Nurse Plus and Carer Plus (UK) Limited

Nurse Plus and Carer Plus (UK) Limited - Suite 18 Ingles Manor

Inspection report

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 13, 14 and 15 June 2016, and was an announced inspection. The registered manager was given 48 hours' notice of the inspection. At the previous inspection on 3 March 2015 breaches were found relating to medicines management, risk management and care planning.

Nurse Plus and Carer Plus (UK) Limited provide care and support to people in their own homes. The service is provided to mainly older people and some younger adults. At the time of the inspection there were approximately 229 people receiving support with their personal care. The service undertakes visits to provide care and support to people in Folkestone, Hythe and surrounding areas. The service can also provide 24 hour support to 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.

People told us they received their medicines when they should and felt their medicines were handled safely. However there were shortfalls in some medicine records and a lack of guidance about some areas of medicine management.

Risks associated with people's care had been identified, but some risks lacked guidance about how to keep the person safe. Guidance in relation to moving a person had been improved, but further work was required, to ensure people were moved safely.

People were involved in the initial assessment and the planning of their care and support and some had chosen to involve their relatives as well. However care plans still required further information to ensure people received care and support consistently and according to their wishes. People told us their independence was encouraged wherever possible, but this was not always supported by the care plan.

The provider had undertaken some work to address the shortfalls identified at the previous inspection and audits had identified the shortfalls found during this inspection. However action had not ensured full compliance.

People had their needs met by sufficient numbers of staff. People did not always receive a service from a team of regular staff. Staffing numbers were kept under constant review. New staff underwent an induction programme, which included relevant training courses and shadowing experienced staff, until they were competent to work on their own. Staff received training appropriate to their role, although further training in diabetes would enhance staffs knowledge skills. Some staff had gained qualifications in health and social care.

People felt safe using the service and when staff were in their homes. The service had safeguarding procedures in place and staff had received training in these. Staff demonstrated an understanding of what constituted abuse and how to report any concerns in order to keep people safe.

People told us their consent was gained at each visit. People were supported to make their own decisions and choices. Some people were subject to an order of the Court of Protection and some people chose to be supported by family members when making decisions. Staff had received training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager understood this process.

People were supported to maintain good health. People told us staff were observant in spotting any concerns with their health. The service worked jointly with health care professionals, such as occupational therapists.

People felt staff were caring. People said they were relaxed in staffs company and staff listened and acted on what they said. People were treated with dignity and respect and their privacy was respected. Staff were kind and caring in their approach and knew people and their support needs.

People told us they received person centred care that was individual to them. They felt staff understood their specific needs relating to their age and physical disabilities. Staff had built up relationships with people and were familiar with their personal histories and preferences.

People told us that the communication with the office had not always been good and some felt there was still room for further improvement. People felt confident in complaining, but did not have any concerns. People had opportunities to provide feedback about the service provided. Any negative feedback was used to drive improvements to the service. People felt there had been many changes at the office, which had impacted on the service delivery.

The provider had a set of values. This included providing and maintaining a high quality of care and support to each person based on person centred care and individual needs. Staff were aware of these and felt they were followed through into their practice.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

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 always safe.

There were shortfalls in medicine records and a lack of guidance about some areas of medicine management.

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

People's needs were met by sufficient numbers of staff and these were kept under review.

Is the service effective?

Requires Improvement

The service was not always effective.

People's care and support was not always delivered by regular staff, who were familiar with people's preferred routines.

People received care and support from trained and supported staff, although further diabetes training could enhance staff's knowledge. Staff encouraged people to make their own decisions and choices.

People were supported to maintain good health. Staff worked with health care professionals, such as occupational therapists.

Is the service caring?

Good

The service was caring.

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

Staff supported people to maintain their independence where possible.

Staff listened acted on what people told them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always reflect all the detail of their personal care routines, their wishes and preferences or what they could do for themselves, to ensure consistent care and support.

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

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

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were audits and systems in place to monitor the quality of care people received. However action was not always taken in a timely way to address identified shortfalls to ensure compliance.

