection no one had been involved in such meetings.

New staff underwent a two day formal induction period, linked to the Care Certificate, a nationally agreed set of care standards which must be met to ensure safe and effective care is delivered. The staff records showed this process was structured and allowed staff to familiarise themselves with the policies, protocols and working practices. New staff shadowed more experienced staff for a minimum of fifteen hours or until such time as they were confident to work alone.

Staff told us and records showed that they had received training relevant to their role, such as moving and handling, medicine management and infection. Some staff were also in the process of completing distance learning training in end of life care. Although basic training for staff had been provided, staff had not received more specialist training to support people living with dementia or diabetes.

There were systems in place to ensure that new staff were monitored and observed by senior staff before they were signed off as being competent. If new staff did not feel confident at the end of their induction period, further shadowing of experienced staff was offered or they continued to work with staff on double handed calls to improve their competence.

Some people receiving care felt that new staff did not have the skills and experience to meet their needs. One person with complex needs said that they preferred established staff as they had to teach the new staff what to do. The regional manager confirmed that if people raised concerns on staff competency they were removed from the call and replaced by experienced staff. The new member of staff was then monitored or given further training to address the issues. One person told us that they had requested that some staff did not complete their calls and the office acted on their request and changed the staff members.

Staff were regularly supervised and appraised by the management team. Staff had received one to one meetings with their line manager and an annual appraisal to discuss

Is the service effective?

their training and development needs. Staff were subject to regular, unannounced 'spot' checks from managers during the course of their duties. At that time they were questioned on their level of knowledge of the people they were caring for and the rationale for the care they were providing. This was to make sure staff were providing the care and support that people needed. Staff were also assessed on their appearance and communication skills and were given feedback from managers concerning their performance.

Staff meetings were also held to give staff an opportunity to raise any issues with the service.

Staff were able to contribute to the meeting and to make suggestions of importance to them. However, the minutes did not contain a review of the minutes of the previous meeting. In addition, the minutes did not contain a plan to decide what action would be taken as a result of the issues raised, by when and by whom. Therefore, it was not possible to judge the effectiveness of staff meetings or to know if staff's concerns or requests had been dealt with.

There were mixed views from people about the continuity of care to make sure people received their care from regular staff who knew them well. Some people said that the staff arrived on time, but one person said only four in ten staff arrived on time. People said that communication could be better with the office as they did not always get a call to tell them the staff were running late.

People said: "They come mostly on time, I am not rushed and I feel safe and comfortable with them". "I have the same member of staff every morning; she gets me out of bed and returns at lunch time". "It's normally the same carers; they are normally on time and always ask if I need anything else". "I have had the same carer for many years". "The carers come early if I have an appointment". "Sometimes the call runs over the time and the carers always stay". "I never know who is coming, I have a list of them all but there is no rota". "The lunch time is sometimes erratic; it can vary from 12 noon and be as late as 2.15 pm". "I am not happy with the amount of different carers, I always have to tell them what to do". Records for one person who received care from two staff three times a day showed that over a period of seven days (a total of 42 staff was required) they had 19 different care staff. The person was living with dementia and so many different staff could make them anxious. Staff told us, and a relative confirmed, that this person did know all of the care staff who visited and this had occurred due to sickness and annual leave cover.

A relative told us that the majority of calls were always covered, however on two rare occasions they had helped to move their relative with the hoist as only one member of staff was available, when there should have been two. They said that this was due to cover for sickness and when two regular experienced members of staff work together the call goes very well. Although five minutes between calls was added on the system for travel time, staff told us that this was not always sufficient, which had an effect on the timing of the calls. The office staff told us that they were endeavouring to improve this by re-arranging schedules more geographically to reduce the travelling times between calls.

