Meritum Integrated Care LLP

Meritum Integrated Care LLP (Folkestone)

Inspection report

Unit 28 Folkestone Enterprise Centre
Shearway Business Park
Folkestone
Kent
CT19 4RH

Tel: 01303297010
Website: www.meritum.org.uk

Date of inspection visit:
17 October 2016
18 October 2016
19 October 2016

Date of publication:
30 November 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Meritum Integrated Care LLP (Folkestone) provides 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 121 people receiving support with their personal care. The service provided care and support visits (usually between ½ hour and two hours) to people in Folkestone, Hythe and surrounding areas.

In October 2015 72 people's packages of care and 39 staff had transferred from another provider to this provider. Since registration the provider had worked hard to ensure this transfer went as smoothly as possible. In addition the care and support and 24 hour on call provided at Summer Court in Hythe was also transferred to this provider. This is a block of flats with additional communal facilities available for people that live there.

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

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

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 varied in the level of detail and some 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.

There were audits and systems in place to monitor that the service ran efficiently. These had been effective in identifying most of the shortfalls highlighted during the inspection, but not all. People told us that communication with the office was polite and courteous although some felt they did not always receive a telephone call back when told they would. People had opportunities to provide feedback about the service provided. Some people felt the service could be better organised particularly around arranging their visits.

People had their needs met by sufficient numbers of staff. All of people's visits were allocated permanently to staff schedules and these were only changed when staff were on leave. However a number of people felt staff were "often late" for their visits and this is an area we have identified for improvement. People on the

whole received a service from a team of regular staff. New staff underwent an induction programme, which included relevant training and shadowing experienced staff, until they were competent to work on their own. Staff received training appropriate to their role and more than half of the staff team had gained qualifications in health and social care or were working towards this.

People told us their consent was gained at each visit. People were supported to make their own decisions and choices. No one was subject to an order of the Court of Protection although people had made Lasting Power of Attorney arrangements and one person had a Do Not Attempt Resuscitation (DNAR) in place. Some people chose to be supported by family members when making decisions. The Mental Capacity Act 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 and they told us staff were observant in spotting any concerns with their health and taking appropriate action.

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 well.

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.

There was an open and positive atmosphere in the office and staff were receptive to improving services people received. The provider's aim for the service was included in literature people received and we found these principles were followed through into practice.

We found two 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 some 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. However the timing of visits is an area identified for improvement.

Is the service effective?

Good

The service was effective.

People's care and support was delivered by staff whose knowledge and training was up to date, to ensure it was effective.

Staff encouraged people to make their own decisions and choices. People's arrangements for decision making and legal powers in place were recorded.

People's health needs were met and staff were observant in spotting concerns and took appropriate action.

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 took the time to listen and interact with people so that they received the care and support they needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

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

People had opportunities to feedback their views on the service provided.

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 always well-led.

There were audits and systems in place to monitor the quality of care people received. These had identified most of the shortfalls highlighted during the inspection, but not all.

People felt communication with the office was polite and courteous, but felt their visits could be better organised. The office staff were open and receptive to driving improvements.

The provider had an aim for the service and staff followed this through into their practice.

Meritum Integrated Care LLP (Folkestone)

Detailed findings

Background to this inspection

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

This inspection took place on 17, 18 and 19 October 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 a family member. This was the first inspection since the service had moved and registered at the new offices in Shearway Business Park.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed this and other information we held about the service, we looked at 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 nine 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.

We spoke with 20 people who were using the service, four of which we visited in their own homes, we spoke with eight relatives, the registered manager, the company director and regional manager and nine members of staff.

Before the inspection we sent surveys to people who used the service, relatives and professionals who had

had involvement with the service. We received feedback from 20 people who used the service, 3 relatives and 1 professional.

Following the inspection we received feedback from a social care professional who had had contact with the service, which was positive.

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. Comments included, "I feel very safe" and "absolutely". "They (staff) look after me well. They are nice and I feel very safe with them".

People told us they felt they received their medicines when they should and staff handled them safely. However people were not fully protected against the risks associated with medicine management.

