

# Care at Home Services (South East) Limited

## Beech Tree Total Care

### Ashford and SKC

#### Inspection report

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#### 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?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This inspection was completed on 30 and 31 October 2018 and was announced. The inspection was announced so that we could ensure people and records we would need to see were available.

Beech Tree Total Care Ashford and SKC is a domiciliary care agency. It provides personal care to people living in extra care housing units, in their own houses and flats in the community. It provides a service to a range of people including older adults. Not everyone using Beech Tree Total Care Ashford and SKC receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of our inspection there were 130 people using the service.

Beech Tree Total Care Ashford and SKC was last inspected on 27 and 28 June 2017. This was the first inspection of the service, under a new registration due to changes to the details of the providers registration on 19 June 2017, therefore the service could not be rated.

There was a registered manager in post at the time of our inspection. 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 did not consistently receive their medicines as prescribed, and documentation relating to prescribed creams was not routinely completed. Audits completed by senior staff and the registered manager had not been proactive in identifying the shortfalls we raised during inspection.

Staff understood how to recognise and report abuse. Any potential instances of abuse had been reported to the local authority safeguarding team. People were supported safely around risks. Staffing levels met people's assessed needs, and people told us they received the support they required.

Staff had been recruited following the providers robust recruitment processes. Staff received the training, support and supervision to allow them to complete their role effectively. Staff knew how to protect people from the risk of infection. Accidents and incidents had been reported, and action taken to reduce the likelihood of them reoccurring.

People's needs were assessed before they received a service. The assessment focused on supporting the person to remain as independent as possible. Staff had formed positive working relationships with external professionals to ensure people received ongoing healthcare support. Where required, people were supported to eat and drink sufficient to maintain a balanced diet.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff had an

understanding of people's equality and diversity needs and told us they would challenge discrimination in any form.

People were supported in a person centred way. People told us they were treated with kindness and compassion. Where possible people received support from a consistent staff team, that knew people well. People were supported to be involved in their care and treatment. People told us their privacy and dignity were respected. People told us they valued their staff. Staff encouraged people to remain as independent as possible.

People knew how to raise concerns and complaints. Complaints were used as a tool to drive improvements at the service. People were supported to have a dignified, pain free end of life.

There was a positive and inclusive culture at the service. People, their relatives and staff were engaged in the running of the service, and spoke highly of the service.

We found two breaches of 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.

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

We always ask the following five questions of services.

### Is the service safe?

The service was not consistently safe.

Medicines were not always administered or recorded as required.

Risks relating to people's care were assessed and minimised.

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

People were protected from the risk of infection.

Staff were aware of how to protect people from possible harm and abuse.

Accidents and incidents were documented and used to improve the service.

**Requires Improvement** ●

### Is the service effective?

The service was effective.

Assessments were completed to ensure effective support outcomes were achieved for people.

Staff received training and support to meet people's needs.

People were supported to eat and drink sufficient amounts.

Staff members worked well with other agencies to ensure a smooth transition when people moved to or from the service.

People were supported to remain as healthy as possible.

People supported to consent to their care and treatment.

**Good** ●

### Is the service caring?

The service was caring.

**Good** ●

People were supported by staff who were kind, caring and knew them well.

People were involved in the development of their care plans and had been supported to make decisions around their care.

Staff respected people's privacy and dignity.

### **Is the service responsive?**

**Good** ●

The service was responsive.

Staff provided people with person-centred care.

People's wishes regarding what they wanted to happen at the end of their lives were recorded and followed.

Complaints were recorded, responded to and used to improve the service.

### **Is the service well-led?**

**Requires Improvement** ●

The service was not consistently well-led.

Systems for assessing, monitoring and developing the quality of the service did not identify issues consistently.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

The views of people, their relatives and staff were actively sought and acted on.

The service continuously learned and improved and had audits of quality.

The service worked effectively in partnership with other agencies.

# Beech Tree Total Care Ashford and SKC

## **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 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 30 and 31 October 2018 and was announced. We gave the service notice of the inspection site visit because we needed to be sure that people who wanted to speak to us were available during the inspection. The inspection team consisted of two inspectors, a bank 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.

Inspection site visit activity started on 30 and ended on 31 October 2018. It included talking to and meeting people using the service and their carers, interviewing staff, pathway tracking and reviewing records. We visited the office location on 30 and 31 October to see the registered manager and office staff; and to review care records and policies and procedures.

Before the inspection, we gathered and reviewed information we held about the service. We looked at the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. 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. We used all this information to plan our inspection.

We spoke to 14 people that use the service, two relatives, eleven staff, the training manager, the office manager and the registered manager. We visited and spoke to five people receiving care from Beech Tree Total Care Ashford and SKC. We made observations of staff interactions with people during visits. We looked

at 14 care plans, three staff files, training records and quality assurance documentation.