People's needs in relation to support with eating and drinking had not been fully identified when they first started receiving care. One person had food and fluid charts in place, the care summary said 'complete food and fluid chart and document how much eaten at lunch and how much supplement drink had been taken, but there was no guidance in the care plan to show how this information was being used to make sure the person was eating and drinking properly. There was no record to show when staff should contact health care professionals for advice. Staff told us that this person had a history of poor nutrition and that health care professionals had been involved in their care. There was evidence that staff had contacted the office when they had concerns and staff were encouraging the person to eat more, such as leaving out drinks and snacks. However the care plan had not been reviewed or updated to ensure all staff would be aware of this current guidance.

People told us that the staff made them meals of their choice and left out flasks and drink for them to enjoy later in the day. People said: "If my carer makes a salad, it always looks so interesting and appetising". "I always get a choice for lunch and my drinks are always left for me". "I can make my own decisions so I decide what I want for lunch and the staff always make it for me". "My carers always make sure they leave my drinks, they never leave without doing this".

Requires improvement

Is the service caring?

Our findings

People and their relatives told us that the staff were kind and caring. They said: “The carer’s are lovely”. “The carer makes me laugh; she is nice to talk to”. “Staff are very good on interpersonal relationships, they are very warm, caring and efficient”.” We have got to know each other very well and she makes me smile”. “I am happy with them, I can’t do without them”. “I am very happy with the staff, I am sure I am well looked after”. “The carers do anything I ask, they are most helpful”. “My regular carers know what I need”. “The staff do everything well, they are very caring. They give me everything I want”. “My carer goes out of her way to make sure I have everything I want”. “They are all very good, I know most of them very well”

People’s relatives said: “The staff are very pleasant, I cannot fault them”. “Most of the staff are very dedicated, some of them go beyond what they need to do”. “The staff are always polite and respectful”. “I am very grateful for the service, the staff are always polite and respectful”. “My regular carer is very friendly and very nice”.

Staff knew people well and described their daily routines and how they liked their care to be delivered. However, care plans were not personalised to show that people had been asked about their preferences, including if they preferred a male or female staff. Some people said they preferred female staff and had refused a male, whilst others said they had got used to the idea of male staff. People’s preferred name was not recorded to ensure they were addressed by their preferred name. Care plans did not contain any details of their personal history so that staff would be able to discuss things that were important to them.

Some people said that they were involved in planning their care and were able to make their own decisions. Others said that they had not been involved but were able to tell staff what they needed. Care plans lacked evidence to show that people were encouraged and supported to be involved in the care planning and how they made decisions about their care. One family member told us that they were very involved in the care of their relative but this information was not recorded in the care plan. Advocacy services were available but there was no one using this service at the time of the inspection.

During our visits to people’s homes we observed that staff spoke with people respectfully. They took time to listen and patiently waited for people to discuss what they wanted before responding.

Staff talked about people in a respectful and caring way. One staff member said: “We always treat people as we would like a member of our own family to be treated”. Staff had received training in treating people with dignity and respect as part of their induction.

People told us that their privacy and dignity was always respected and staff made sure that doors and curtains were closed when providing personal care. People said: “Yes I am always treated with dignity and respect”. “Staff always make sure we are private when I receive my personal care”.

Staff told us how they encouraged people to be as independent as they could by, by passing them their flannel to wash their hands and face for example while bathing However, people’s personal hygiene care plans did not detail what people could do for themselves and the areas where they needed support.

Requires improvement

Is the service responsive?

Our findings

People had care needs assessments before they started using the service. People said that they had received a visit from the office staff to talk about the care to be provided and talked about what they expected from the service. One person told us that the service had visited them over a year ago to discuss their care plan but they had never received an updated copy.

At the last inspections in May 2014 we asked the provider to take action to make improvements to protect people from the risk of inappropriate and unsafe care. This was to make sure they received the care and support they needed regarding their health care needs. Following the inspection the provider sent us an action plan to tell us of the improvements they were going to make by September 2014, however this plan had not been fully implemented to comply with the regulations.

People had minimal documentation in place at their homes for staff to follow. For example, the care plans were not complete and did not give staff the information and guidance about how to care and support people in the way that suited them best. Guidance about how staff should move people safely was missing in some cases.