There was medicines policy and procedures in place, which had recently been reviewed and updated. This included a procedure for medicine administration, including a step by step guide to administer eye drops, eye ointment, ear drops and inhalers and guidance on administering medicines prescribed 'as required' or 'as directed'. Staff had received training in the management of medicines and their competency was checked by senior staff.

A medicines risk assessment had been undertaken for each person. This identified who managed/administered the person's medicines. However where the arrangements were different for topical medicines this was not identified within the risk assessment. People had consented to the arrangements in place by signing their risk assessment, but there was a risk that staff would be unclear about whether they should apply any topical creams.

Where people were prescribed medicines on a 'when required' or 'as directed' basis, for example, to manage constipation, pain or skin conditions, there was generic guidance about in place regarding the administration of these medicines when the person had capacity to direct staff. However there was a lack of individual guidance for staff on the circumstances in which these medicines were to be used safely, where (for topical medicines), and when they should seek professional advice on their continued use. For example, people were prescribed different creams/sprays, but there was not always guidance about where or when these should be used. This could result in people not receiving the medicine consistently or safely. A form to record this information clearly was developed during the inspection.

Medication Administration Record (MAR) charts were in place where staff were involved in the administration of medicines in all but one case. One relative told us staff applied a prescribed cream, but there was no MAR chart in place. Where staff were involved in the administering, medicines from a dossette box (monitored dosage system) there were no records of what medicines the dossette box contained, so we were unable to ascertain what actual medicines had been administered to people.

In some cases staff told us that a relative might have given the medicines, but there was no code in place for staff to use so that it was clear the medicine had been administered.

One person had medicines left in a pot for them to take later. However this was not recorded in the risk assessment, which the provider's policy stated it, should be. Staff were on most occasions signing the MAR chart, which should mean they have seen the person take the medicines, but they had not. In some cases

they also used the code 'U', which was the correct according to the provider's policy, but this code was not identified or explained on the MAR chart.

Risks associated with people's care and support had mostly been identified. For example, risks in relation to people's environment, falls and moving and handling people. People told us that they felt risks associated with their support were managed safely. Some people had risks associated with their care and support that had not been assessed, such as diabetes. Where people had catheters in place staff monitored the output of urine including the colour, but risk assessments did not detail this. Records showed staff were moving people up the bed using a slide sheet and one person used an electric bath chair, but again this was not included in the risk assessment. Records did not always show how or where staff should dispose of clinical waste, such as continence products.

The provider had failed to have proper and safe management of medicines. The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. 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 for events, such as power failure, fire or bad weather. These included measures, such as running the service from another of the provider's locations, access to 4x4 vehicles, staff working locally to where they lived, to ensure people would still be visited and kept safe.

People were protected by safe recruitment procedures. We looked at three recruitment files of staff that had been recruited this year. 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 staff felt there was sufficient staff to meet people's needs on the whole, but this could be stretched in times of sickness. The provider kept staffing numbers under review and told us that the service had an ongoing recruitment programme in place and turnover of staff was low. At the time of the inspection there were two staff undertaking their induction training before they would start work. Senior staff told us 100 per cent of people's visits were allocated permanently to staff schedules and these were only then changed when staff were on leave or sick. There was an on-call system covered by senior staff, which had the support of management.

People had very mixed opinions about whether staff arrived on time. Some people told us that staff "more or less" arrived when they were expected barring emergencies. Some people said, that weekends "do fall apart a bit". However 17 out of 51 people and relatives felt that staff were "often late". Some people told us they felt a lack of travel time on staff schedules was responsible for them being late. However records showed that travel time was incorporated into the schedules at certain points, but not between every visit if these were located close to one another due to the capacity of the computer system. Staff told us they generally worked in one geographical area. During the inspection discussions highlighted three people who were not happy with the time of their visit, which the provider was aware of and told us that as soon as more suitable time slot became available this would be changed. A high number of people contacted were not satisfied that staff arrived on time and this is an area we have identified that the provider could make improvements. Most people said staff "generally" stayed the full time or did all the tasks required. One person talked about staff that "will sometimes overstay to finish up".