There was a registered manager who was supported by a team of senior staff team who worked hard to deliver a service to people.

There was an open and positive culture within the service, which was focussed on people. Staff were aware of the provider's values and this was followed through into their practice.

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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 13, 14 and 15 June 2016 and was announced with 48 hours' notice. The inspection carried out by an inspector and an expert by experience. 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 expert by experience had personal experience of caring for older family members who have used regulated services.

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, such as the previous inspection report, we held about the service, we looked at any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we reviewed people's records and a variety of documents. These included 11 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.

We spoke with 25 people who were using the service, four of which we visited in their own homes, we spoke with two relatives, the registered manager, a member of the organisations compliance team and ten members of staff. We also used the feedback from the provider's most recent quality assurance surveys

where 73 surveys were returned from people and their relatives.

Before the inspection we contacted three social care professionals who had had contact with the service and received feedback.

Requires Improvement

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 told us, "Heavens yes". Another person said, "Yes very safe". People said that staff checked any equipment they used to ensure it was safe before using and those people that required a hoist said they felt safe when staff transferred them. People were asked about the safety of the care provided during review visits made by senior staff and comments had been positive.

People told us they felt they received their medicines when they should and staff handled them safely. At the previous inspection we found shortfalls in the management of medicines and the provider had taken steps to address the shortfalls identified during that inspection. However we found further shortfalls during this inspection.

There was a clear medicines policy in place, which had been reviewed since the last inspection. Staff had received training in the management of medicines and their competency was checked by senior staff. A senior manager told us that the training was in the process of being changed to include practical examples and experience of administration and recording to increase staffs competency and confidence.

Where people were prescribed medicines on a 'when required' or 'as directed' basis, for example, to manage skin conditions, there was a lack of clear individual guidance for staff on the circumstances in which these medicines or topical medicines were to be used safely and when they should seek professional advice on their continued use. For example, people were prescribed different creams/sprays and in most cases there was guidance, such as a body map, about where these should be applied, but a lack of guidance about when, such as when the skin is red or sore. At times there was conflicting information about prescribing instructions in records. For example, in one record it stated 'as required' and in another it stated 'daily'. This could result in people not receiving the medicine consistently or safely.

Medication Administration Records (MAR) charts were in place where staff administered people's medicines. Medication Administration Records charts did not always reflected that medicines had been administered or a code entered as to the reason they were not, so we were unable to ascertain whether people had received their medicines. In some cases daily reports made by staff showed that medicines or creams had been administered, but the MAR chart had not been signed.

Medicine information in care plans did not always reflect medicines records or practices by staff. For example, people had purchased a cream or gel from the chemist and daily records made by staff showed they were applying these, but there was no mention in the care plan or medicine risk assessment.

One person received their medicines in a monitored dosage system. However it was clear they could not manage this aid and staff visits did not coincide with their medicines times so staff had developed arrangements, such as secondary dispensing the entire week's morning medicines into an aid that the person could use and also dispensing lunch and tea time medicines into two other containers, which the person could access. None of these arrangements had been assessed by senior staff or incorporated into

the care plan/risk assessment to ensure they were safe. The registered manager agreed to arrange a review visit to this person.

At the previous inspection we found that risks associated with people's care and support had in most cases been identified, but there was not sufficient guidance in place to fully reduce those risks. In particular moving and handling risk assessments only identified the equipment used and the number of staff required to move a person. The provider had taken steps to address the shortfalls, but there remains further work to achieve compliance and ensure risks were mitigated. The provider had introduced a 'TILE (Task Individual Load Environment) assessment' and in some most these described the personalised way to move the person safely although omitted to identify which sling hooks to use to ensure the person was in the right position when moved. However one referred to moving and handling training or procedures and did not inform staff how to move the person safely. For example, we asked staff to describe how a people was 'assisted' out of bed safely, the person was able to manage some parts of this themselves, but needed a supporting hand around their back for another part, also staff were required to position their walking frame directly in front of them, once sitting on the edge of the bed, to enable them to stand up, none of this detail was in the risk assessment or care plan. In one assessment information was contradictory in that it stated that the person could 'stand using my frame for a short period of time', but in another section said 'I am unable to weight bear'. The daily notes made by staff stated that a certain sling should not be used as it hurt the person's shoulder, but the TILE assessment did not reflect this information.

