Care at Home Services (South East) Limited

Care at Home Services (South East) Ltd - Herne Bay

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

Overall summary

The inspection took place on 28 and 29 September 2015 and was announced. Forty eight hours' notice of the inspection was given, as this is our methodology for inspecting domiciliary care services. The previous inspection on 23 April 2014 found no breaches in the legal requirements.

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 inspection105 people were receiving care and support from the service.

Summary of findings

The service is run by a registered manager, who was present on the day of the inspection visit, together with the regional manager and operations director. 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 did not have guidelines for staff to follow to ensure that risks were being managed and people were being moved safely.

Medicines were not always 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 in some cases there were no proper records maintained to say what and when creams should be applied.

Some people told us they were involved in the assessment and planning of their care and support, however, this detailed information was not included in the care plans to reflect the care being provided. There was a lack of information about people's skills in relation to tasks and what help they may require from staff, in order that their independence was maintained. Some plans had been reviewed but any changes were only recorded on a review form and this information was not transferred to the content in the care plan to make it clear to staff what changes had been made.

People's care plans did not always contain the guidance that staff needed to support them with their specific health care needs, such as diabetes and catheter care. 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 and mental capacity assessment forms were in place. Not all staff had received training on the Mental Capacity Act 2005. The Mental Capacity Act provides the legal framework to assess people's capacity to make certain decisions. Training to address this shortfall had been booked to ensure all staff received this training. Staff were aware that meetings would be held involving relatives and other health care professionals to make decisions in people's best interests.

Records were stored safely but were not always updated and completed accurately. Some medicine records were hand written and not checked to make sure the correct medicines had been recorded.

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.

Staff had schedules to plan the delivery of care so that people received care from regular staff. People's calls were allocated permanently to staff rotas and these were only changed when staff were sick or on leave 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. There was an on-call system covered by the registered manager and senior staff, which people could access if they needed to.

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 end of life and diabetes training. Staff practice was monitored 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. Within the domiciliary care service most people required minimal support with their meals and drinks. People told us that staff always offered them a choice of what food and drink they wanted. Staff ensured drinks were left out for people to access before they finished their calls.

Summary of findings

People were treated with respect and their privacy and dignity was maintained. People we visited told us the staff were polite, caring 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 had information about how to complain within the folder kept in their home, so that they were aware how to complain. People we visited were confident they would complain if necessary but did not have any concerns. There were systems in place to monitor and follow through minor concerns as well as complaints.

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 reviewed and actioned to continuously improve the service.

People had opportunities to provide feedback about the service provided. Quality assurance questionnaires were sent out annually but the results had not been summarised and there was no evidence to show what action had been taken to address any comments made and measures implemented to improve the service. 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.

People told us that communication with the office was good. Staff said that the service was well led and they were supported well by the management team. They were clear about their roles and responsibilities and felt confident to approach senior staff if they needed advice or guidance.

We found three 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.

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 and not 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 diabetes training.

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

People were being supported to make decisions in their best interests.

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

Is the service caring?

Good

The service was caring

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

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

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Care plans varied in detail and did not always reflect people's full personal care routines or their wishes and preferences. The plans were not consistently reviewed to make sure staff were aware of people's current needs.

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.

Summary of findings

Is the service well-led?

The service was not always well-led.

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

people received, however these were not always effective as they did not show what action had been taken to continuously improve the service.

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.

Requires improvement

Care at Home Services (South East) Ltd - Herne Bay

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 28 and 29 September 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.

One inspector, a specialist adviser, with a background in medicines 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.

A Provider Information Return (PIR) was submitted by the service 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 12 people who were using the service, three of which we visited in their own homes, and two relatives. We spoke with the registered manager, operations director, the regional manager, and two co-ordinators who organised the work for the staff. We reviewed people's records and a variety of documents. Three care plans were looked at in people's own homes and five care plans were looked at in 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 three health care professionals for feedback about the service and one response was received.

The previous inspection of this service was carried out in April 2014. The previous inspection on 23 April 2014 found no breaches in the legal requirements.

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, I trust the staff". "I do feel safe at home, because I know the staff will listen to me". "The staff encourage me to be independent, but they also make sure I'm safe".