People were protected from harm or abuse by staff. There was a clear 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. There had been safeguarding alerts in the last 12

months and the registered manager was familiar with the correct process to follow when any abuse was suspected; and knew the local Kent and Medway safeguarding protocols and how to contact the Kent County Council's safeguarding team. Where the safeguarding had related to poor practice by staff the provider had taken appropriate action to protect people, including monitoring staff closely and further training for staff.

Good

Is the service effective?

Our findings

People and relatives were satisfied with the care and support they received. Comments included, "The cares pretty good". "I'm happy with the service I am getting". "At first there was teething troubles, but now can't fault them". "I am very happy with Meritum". "They do a good job for us, couldn't be without them and wouldn't want any changes". "The care my (family member) received was excellent".

Care plans contained information about how a person communicated and what support was required to enable good communication, such as 'please stand on the left side so (person) can see you well".

Most people told us they usually received their care and support from a team of regular staff and were happy with the number of staff that visited them. One person told us they liked "to have a variety" of different staff, but most felt that the better the continuity the better their satisfaction. One person said, "I have the same person for five out of the seven days and she knows what I like". Records showed that people were visited by regular staff and some people received better continuity than others. Senior staff told us that following an initial phone call where they discussed people's needs they matched 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. Records and discussions with people showed that when people were not happy with a particular staff member there had been no problem with changing. When people did not want a particular care worker this was recorded on the computer system, which blocked them from being scheduled to undertake visits to that person. Most people said they usually knew who was coming because staff told them although this was not always the case for people at weekends. Senior staff told us people could receive a schedule of their visits in advance if they requested this.

People had signed their care plans and risk assessments as a sign of their consent. People said their consent was also achieved by staff discussing and asking about the tasks they were about to undertake. One person told us, "If I don't feel like a shower then they don't insist. I like I can make my own decisions".

Staff were trained in the Mental Capacity Act (MCA) 2005. The registered manager told us that no one was subject to an order of the Court of Protection although six people did have Lasting Powers of Attorney arrangements in place and one person had a Do Not Attempt Resuscitation (DNAR) order. Information about people's arrangements was recorded to ensure people's wishes would be followed and staff acted legally. 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 not been involved with any best interest decision making to date, but demonstrated they understood the process that would be followed.

Most people and relatives felt staff had the right skills and knowledge to provide care and support that met people's needs. One person commented, "Definitely". One relative said, "I think they (staff) are really well trained in the care they deliver".

Staff understood their roles and responsibilities. Staff had completed an induction programme, which included shadowing experienced staff, attending training courses and completing knowledge tests and staff also received a staff handbook. The induction was based on the Skills for Care Care Certificate. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. Thirty nine staff had transferred to this provider from their former provider in October 2015. The provider was in the process of checking all staff files to ensure what training each member of staff had undertaken and then providing further training so all staff would be trained to include the 15 standards.

Staff attended training courses relevant to their role, which were refreshed. This included food hygiene and nutrition, safeguarding vulnerable adults and the mental capacity act, fire safety, infection control, medicine administration, general care enablement and end of life, moving and handling and health and safety.

The provider had recently introduced an emergency first aid at work training course accredited to OFQUAL. OFQUAL is the office of Qualifications and Examinations Regulations, which regulates qualifications, examinations and assessment in England. Twenty four staff had so far obtained their certificate.

The service had 55 care staff and 25 had achieved a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above and another 17 were working towards the qualification. 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 felt well supported and received opportunities for support and supervision. Staff felt senior staff were always available and approachable. Staff told us they received spot checks on their practice. Spot checks were undertaken unannounced, by senior staff, whilst staff were undertaking visits to people. During these observations staff practice was checked against good practice, such as communication and offering choices, privacy and dignity and encouraging independence. Staff received an annual appraisal and they told us they had had opportunities to discuss their learning and development. Team meetings were held where staff were able to discuss any issues and policies and procedures were reiterated.