Some care plans did have brief details of people's preferences, such as what they liked for breakfast and to leave out drinks, whilst other plans did not contain information that was important to people, such as their likes, dislikes and personal preferences.

For example, one family member told us they had discussed with staff how to place their relative's pillows each night so that they were safe and comfortable in bed, they told us that staff made sure this was done, but this personalised information was not included in their care plan. Another plan stated 'offer personalised care' but it did not detail what this meant or how to provide the care. The plan also stated that this person may require some support with personal care when having a 'bad day' but it did not say what this support was or detail how 'the bad day' affected the person and what extra care may be needed. Some plans included a form entitled 'planned delivery of care', which was a tick box format of options in each section such as, assist me to get up and dressed, or assist me to bed. Ticks had been recorded that the person required this care but there were no other details to show what assistance meant to them personally to ensure they were receiving the care they needed.

Care plans did not identify that some people may need care and support to keep their skin healthy and intact. There was no information in any of the care plans to inform staff on how to deliver care to people whose skin may be at risk of breaking down. There was no information about what signs to look for in case sores were developing and what action they should take, like contacting the doctor or district nurse. There was no information about how people should be positioned or what equipment needed to be in place to prevent their skin from deteriorating further. When people did have pressure sores the local district nurses were visiting.

The care plans did not show that people had been involved in the development and review of their care plans in a meaningful way. People's care needs were not reassessed regularly and this resulted in their care plan being out of date and not reflecting their current needs. Only one person said that their care plan had been reviewed, other people told us that they had not received a visit from the office staff to review their care.

Some people needed a lot of support and equipment to move and transfer around their homes. However, there was no detailed guidance on how to safely move and handle people, explaining what equipment to use and how to use it. One person had received a visit from an occupational therapist on 29/05/15, which resulted in a significant change to their moving and handling needs; however, at the time of the inspection the plan had not been reviewed and updated to ensure staff had the current guidance to move this person safely.

The provider has failed to make sure that people received person centred care and treatment that was appropriate, meet their needs and reflected their personal preferences. This was an ongoing breach of Regulation 9 (1), 9(3)(a)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The operations director told us that a new format of care planning was being discussed and would be implemented in the near future.

People had information about how to complain within the care plan folder kept in their home, so people would know

Requires improvement

Is the service responsive?

how to complain. The service had policies and procedures in place to explain how they would respond and act on any complaints that they received. People told us that they did not have any complaints but would not hesitate to raise any concerns. One person said: "I am very satisfied, they are all lovely, no complaints at all they are all very good"

People had also praised the service about the care they had received. Recent compliments included: "Thank you for all the care and everything you did for my relative". "Thank you to all the carers who looked after my relative so well".

Requires improvement

Is the service well-led?

Our findings

The majority of people told us that they were satisfied with the care being provided. However, some people felt the management of the service could be improved. They told us that communication with the office was not always as good as it could be and the recruitment and retention of staff could be improved. One person felt that the organisation of the service was poor as they did not receive the same regular staff members. One person said: "I am more likely to complain about the management than the carers." Other people told us that they would recommend the service.

The operations director told us that recruiting staff was a challenge and they had an ongoing recruitment drive to continue to maintain staffing levels.

The provider had failed to fully implement the action plan to improve the service sent to CQC in September 2014 and the service continued to be in breach of three regulations, safe care and treatment, person centred care and good governance. The shortfalls that remained were, the lack of detailed, personalised care planning, including risk assessments. Care plans had not been regularly reviewed or updated. Although there was information about people's medical conditions guidance was still not in place to show staff what to do in case of deterioration in people's health and when to seek medical advice. The recording and management of medicines was not safe. Records were not accurate or completed properly. The timescale for completing this action plan was September 2014, which had not been met. There was a lack of leadership and oversight to make sure that effective planning and improvements were made to become fully compliant with the regulations.