Risks to people had been identified and assessed but guidelines to reduce risks were not always in place and were not clear. Risk assessments to support people with their mobility lacked detail. Some people were moved using special equipment like hoists and slings, but risk assessments did not tell staff how to do this safely.

The moving and handling risk assessments did not always have the full list of equipment required to move the person safely, for example one person told us how staff moved them with slide sheets in their bed but this was not recorded in the care plan or shown on the risk assessment. Some people had medical conditions, such as arthritis and Parkinson's, but this information was not included in the risk assessments to ensure they were moved safely in line with their medical conditions. Another person's moving and handling risk assessment stated that they were high risk, but the only information on the risk assessment was 'all transfers with the use of the full body hoist, standard sling and two carers', there was no information to demonstrate how staff were to manage the risks and move the person safely. 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.

One person's assessment stated that they had no risks but they were living with dementia and also had diabetes. There was no information of what risks the person may have due to their dementia or health care needs. There was lack of information in other care plans to give staff a better understanding of individual medical conditions such as diabetes, to enable them to recognise the signs that might indicate people's conditions was becoming unstable and what appropriate action they had to take.

Staff told us they 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. They told us they relied on other members of staff to show them how to move people as the risk assessments only showed how many staff were required and to use the hoist.

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.

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 is a 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. However there were shortfalls in the management of medicines. The systems in place to manage the medicine were not effective because they did not ensure that medicines was being handled and recorded safely.

Details about what medicines people were prescribed were not always up to date in the care plan. There was a section to complete details of the medicines taken by each person, the dose of the medicine, when it started or ended, and the reason why, but in some cases this had not been completed.

One person's care plan stated that they were 'prompted' to take their medicines, however it was confirmed by the registered manager that staff were actually giving this person their medicines and not just prompting. The care plan, therefore, had conflicting information as to what level of assistance was actually being provided for this person to take their medicines safely. There was no clarification in the medicine policy to guide staff on what constituted prompting and the administration of their medicines.

The medicine policy also stated that 'home carers must not undertake the administration of controlled drugs'. However, records showed that controlled drug pain patches were being administered to one person. The patch should be applied every three days in the mornings; however records showed on 25/07/15 and 24/08/2015 that this had been applied during the evening call. The patch should be worn continuously for 72 hours, after which the patch should be replaced. A new patch should always be applied to a

different site from the previous one. The same application site may be re-used only after an interval of at least 7 days. There was no record to show that this patch had been applied in line with the prescriber's instructions to ensure the person was receiving their pain relief effectively. Records also showed that for four days in June 2015 the patch was not applied as the medicine could not be located.

There was a lack of robust audit procedures in place to recognise medicine errors and take appropriate action. None of these discrepancies or late applications had been recognised or documented on the monthly medication audit, to ensure the safe administration of the prescribed medicine.

The registered manager told us that this would be investigated and reviewed to address the shortfalls, and action would be taken to reduce the risks of this happening again.

Staff were not completing medicine records accurately to reflect the exact medicine given to each person. For example one person was prescribed as needing their medicine four times a day, but staff were only visiting this person twice a day. Staff were leaving medicine out for the person to take between their calls, however there was no risk assessment in the care plan to show how this was being monitored to ensure it was safe, and there was not always a code recorded on the medicine record to confirm the medicine had been left out for later. The registered manager told us that the doctor had confirmed that the medicine could be administered twice daily to mirror the two visits by staff; however the medicine record showed multiple entries four times a day, therefore it was not clear that the prescriber's instruction had been followed correctly. Another person had their medicine prescribed four times a day and staff only visited three times a day, however, the record had been signed four times a day but the code did not indicate that the medicine was left out for the person to take later. The medicine policy had no reference to doses left out for later and how this may be managed.

Some people needed medicines on a 'when required' basis, like medicines for pain. One person's medicine sheet recorded that when they needed their pain relief, to take one or two tablets, three times a day when needed. There was no evidence on the record to show whether the person had been given one or two tablets. There was no guidance or direction for staff on when to give these medicines safely. Another medicine record sheet showed that one person's regular medicine which was originally prescribed as twice daily, had had been changed to as and when required. There was no evidence to show this had been changed on the advice of a health care professional.