People's needs in relation to support with eating and drinking had been assessed and were recorded. Most people required minimal support with their meals and drinks if any. Staff told us where people were at risk of poor hydration measures were in place to reduce these risks, such as fluid charts to monitor their intake and leaving drinks within reach. Some people who were at risk of poor nutrition were prescribed meal supplements. One staff member talked about a person where they coincided their lunch visit with the person's lunch delivery and so could sit with them whilst they ate their lunch as this encouraged them to have a better appetite. Staff usually prepared a meal from what people had in their home. Special diets were supported including diabetes and fortified diets. One person used a special bowl, which enabled them to be more independently and another person an adapted cup. People said staff encouraged them to drink enough and would leave a drink or drinks for later.

People were supported to maintain good health. People told us staff were observant in spotting any concerns with their health and took any appropriate action when they were concerned. The provider had developed detailed factsheets relating to conditions staff were most likely to come across to help ensure people remain healthy, including dementia awareness, warfarin awareness, continence awareness, anaphylaxis, angina and heart attacks, diabetes and epilepsy and seizures. Staff talked about when they had come across situations when people had been unwell. One person had not really been themselves and their communication had deteriorated so staff called an ambulance and they were admitted to hospital. Another

staff member found a person unwell when they arrived and called an ambulance, it was found they had a bad water infection. Two relatives told us that staff had noticed changes in their family member's skin condition. One said, "Recently it was a carer who alerted me to my (family member) starting to develop a pressure sore. She told me to contact the doctor and now the district nurses are coming in". One person told us, "I need to do my exercises everyday using my frame and they (staff) support me with that to make sure I don't fall".

Good

Is the service caring?

Our findings

People told us staff were caring and listened to them and acted on what they said. People were relaxed in the company of staff and they and relatives were complimentary about the staff. Comments included, "The carers are excellent". "The carers are friendly and good". "The carers are good". "(Member of staff) is like a daughter to me, I feel so comfortable". "I have a natter to all of them". "(Member of staff) is excellent". "I'm glad I've got the carers I've got and glad (senior staff member) is here. You can go to (senior staff member) or the carers and they offer to help". "Jolly nice all round and very caring". "Some are better than others". "They are very very caring". "I can't fault the regular one (staff) who comes all week". "I'm very happy with the carers. I tell them what I need and they are really obliging". "They are all really nice".

One social care professional told us I have heard compliments in particular from several males who have been receiving support from male staff who have praised the fact that these staff go over and above their role to assist them.

People and relatives felt staff treated people with dignity and respect and that the staff were kind. People were asked during review visits if they were happy with standard of staff visiting them, if staff treated them with respect, if their privacy was respected and if they felt they had a right of choice and all those seen contained positive comments. Some people talked about staff that 'Went that extra mile'. One person told us, "(Member of staff) is very good at her job; she knows everything and gets things done". Another person said, "(Member of staff) has been here a long time. I've jelled with her, but they are all friendly and approachable". A relative talked about a member of staff who always "talks to her (family member) and really reassures her, gets down on her knees to do it". Another relative said, "(staff member) I couldn't ask for anyone better in everything she does, very caring, clean and honest".

During the inspection senior staff took the time to listen to feedback and answer people's questions. When people raised concerns or wanted to make changes to better suit them, senior staff listened, looked at the daily report book to check information and explained what options were available to improve things for them. We observed a member of staff arrive at a person's house; we saw there was a good rapport between the person, their relative and the staff member with good humour and jokes.

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 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.

Most people told us their independence was encouraged wherever possible. One person told us "They (staff) know that I am independent". People were also asked during visits from senior staff if they felt that they maintained their independence to their full capacity and those seen had replied "Yes". Staff talked about one person who had been supported and encouraged by staff so now feels able and more confident to "tackle things", like making a cup of tea. One social care professional told us generally staff are enabling

people to manage what they are able to do still, and only supporting them with tasks that are a struggle.

People told us they were involved in the initial assessments of their care and support needs and planning their care. Some people had also involved their relatives. Most people told us that senior staff visited periodically to talk about their care and support and discuss any changes required and reviewed their care plan. People felt care plans reflected how they wanted the care and support to be delivered.