Some people had diabetes, but there was not always guidance in place, in case they became unwell due to their diabetes to ensure they remained healthy and staff took appropriate action to keep them safe. Records showed that one person's sugar levels were erratic and we spoke to the registered manager about this. Discussions confirmed that arrangements were in place to ensure this person was closely monitored and remained healthy, but none of this information was recorded in the care plan or a risk assessment. The registered manager agreed to update the records.

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.

The registered manager told us they had a risk assessment in place in the event of emergencies that might affect the service. These included bad weather measures, such as access to 4x4 vehicles and staff working locally to where they lived, to ensure people would still be visited and kept safe.

People were protected by robust recruitment procedures. We looked at three recruitment files of staff that had been recently recruited. Recruitment records included the required pre-employment checks to make sure staff were suitable and of good character.

People had their needs met by sufficient numbers of staff. Most people told us staff did "generally" arrived when they were expected, "mostly" stayed the full time or did all the tasks required. One person said, "Weekends occasionally there are little hiccups, but if you phone someone arrives shortly afterwards". Another person said, "There have been a few chaotic situations from time to time". People had mixed opinions about whether if the staff were running late the office let them know. Records showed that spot checks were used by senior staff to check staffs arrival times and ask people if there were any concerns. In the providers most recent quality assurance survey's most people and their relatives rated staff arriving on time and staying the full time as adequate to very good. Records and discussions with the registered manager confirmed that the staffing numbers had increased over recent months despite some staff leaving. In addition a number of staff were undertaking induction training during the inspection week and others

were undergoing their final recruitment checks.

The registered manager told us approximately 80 per cent of people's visits were allocated permanently to staff rotas and these were only then changed when staff were on leave. This meant that 20 per cent of visits had to be scheduled each week, which may impact on the timing of people's visits and also the continuity of staff undertaking their visits. Staff usually worked in a geographical area and the registered manager kept staffing numbers under constant review, with an on-going recruitment programme in place. There was an on-call system covered by the coordinators and the registered manager and a member of staff was also on stand-by to cover visits on Saturday and Sunday mornings.

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 relatives were satisfied with the overall care and support received. One person said, "I am pleased with what I am getting".

Care plans contained information about how a person communicated and what support was required to enable good communication, such as 'Carers to be mindful of non-verbal gestures, nodding/shaking my head and pointing. Please keep a calm voice and always explain what you are about to do clearly. Please ensure you are eye level to me when you are talking to me'.

People, relatives and a social care professional told us staff had the right skills and knowledge to provide care and support that met people's needs. In the provider's most recent quality assurance survey most people and their relatives felt staff had the right skills to meet people's needs.

Most people told us they received their care and support from a team of regular staff and were happy with the number of staff that visited them. Although others told us they would prefer better continuity. One person said they were "trying to get it (the numbers) down" because they got agitated if different staff "just turn up and don't know what know what to do". They told us the school holidays could be difficult. Another person told us, "It took a long time to get a permanent girl". Other comments included, "The carers always changes and I don't like it". "The regular care has been taken off and we don't know why". In the provider's most recent quality assurance survey most people and their relatives rated continuity as adequate to very good. Not everyone received good continuity of care. Records showed that one person had 20 visits in one week and had nine different staff. Another person had 38 visits one week and 16 different staff and another person had 42 visits and 13 different staff. This is an area we have identified that requires improvement.

The registered manager told us that following an initial phone call where they discussed people's needs they match members of staff to cover the visits. The matching process was based on gaps within staff schedules, staff working in the geographical area, people's preferences and staff skills and experience. People told us when they had not been happy with a particular staff member there had been no problem with changing. People said they knew who was coming because they received a schedule of visits in advance.