Some people were able to manage their medicines themselves and had risk assessments on file; however these had not been reviewed every six months in line with the policy.

There were body maps to indicate where creams should be applied on a person's body, but the application of the creams was not always 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.

There were two different formats of medicine records, one medicine administration record sheet (MAR) supplied by the community pharmacists and an 'in house' record sheet. When staff completed 'in house' forms, there were no systems in place to check that the medicines recorded were correct to ensure people received their prescribed medicines.

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 is a 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 were knowledgeable in recognising signs of potential abuse and how to report abuse within the service and to outside organisations, 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,

Requires improvement

Is the service safe?

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. Staff had permanent schedules to provide care to the same people in their homes. These calls were geographically placed to reduce travel time to try to ensure staff arrived on time. The service had sufficient numbers of staff to meet people's needs and cover holidays and sickness absences. The office staff and registered manager would also cover calls and provide direct care.

Staff told us that, on the whole, the 'on call' system worked well, however they felt it could be improved as sometimes the on call person completed calls during the hours of 7 am to 9am and this restricted their availability to respond to situations when people needed support.

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

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. People said: "Everything's going ok". "The staff make me feel looked after". "The staff always ask how I am and check if there's anything else before they go".

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.

Some people had catheters in place. A catheter is a tube that it is inserted into the bladder so that urine can drain freely. In the daily notes for one person it was recorded that the person' was ok but the catheter had leaked', there was no further information of what action staff took to make sure this did not reoccur. 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.

The daily notes in one person's care plan stated that paramedics were there when staff arrived, and the person was ok, there was no further information to show why paramedics had attended or what if any additional care was required as a result of this incident. We asked the registered manager if there was information recorded in the health care notes on the system in the office but there was no record of this incident. We could therefore not be sure that appropriate action had been taken to ensure that this person was receiving the care they needed.

Some records did show 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 they 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. Each person had a mental capacity form in their care plan to indicate their capacity. Staff had received, or were booked on 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, staff were aware that a best interest meeting would be held 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. One health and social care professional felt that staff had an understanding of mental capacity but felt improvements could be made when reporting this information to the case managers.

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 spoken with told us that they were supported well during their induction training.

Staff told us and records showed that they had received training relevant to their role, such as moving and handling, medicine management and infection control. Not all staff had received fire training, mental capacity and updates in first aid training. We discussed this with the regional manager who told us that this was in the process of being arranged and would be completed by the end of November 2015. Staff had completed dementia training but other specialist training such as diabetes had not been provided. People told us that they felt staff were well trained and knew how to care for them. People said: "My carer knows what she is doing". "They seem to go off training sometimes". "Yes I think they have the skills and experience, I am not unhappy with any of them, I've no complaints in this area".

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.

Requires improvement

Is the service effective?

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 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.

People told us that the continuity of care was good to make sure people received their care from regular staff who knew them well. People said staff arrived on time and stayed the full duration of the call. They said: "I'm happy with the care they are providing. They do a thorough job. They turn up on time and leave me with a cup of tea and a smile. I would definitely recommend them". "It's going wonderful. I have one carer who comes once a day every day and they are wonderful. I would recommend the service because of them". "The staff don't let you down, they are reliable" "If the staff are going to be late due to an emergency they will contact me". "Sometimes I don't know who is coming, but I do know the staff when then come". I have the same carer each day". People knew who to call if staff were late and were aware of the on call system. Staff told us that, on the whole, the on call system worked well; however they felt it could be improved as sometimes the on call person completed calls during the hours of 7 am to 9am and this restricted their availability to respond to situations when they needed support.

Most people required minimal support with their meals and drinks. People said the food staff prepared was in line with their wishes and staff left out drinks or snacks for them to enjoy later. People we visited had drinks and snacks left within easy reach to ensure they received the nutrition they needed. One person said: "Mr carer makes me the drinks I like and will leave me out a sandwich or snack of my choice".

Good

Is the service caring?