Senior staff 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 did or chose to, they 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 had their privacy respected. 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. Information within the service user guide confirmed to people that information about them would be treated confidentially. The service user guide was a booklet that was given to each person at the start of using the service, so they knew what to expect.

The registered manager, a director and a senior member of 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. As a result dementia training for all staff had been delivered.

Requires Improvement

Is the service responsive?

Our findings

Most 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 been involved in these discussions. One person told us that "(Senior staff member) was very helpful". Another relative said, "They did an assessment of my (family member's) needs at the beginning and they wrote down what needed to be done". Assessments were undertaken by senior staff. In addition when contracting with the local authority the service had obtained some information from health and social care professionals involved in people's care and support, to make sure they had the most up to date information on the person. People had signed records showing their consent for care and support to be delivered in line with their assessments and care plan.

Assessments of people's needs included areas, such as physical well-being and medical history, personal care, nutrition, daily life and communication.

Care plans were developed from discussions with people, observations and the assessments. Care plans should have contained a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. They did vary in detail and some required further detail to ensure that people received care and support consistently, according to their wishes. For example, daily notes showed that staff did things, such as empty a catheter or tidy the shower and mop the floor, but this was not detailed in the care plan. In another care plan there was good detail about when staff emptied the catheter. Some people had MAR charts in place, which showed staff were applying creams, but there was not mention of this in the care plan. Some care plans asked staff to 'change pad (continence) if required'. However there was not always detail about what personal care would be required to support this to ensure the person's skin remained healthy.

In particular care plans required further information in order that staff would promote people's independence. Where there was a good detailed visit plan this showed what people could do for themselves and what actual support was required by staff in order that the person remained as independent as possible, but they were not all sufficiently detailed to enable this. One staff member talked about what one person could do for themselves, but told us they had to really encourage this otherwise the person would let the staff do it all and then lose this independence. However the care plan did not show what the person could do for themselves and if another staff member covered the visit there was a risk this independence might not be encouraged. A person told us what they could do for themselves when having their shower, but again this detail was not in the care plan. A relative talked about a special bowl that their family member used with high sides to enable their independence, but again this detail was not in the care plan.

Assessments showed what help people required with some personal care tasks, but not all. For example, 'wash hands and face' was included, but washing other parts of the top half of the body or lower half of the body were not included and therefore this information was not always recorded. The assessments then coded the tasks from four options, 'can complete without help or supervision', 'requires supervision', 'requires help' and 'cannot complete'. When 'requires supervision' or 'requires help' was identified we often had to ask staff what this meant and what the person could actually do for themselves and what support

staff would give as this information was not detailed in the care plan. For example, one care plan stated the person could wash their hands and face, but staff told us the person could do more than this for themselves.

Care plans were not always up to date. One care plan stated that the person had a catheter, but staff told us this had been removed in July 2016 and the care plan had not been updated. One person had increased their visits to include a tea call in July 2016, but the care plan had not been updated to show staff what they were required to do during this visit. Another person had reduced their visits and the duration of the visits, but again the care plan had not been updated. One person's had been diagnosed a diabetic in August 2016 and although senior staff had visited the person did not have their up to date care plan. Another person's care plan stated staff should apply cream to their head and apply eye drops, but a relative told us staff no longer did this. The person now had a bath two days a week, but the care plan stated once a week.

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 told us, "If it is the regular person everything runs well, but if it's somebody else then we have to explain everything they need to do. They never know".

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

People were not socially isolated. Some people said they looked forward to the staff visits each day and told us this in itself sometimes ensured they were not lonely. Some relatives were supported to have a break and go out. Other people had good family support or visitors or were able to get out and about in the community.

Most people told us they knew how to make a complaint and if they had complained previously most felt the service had responded well to concerns raised. The complaints procedure was contained within information in people's care folders, which were located within their home along with their care plan. Records showed there had been three formal complaints since the start of the year, which had been investigated and responded to. Complaints had been about staff conduct and the provider had taken action including further supervision and training to resolve these.