Staff understood their roles and responsibilities. Staff had completed an induction programme, which included reading policies, attending training courses and undertaking knowledge competency tests and staff also received a staff handbook. In addition staff also undertook shadowing of experienced staff until they were signed off as competent in a variety of tasks. 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 said staff received induction training and then this was refreshed every year with a further two days of training. Training included enablement, stoma and catheter care, nutrition and hydration, health and safety, moving and handling, fire safety awareness, emergency first aid, infection control and basic food hygiene. Staff received some specialist training, such as dementia care including

dealing with challenging behaviour.

Staff supported a number of people that had diabetes. Training staff told us that diabetes awareness was covered during staff's induction. However staff could not remember receiving this training and not all staff could tell us about the signs and symptoms if someone became unwell due to their diabetes. This is an area we have highlighted that requires improvement. The registered manager discussed with training staff organising these courses before the end of the inspection.

The service had approximately 75 staff and 18 had achieved or were undertaking 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. Staff felt the training they received was adequate for their role and enabled them to meet people's needs.

Staff told us they had opportunities to discuss their learning and development through team meetings, unannounced spot checks and an annual appraisal. Unannounced spot checks were undertaken by the senior staff, these were unannounced, whilst staff were undertaking visits to people. During these observations staff practice was checked against good practice. Team meetings for staff were held. Staff were able to discuss any issues and policies and procedures were reiterated. Staff said they felt well supported.

People said consent was achieved by staff discussing and asking about the tasks they were about to undertake and made their own choices. People said staff offered them choices, such as what to have to eat or drink or what to wear. People were asked whether staff respect their choices during review visits and comments had been positive.

Staff were trained in Mental Capacity Act (MCA) 2005. The registered manager told us that no one was subject to an order of the Court of Protection at the time of the inspection although 20 people had Lasting Powers of Attorney arrangements in place and one a Do Not Attempt Resuscitation (DNAR) in place. 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 told us they had been involved in a best interest meeting about the future arrangements of a person's care and support. The decision making had involved the person, their care manager, family and staff. They demonstrated they understood the process to be followed.

People's needs in relation to support with eating and drinking had been assessed during the initial assessment and recorded. Most people required minimal support with their meals and drinks if any. People that were at risk of poor nutrition or hydration had food and fluid intake charts in place so this could be closely monitored. Staff talked about people they supported who were prescribed meal supplements or had a liquidised diet. One person had recently seen a dietician and the registered manager was arranging a review of their care plan to ensure it reflected their advice and guidance. Food and fluid charts were implemented during the inspection. Staff usually prepared a meal from what people had in their home. People said staff encouraged them to drink and eat enough and would leave a snack or drinks for later. Care plans showed that staff left food and drinks to promote a healthy diet and sufficient fluid intake.

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 they were unwell and called an ambulance and they were admitted to hospital. Other people said staff had called an ambulance or contacted a relative. Observations showed staff reported concerns to the office and these were acted upon.

For example, staff reported one person was unwell and staff arranged a doctor's visit. Appropriate referrals were made to health professionals. For example, the occupational therapist to assess or reassess for equipment. Information about most people's health conditions were incorporated into people's care plans to inform staff about people's health needs. A social care professional told us that any advice and guidance was followed through into care plans and practice.

Good

Is the service caring?

Our findings

People told us staff were caring and listened to them and acted on what they said. People and their relatives told us and we observed this sometimes included the use of good humour. People were relaxed in the company of staff. People and relatives were complimentary about the staff. Comments included, "They (staff) cheer me up, and we have good interactions". "I feel confident with my main carers". "(Staff member and staff member) deserve gold stars, they are always patient, on time and do the little jobs".

In the provider's most recent quality assurance survey people rated staff being polite and treating them with dignity and respect as adequate to very good, with the majority rating staff as good or very good.

Some people talked about staff that "Went that extra mile". One person told us that "(Staff member) is the most reliable carer I have ever had. We have a laugh and a joke". Another person talked about two staff who were "very good and know my routine". Another person told us, "(Staff member) is really supportive and calms me when I am stressed, she is very calming". One person said, "There are two that are like granddaughters to me. They make sure everything is OK and really check out any problems and go a little bit beyond the others".