Our findings

People and their relatives told us that the staff were kind and caring. They said: “The staff are very friendly, I look forward to our ‘banter’ each visit”. “The staff are very kind, one male member of staff is very charming and knows his job well”. "I am so grateful the staff come and do the things for me”. “The staff are good at everything they do, very kind”. “The staff are all very nice and very good. I can’t complain about the service at all. I can’t find fault with it as my carers are very nice and very polite. They are all so good to me”.

People’s relatives said: “The staff are fine, they know my relative well”. “The staff go out of their way to get everything just right”. “The staff do everything they need to do and make my relative laugh”.

Staff knew people well and described their daily routines and how they liked their care to be delivered. A relative said: “The care staff know my relative well and know what to do to make her less anxious”.

People said that they were involved in planning their care and were able to make their own decisions. They told us that staff routinely asked for their consent to the care being provided and confirmed they had been consulted to agree if they would have a male or female member of staff. One person said: “No I don’t mind the male staff; sometimes they are better than the girls”. Advocacy services were available but there was no one using this service at the time of the inspection.

People and relatives told us that the communication with the office staff was very good and they responded to their issues or questions positively. One person said: The office staff are very nice on the phone”.

During our visits to people’s homes we observed that staff spoke with people respectfully. They took time to listen and people were relaxed and comfortable chatting about their daily lives. People said that they looked forward to the staff visiting and appreciated their company.

Staff talked about people in a respectful and caring way. Staff had received training in treating people with dignity and respect as part of their induction. Staff told us how they supported people to have privacy in their own homes, for example making sure they had privacy when receiving personal care. Staff understood the importance of keeping people’s confidentially and how not to discuss any private information in front of other people.

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 they respect me, they are alright”. “Yes they respect my dignity; they come in and look after me”. Yes they respect my dignity, very much so”. Privacy and dignity is good, the staff so their job well, I always get a good shower”. “The staff talk to you and make you feel comfortable”.

People’s relatives said: “The staff always treat my relative with privacy and dignity. They are polite and treat them with respect”. Staff told us how they encouraged people to be as independent as they could by, by helping them to dress themselves. People told us they were supported by staff to remain as independent as they could. They said: “The staff help me to put myself to bed”. “They make sure I’m safe with what I’m doing”. “They know how independent I am”. “The staff encourage me as they know I am trying to be as independent as I can”.

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.

The initial assessment of people's care needs was completed by the registered manager or co-ordinators from the office. People told us they were involved in the assessment process and planning their care. Care plans had been signed to confirm people's consent to the care being provided. When people's needs changed further assessments had not always been carried out, for example, when additional care needs had been identified or when people returned home from hospital. There was therefore a risk that people would not be receiving the care they needed in line with their current needs.

One person had a food and fluid chart in place as it had been identified that this person was not eating properly but this information was not followed through in the care plan to show what if any action needed to be taken. There was no explanation in the care plan to identify what staff needed to do with this information or when they needed to take action, such as involving the doctor or dietician. One person was losing weight and staff told us that they had been referred to a dietician but there was no record on the care plan, or on the computer system in the office, to confirm this had taken place.

Care plans were not personalised with detailed information about people's personal care routines, for example in the section 'service user delivery of care' the plans stated minimal information, such as, 'assist me to get up/dressed, requires hoisting with two carers', the information did not say what 'assist' meant to the individual or take into account people's medical conditions when they were being supported with their mobility. There was no guidance of how people were being supported to remain independent and show what they could do for themselves. Some care plans did not contain any details of people's personal history so that staff would be able to discuss things that were important to them.

The care plans for one person living with dementia did not contain sufficient detail to ensure they received the care they needed, for example the care plan identified that the person could be anxious but there was no guidance for staff to follow to show how they reduce this anxiety. The plan stated that this person needed two members of staff to assist them but there were no details of their daily personal care routines to demonstrate their needs were being met in line with their preferences and wishes.

One person had been identified as passing out sometimes due to their medical condition but there was no detailed information about their illness or how this was being monitored to ensure that staff would identify the signs and symptoms to ensure that medical attention would be sought if required.

The daily notes in one plan stated that the person's hearing aid should be removed each night but there was no further information in the care plan about how to support their communication needs.