Care plans and some medicine records had been audited, however, the shortfalls detailed in this report had not been identified or actioned to improve the service and support that people required. The care plan audit checked that the appropriate paperwork was in place but the quality of the plans had not been checked. The medicine records had been signed to say they had been checked but there were gaps in the recording of the medicines and there was no record of what, if any, action had been taken to address the issues.

The provider failed to ensure that systems were established and operated effectively to ensure compliance with the regulations. The systems and procedures in place in order to assess, monitor and drive improvement in the quality and safety of people were not effective.

This was an ongoing breach of Regulation 17(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service was currently being run by a registered manager (who is also the registered manager for the organisation's location in Herne Bay) and two co-ordinators. The operations director told us that a Deputy Manager was to be appointed to the Broadstairs location in the near future.

At the last inspections in May 2014 we asked the provider to take action to ensure that proper and accurate records were in place. At the time of this inspection the provider had not always ensured that people's records gave clear information about how to protect them against the risks of unsafe care and treatment.

Records were not always fit for purpose. Care plans and risk assessments completed by the staff were not accurate and did not contain the information to make sure people received the care and support that they needed that kept them as safe as possible. In some cases, there were no personalised care details in place, or moving and handling risk assessments. Medicine records were not accurate or completed properly. Some records had not been signed and dated by staff to show who was accountable for completing the information.

The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records. This was an ongoing breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records were secure and stored appropriately and all records requested at the time of the inspection were available.

Some people told us that they had been asked for their views about the service. They said they had received quality assurance surveys to complete; others said they had never received a questionnaire. The questionnaires covered areas such as consent to care and treatment, the

Requires improvement

Is the service well-led?

quality of care and the promptness and courtesy of staff. Seventeen people had returned forms. The responses were mostly positive but two people were dissatisfied with aspects of their care. We asked how this information was used to improve the service. We were told individuals were given the opportunity to discuss issues privately with the provider and that care plans were amended if necessary to reflect the current needs of the person. However, there was no evidence to confirm this had been done.

Although feedback had been received from some people, the provider had not actively encouraged feedback about the quality of care from a wide range of stakeholders, such as staff, visiting professionals and professional bodies to ensure continuous improvement of the service.

Staff knew about the visions and values of the organisation and told us how they cared for people in an individual way, respected their dignity and helped to keep them as safe as possible. Staff said that they worked hard as a team to make sure people received the care they needed.

Staff said they understood their role and responsibilities. They were clear about their responsibilities to the people and to the management team. They told us they were well supported by the management team.

There were systems in place to monitor that staff received up to date training, had regular team meetings, spot checks, and supervision meetings. This gave staff the opportunity to raise any concerns and be kept informed about the service, people's changing needs and any risks or concerns.

The managers attended conferences to improve their practice, for example; the regional manager had just attended a two day conference with the Health Plus Care Provider. They regularly met with the local authority to share good practice and were members of the Kent Community Care Association. The service was also a member of the local chamber of commerce and had been involved in participating in events to support the local community.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. This meant we could check that appropriate action had been taken. We had received notifications from the service in the last 12 months to advise us of events that affected people in the community.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for people because the provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated. There was a risk of people not receiving their medicines as prescribed. The provider had failed to ensure that people were receiving their medicines safely. This was an ongoing breach of Regulation 12 (1) (2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider has failed to do to make sure that people received person centred care and treatment that was appropriate, meet their needs and reflected their personal preferences. This was an ongoing breach of Regulation 9 (1), 9(3)(a)(d)**)** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider failed to ensure that systems were established and operated effectively to ensure compliance with the regulations.

This section is primarily information for the provider

Action we have told the provider to take

The provider has failed to ensure that suitable systems and procedures were in place in order to assess, monitor and drive improvement in the quality and safety of people.

The provider has failed to mitigate risks relating to health, safety and welfare of service users.

The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records.

This was an ongoing in breach of Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014