The registered manager talked about a member of staff who visited a person whose first language was not English. They had downloaded an app on their mobile phone and used this to aid translation. Two other staff were shadowing this staff member to improve communications.

The service had received some compliments letters about the care and support provided. One person said, "having (staff member) has really transformed my day. She is a real treasure".

During the inspection we observed staff took the time to listen to people and their feedback and answer people's questions.

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

People told us their independence was encouraged wherever possible. One person said, "They (staff) let me do what I can do and give me time to do things". Other people gave us examples of how staff encouraged them to be independent. A social care professional told us that people's independence was maintained.

People told us they were involved in the initial assessments of their care and support needs and planning their care. Some people had also involved their relatives. People told us that senior staff visited periodically to talk about their care and support and discuss any changes required or review their care plan. People felt

care plans reflected the care and support they received. The registered manager told us at the time of the inspection most 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 service.

People told us they were treated with dignity and respect and had their privacy respected. Staff had received training in treating people with dignity and respect as part of their induction and had their practice observed during spot checks. 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. A social care professional felt staff treated people with dignity and respect.

Eight staff were dementia friends. Signing staff up as a dementia friend is a national government funded initiative to improve the general public's understanding of dementia. The registered manager told us it was about gaining and updating knowledge, volunteering and giving back to the community and raising awareness and how staff had held some charity events to raise money.

Requires Improvement

Is the service responsive?

Our findings

People told us they were involved in the initial assessment of their care and support needs and in planning their care. Some people told us their relatives had also been involved in these discussions. Senior staff undertook these initial assessments, which included details of other health and social care professionals involved in the person's care and support. People or their representative had signed the assessments as a sign of their agreement with the content.

Care plans were developed from discussions with people, observations and the assessments. At the previous inspection we found shortfalls in care planning and there was some improvement, but care plans continued to not contain a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. People had mixed opinions about whether their care plan reflected the care and support they received. Records and discussions showed that not all care plans were up to date reflecting people's current care and support needs.

Care plans varied in detail and all required further detail to ensure that people received care and support consistently, according to their wishes and staff promoted people's independence. Some care plans did show people's preferred personal care routine and reflected what they could do for themselves in relation to washing, but when it came to drying and dressing there was not sufficient detail as care plans showed statements, such as 'assist me to dry' or 'assist to dress' and 'assist with oral hygiene', this did not promote or ensure people's independence maintained.

Daily notes showed that people had little things done, which enhanced the care and support they received, such one person had a pillow put under their legs for comfort, but this information was not in the care plan.

One person's care plan stated 'assist with full body wash or bath or shower, assist me with undressing and encourage me to do as much as I can for myself'. In another section it stated 'I may require some assistance with personal care. I am able to communicate my wishes. However if I having a bad day I am happy for (relative) to direct carers'. 'I will require assistance with my lunch please encourage me to do as much as possible for myself'. Staff told us this person 'may need help with personal care' due to their continence needs and also required staff to sit with them to ensure they ate because there had been periods when they hadn't eaten much, but none of this detail was in the care plan. The care plan talked about needing assistance with the person's 'daily physio routine', but staff told us they did not do this any longer. It also stated that speech therapy exercises were displayed for carers to follow', but staff said they no longer did these either.

Another person's care plan stated 'assist with shower or full body wash. I can direct the carer on the day'. 'Please assist with dressing'. This person's care plan also stated that they were living with dementia so directing the staff each day may be difficult and would become more difficult for them.

One person's care plan showed that they used a bed pan, but staff told us this was not right and the person

now had a commode, which they used. Their visits had been changed and a lunch call had been cancelled, but the care plan had not been updated to reflect this.

This meant that people would have to explain their preferred routine to any new staff that visited or would not receive consistent and safe care particularly when their regular staff member did not visit. One person said, "The regular ones (staff) know what to do, but the new ones you have to explain what they have got to do. I have put some notices up to help". Another person told us, "It's very frustrating when they send someone who doesn't know me".