People had opportunities to provide feedback about the service provided. People were visited by senior staff as part of staff's observational supervision and had the opportunity to raise any concerns during this visit. In addition when people received a care plan review visit they were asked for their feedback about the service they received. The provider sent out questionnaires at the beginning of 2016 following the transfer of people's packages and staff from another provider, to gain their people's feedback about the service and an action plan was put in place to address any negative feedback and make improvements.

Requires Improvement

Is the service well-led?

Our findings

There was an established registered manager in post. They were registered for the Folkestone service, but also worked in other branches own by the same provider. They worked Monday to Friday each week and their time spent in the Folkestone office or at Summer Court was usually two days a week, but could be more depending on the needs of the service. The registered manager was supported in the Folkestone office by two full time coordinators and a full time senior carer, who undertook the initial assessments, care plan reviews, quality assurance visits, staff supervision and appraisals as well as coordinating visits to people. Two further senior carers were at the time of the inspection being recruited. The registered manager was supported at Summer Court by a field manager. People told us they did not really have any contact with the registered manager although they were familiar with the coordinators or senior carer that oversaw the service.

There were audits and systems in place to ensure the service ran smoothly. However they had not been totally effective in identifying all the shortfalls highlighted during the inspection. Effective quality monitoring is an area that we have identified as requiring improvement to ensure shortfalls are identified and action can be taken in a timely way to ensure compliance.

The past 12 months had been one of major change for the service with the transition of 72 people's packages and 39 staff from another provider as well as the support arrangements in Summer Court. The team had worked hard to try to ensure this transition went as smoothly as possible for people. The provider told us at the time of the transfer missed visits was "the norm". Records and discussions showed that this was no longer an area for concern, but feedback from people showed that the timing of visits continues to require improvement and this was part of the provider's action plan following the last quality assurance surveys, together with continuity of care. One person told us, "Yes it's better than it was, continuity is better".

The system to monitor that people received care plan reviews was effective in ensuring that peoples' care plans were reviewed at least annually. However when changes happened or people's needs changed there had been slippage. During the inspection the provider introduced a new visual system within the office to reduce the risk of this happening in future.

People had mixed opinions about the management of the service and felt that the organisation of their visits could be better. Most people felt that communication with the office team was polite and courteous, although a few said when there had been a promise to ring back this had not happened or they had not been advised when staff were running late. Two staff also told us they felt the service did not always advise people when they were running late. During the inspection there was an open and positive culture within the office, which focussed on people. The office team demonstrated a commitment to learning and making improvements to the service people received. It was evident during the inspection that the office staff worked hard as a team to help ensure the service ran smoothly.

A social care professional told us when they have telephoned the office staff have always seemed to have a

knowledge and understanding of that particular person's needs. They have always found the office staff helpful and try to do the best to support people particularly in a difficult situation.

Staff understood their role and responsibilities were happy in their role and felt they were supported. Two staff members who had transferred during the transition from another provider told us "Things are a lot better and a better atmosphere, they are more approachable, you can openly go to them and sort out problems" and "Working for Meritum is a breath of fresh air in the way they communicate, they are well-organised and inclusive". There was an effective system to monitor that staff received training, spot checks, supervision and appraisals. Most of the staff training was undertaken at another location owned by the provider. There were very few accidents and incidents, but these were monitored and analysed to see if any learning could be taken from these and used to reduce the risk of further occurrences. Other audits included people's care records held in the office, MAR charts and daily reports returned to the office.

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

The provider was a member of the United Kingdom of Home Care Association. The management team also net worked with other local service providers and attended forums and meetings with the local authority and the wider health and social care field. This all helped in order to share good practice and keep up to date with changes. The provider had also been involved in a piece of work by the King's Fund/Nuffield Trust looking at care research into the current and future of the social care market.

The provider's aim was set out in a mission statement 'to deliver a service of personal care and associated domestic services to meet the needs of dependant clients (service users) in their own (home) environment. This will be achieved by promoting a standard of excellence which embraces fundamental principles of Good Care Practice that is witnessed and evaluated through practice, conduct and control of quality care in the domestic environment'. Staff told us they felt the aim was to deliver good care meeting people's needs and promote people's independence.

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 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)

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