People told us that the staff supported them to maintain healthy skin by applying creams and re-position them to reduce the risk of developing pressure areas. However care plans did not contain information to inform staff on how to deliver care to people whose skin may be at risk of breaking down. There was information in the daily records to indicate that staff were applying creams to people's skin but there were not always details of what the cream was. 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 and supporting them.

Not all care plans had been reviewed, one person started the service in June 2014 and no review had taken place to assess if their care needs had changed. One health and social care professional said care plans were not regularly reviewed when people's needs changed and further detail was required in the plans to show how people's needs were being fully met.

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.

The provider has failed to make sure that people received person centred care and treatment that was appropriate,

Requires improvement

Is the service responsive?

meet their needs and reflected their personal preferences. This is a 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 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 know the staff will take notice if I an unhappy". "I have no complaints but know who to complain to and I would not hesitate to do so".

People told us that the service listened to their concerns and took action to resolve their issues. One person told us that they had asked that a particular staff member did not complete their calls, and the office took action and the staff member did not visit them again. Another person said that they had raised an issue with a member of staff and the matter had been resolved appropriately.

People had also praised the service about the care they had received. Recent compliments included: "I am very happy with the staff and everything that they have done since I started the service. I don't know what I would do without them". "A special thank you for to the member of staff who did 'just that bit' extra when my relative was unwell".

Requires improvement

Is the service well-led?

Our findings

People and relatives told us that they were satisfied with the care being provided. They said they had confidence in the management team. They said communication was good, the service was reliable and they would not hesitate to recommend the service.

Staff told us that the service was well led by the management team. They said the management were open and transparent and they would not hesitate to approach them for support and guidance.

One health and social care professional told us that, at times, communication with the team could be improved to ensure they were kept fully up to date with people's care needs.

The service was currently being run by a registered manager (who is also the registered manager for the organisation's location in Broadstairs) and four co-ordinators. The registered manager was visible in the office and routinely covered direct care calls twice a week in the community as part of her duties.

Some audits were carried out to monitor the quality of the service; however the audits in place were not effective as the shortfalls in this report had not been identified. The service did not have a robust system in place to ensure that people's medication was handled and recorded safely. The care plans lacked detail of personalised care, including how to manage and reduce the risks to ensure people received safe care. 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. Records were not all accurate or completed properly. There was no further processes in place to ensure that the actions to address the shortfalls had taken place to ensure continuous improvement of the service.

People told us that they had not recently been asked about their views about the service. Two people said that they recalled a satisfaction survey had been sent out a while ago whilst others could not remember if they had received one. Four telephone quality monitoring calls had taken place this year with positive feedback, such as "The staff always offer to do more if they have time left over, I am very happy". However, this was a minimal number compared to the total number of people using the service. There was evidence of the previous survey sent to people in November 2014 but these had not been summarised or actioned when concerns had been raised. The operations director told us that actions had been taken but there was no evidence to confirm this and people had not been informed of the outcome of the survey to show what, if any action, had been taken to improve the service. 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.

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

Records were not always fit for purpose. Care plans and risk assessments completed by the staff did not contain the information to make sure people received the care and support that they needed that kept them as safe as possible. Medicine records were not accurate or completed properly. For example: On one medicine record there were multiple entries in the care daily record sheets stating 'prompt medication' on some days and on other days records stated 'medication given' therefore records were not clear to confirm what assistance this person was receiving with regard to their medicine. Another medicine record showed that 13 doses of medicine were given but these entries were undated. 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. 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.

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

Requires improvement

Is the service well-led?

make sure people received the care they needed. One member of staff told us that everyone is treated equally and their aim was to keep people safe and improve their welfare. “We look after people how we would like to be looked after ourselves”. “We treat people with utmost respect and dignity; we listen and give them time, which means a lot to people”. “We make sure people are treated fairly”.

Our observations and discussions with people, relatives and staff showed that there was an open and positive culture in the service. 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 the management listened and acted on what they said. 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 a 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 a breach of Regulation 9 (1), 9(3)(a)(d)**)** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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.

This section is primarily information for the provider

Action we have told the provider to take

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