The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. The above is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not socially isolated. Some people were supported to be ready to attend groups and daycentres within the community. At care plan review visits senior staff discussed involvement in the local community and whether the service could do anything to aid this. People said they looked forward to the staff visits each day and most people told us this in itself sometimes ensured they were not lonely.

Most people told us they felt confident in complaining, but did not have complaints. People knew how to make a complaint and most people told us the service had responded to any concerns raised previously. The complaints procedure was contained within people's service user guide, which was located within their care folders in their home along with their care plan. Records showed there had been several complaints in the last 12 months, which had been investigated and responded to appropriately. The registered manager told us any complaints were used to learn from and improve the service.

People had opportunities to provide feedback about the service provided. People were asked informally for their feedback during their care plan review visit and also during staff spot check visits. Some people told us they were also telephoned for feedback. Quality assurance questionnaires were sent out annually. The latest results had just been collated by head office, but the results had not yet been cascaded to the registered manager. Once this had been done an action plan would be put together to address any negative comments and areas that required improvement.

Requires Improvement

Is the service well-led?

Our findings

In the provider's most recent quality assurance survey people and relatives were mixed about the professional attitude of office staff, the ability to contact office staff and the time in which staff responded to people's requests, being informed about changes to their service and the overall level of service provided. The majority rated these areas as adequate to very good, but between one and 11 people rated one or more areas as poor. People told us although they did not have any real complaints they felt the organisation of the service, continuity of care and communication were areas that required improvement.

During the last 12 months there had been several changes within the service that had impacted on services people received. The previous registered manager who managed two locations now only managed the Ashford location and the deputy manager had become the registered manager at this location. In conjunction the area covered by this location had also changed.

The registered manager was supported by coordinators and these had also changed since the last inspection. At the time of the inspection there were three coordinators in post although one was on long term leave. The two coordinators working were both fairly new in post. In addition the office was supported by a new administration assistant. The registered manager told us there was one field care supervisor in post and one vacancy. The field care supervisor had also been spending some time supporting the office. There were seven senior care workers. Coordinators, field supervisors and care workers all worked in geographical areas to aid consistency and effective working. The field care supervisor undertook people's initial assessments and care plan reviews, the coordinators coordinated people's visits and undertook staff spot checks.

Senior management were also supporting the location with a relief manager covering the registered managers leave and also supporting the office undertaking coordinating. They were working with the management staff reviewing operations and there were weekly meetings to discuss action required and monitor shortfalls and progress.

However due to leave during the week of inspection there was only the registered manager and the two coordinators present in the office. On the second day of the inspection two care staff had telephoned in sick just before their visits should have started and the coordinator on call went out to cover some of these visits. This left the registered manager and one coordinator in the office, which we observed was extremely hectic with telephone calls coming in and being made to cover the remaining visits and manage any other problems reported in. Staff told us that sometimes they came into the office with a concern, but it was so busy they went out without discussing it and we saw this could have easily been the case on the second day of the inspection. One staff member said, "Of late it's been a bit up in the air, but (registered manager) is back and that is a sense of relief".

Discussions with people and staff showed that the all the changes and inexperience of the new office staff had impacted on the service people received in the areas of communication, continuity and timing of visits. Staff told us how there had been a period where communication had not been good, but had of late

improved, although they told us there was room for further improvement to ensure the service ran effectively. One person said, "The person I spoke with on the telephone recently was attentive and understood what I required". Other comments were, "It's working, it wasn't working, but it is better now" and "The office is getting better, the earlier part of the year you didn't know who was coming or going". "Communication is lacking at times". "Sometimes there is an issue with communication, but it is getting better". "Communication is not as good as it could be, I leave a message or information to be passed on and it doesn't always get done or passed to the right person. Got better than it was". A social care professional who had visited the service told us that the office staff were pleasant. They said there had been issues in regard to missed and late visits and communication to people if visits were going to be delayed, but that the service had addressed this. They told us that over a period of time the management appeared to have improved with more structure and the registered manager was focused on the role.

Records showed that schedules could not run effectively as staff had schedules sent to them with no travel time between any visits, which would mean they would either have to clip time from visits or run late. Some staff told us they started early to compensate for this, but all this meant people could not be confident that staff would arrive at the same time for each visit. One schedule had a visit that finish at 9.15am, but the next visit on their schedule should have started at 9am. Records and discussion also showed that when staff were running late and relatives were telephoned they preferred or agreed not to have that visit. We heard office staff telephoning staff to cover visits, although going through the schedule they still omitted to include any travel time.

One person told us how they had been looking forward to going to two special events and arranged and changed the time of two of their evening visits in February 2016, to help them get ready to go out for the special events; however the staff had not arrived as requested so they had been unable to go. One person had a recent missed call for their Wednesday domestic and they agreed for this to be covered later in the week.

The registered manager had taken action to address shortfalls that had been identified. Seating arrangements in the office had been changed so that the registered manager and office staff were working in one office so communication could be observed and monitored. Staff now had to telephone in each day and go through their schedule to avoid missed visits. During the inspection we saw that any concerns that were brought to the registered manager's attention were addressed swiftly. Where poor practice was identified staff were brought into the office for supervision and had extra spot checks arranged until management were confident things were resolved. Staff told us they had confidence that the registered manager would deal with things or explain the reasons why action could not be taken. People told us office staff were polite and courteous and responded to their requests.

Senior management received reports from the registered manager regarding accidents, incidents, assessments, spot checks, care plan reviews, recruitment, training, supervisions, team meetings and appraisals. The managers undertook quarterly visits to the service to carry out audits on files and their contents. A report was then produced based on a traffic light system, when the service had not reached green, action was required and an action plan put together, which was monitored until the next audit. The most recent report had identified that some people's files did not yet have a TILE assessment and that more specific/personalised information was required and also care plans needed to be more personalised.

In addition the service had to submit a quarterly return to the local authority that they contract with to enable them to measure the service quality. The return dated December to February 2016 showed the service was operating within the measures set by the local authority.

The provider had already introduced the 'TILE assessment' and in addition a new assessment/care plan format was also about to be implemented, to aid better assessment and planning. A new medicines training workshop had been developed and was about to be rolled out to staff, which would include practical sessions following the care plan and recording administration.

The registered manager and senior management also told us that a new computer system (people planner) was to be implemented. This would incorporate scheduling and would be able to identify when staff were running late and had not undertaken a visit within half an hour of the correct start time, helping to reduce the risk of missed and late visits.

It is acknowledged that the provider, despite the many changes at the location had taken considerable action to address the shortfalls identified at the previous inspection and had identified the shortfalls highlighted at this inspection. However improvements had not been driven in a timely way to ensure compliance.

The provider had failed to establish and operate effectively systems and processes to ensure compliance with the requirements. The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider was a member of the Kent Community Care Association, Contractors Health & Safety Scheme (CHAS), Recruitment and Employment Confederation (REC). These memberships, the internet and attending managers' meeting within the service and meetings with other stakeholders, such as social services was how the registered manager remained up-to-date with changes and best practice.

The provider's values were included in the service user guide and staff handbook. Staff were aware of the values of the service through team meetings and training. They told us the service promoted good quality care, privacy and dignity and respect and independence.

Staff spoke very highly of the registered manager and felt they listened to their opinions and dealt effectively with any concerns. Staff felt changes that were being implemented were for the better. Staff said they understood their role and responsibilities and felt they were well supported. There were systems in place to monitor that staff received up to date training, had regular team meetings, spot checks, supervision meetings and appraisals, when they could raise any concerns and were kept informed about the service, people's changing needs and any risks or concerns.

People and/or their relatives completed quality assurance questionnaires to give feedback about the services provided. During early 2016 73 people responded to surveys sent out by the provider. A high percentage showed people were satisfied with the overall service received. Negative comments related communication, staff not arriving on time and appearing rushed and continuity of care. These had only recently been collated and an action plan was still to be developed, although these areas have already been identified by senior management and some plans were already in place.

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 up to date 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 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 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. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate effectively systems and processes to ensure compliance with the requirements. Regulation 17(1)

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 The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. Regulation 9(3)(b)

The enforcement action we took:

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