# Is the service safe?

## Our findings

Although people told us they felt safe using the service, we found that people were not always supported safely with their medicines. Some people were supported with prescribed creams. We found that in three cases there was no guidance for staff regarding the level of support people required. Staff were also not consistently documenting the application of prescribed creams on body maps or medicines administration records (MAR). We found that staff were not consistently dating when prescribed creams were being opened, and therefore we could not be sure they were being used in line with the manufactures guidelines.

We reviewed MAR for one person, and found that staff had failed to document the administration of medicines, and in some cases, had not administered prescribed medicines. MAR records for October detailed they had been administered a daily prescribed medicine eight times in a 27-day period. We discussed this with a staff member who informed us they had noticed they were the only staff member administering the person that medicine, so they reported this to the office, and subsequently it was administered regularly.

Staff had received training in medicines administration, which included competency checks. However, we could not be assured of the effectiveness of the training, as we identified a number of areas where staff had failed to document, administer and report missed medicines in a timely manner.

There was a lack of proactive oversight regarding medicines management. The registered manager and office manager reviewed people's MAR, however the registered manager confirmed in some cases this could be a considerable time after the medicines had been administered, making it challenging to follow up on any missed medicines. The registered manager informed us moving forward they would insist people's MAR for the previous month are submitted within two weeks of the new MAR being introduced.

Medicine audits completed showed that where gaps in MAR had been identified, the registered manager had organised training, competency testing and discussions with staff.

Following the inspection, the registered manager completed a review of three people's medicines we had visited. An action plan was then completed and shared with us, detailing the action taken in response to our findings. This included completing competency checks on staff members, sending out communication to all staff regarding prescribed creams and organising training for staff administering medicines.

The provider and registered manager had failed to ensure that medicines were managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of abuse. Staff had a good understanding of different types of abuse and told us they felt confident to raise concerns, and that the registered manager would act on them. One staff member told us, "I would immediately report it, you get very protective of the people you support." Staff were aware of the provider's safeguarding and whistleblowing policies. The registered manager had made appropriate safeguarding referrals to the local safeguarding team when potential occurrences of

abuse had occurred.

Risks relating to people's care and support had been identified, assessed and minimised. Some people remained in bed, and were at risk of pressure sores developing. These people had detailed guidelines within their care files, on how staff should support them to minimise the risk of skin breakdown. This included action to take, and the relevant healthcare professional to contact should staff be concerned. Staff told us they were aware of who to report concerns to, including the district nurse or GP. Staff completed documentation on each call to detail if the person's skin was red or if there were areas they were monitoring. Other people were being supported with complex healthcare conditions including diabetes and epilepsy. There was clear guidance in place of what the person's seizure may look like, and when support should be sought, for example from paramedics. One person told us "I am much safer and happier in myself knowing that someone will be here with me even if it is only for half an hour at a time," whilst another said, "I am absolutely thrilled with my carers they help me feel safe, comfortable and happy in my own home what more can I ask for?"

Risks to staff when entering people's homes were assessed. For example, if it was poorly lit or there were trip hazards. Staff knew the risks well, and were able to inform us of which person's house was in an area with poor lighting, and where someone had a potential trip hazard.

People had their needs met by sufficient numbers of staff. The provider used an electronic call monitoring system to monitor and alert office staff to visits where staff were running late so action could be taken as quickly as possible. People told us, and records we reviewed confirmed there had been no missed calls and most people told us their calls were provided at the correct time. One person told us "I'm very happy indeed, they are normally on time and I know when they are going to be here so that makes me relax, safe in the knowledge that I won't be left alone all day." Another person told us "They have never missed a single call." The registered manager kept staffing numbers under constant review, with an ongoing recruitment programme in place.

The majority of people's visits were allocated permanently to staff schedules and these were only then changed when staff were on leave. Staff usually worked in a geographical area or an extra care housing unit.

Most people told us they received their care and support from a team of regular staff and were happy with the number of staff that visited them. The majority of people in the provider's most recent survey rated continuity of staff as acceptable to excellent. When people had not been happy with a particular staff member staff had been changed and blocked from being allocated on the scheduling system. People were asked if they wanted a visit schedule in advance so they knew who would be visiting, although this was subject to change if sickness occurred and some people had chosen to receive this weekly.

Senior told us that following an initial phone call and assessment where they discussed people's needs they began to match people with staff members. The matching process was based on staff working in the geographical area, gaps within staff schedules, people's preferences and staff skills and experience. People were asked about their gender preference for staff supporting them, and where people had preferences, these were documented.

People were protected by robust recruitment procedures. We looked at three recruitment files of staff that had been recently recruited. Recruitment records included required pre-employment checks to make sure staff were suitable and of good character. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff had received training in infection prevention and control and told us how they minimised the risk of the spread of infection when visiting people in their homes. Personal protective equipment such as disposable gloves and aprons were readily available, and people confirmed that staff used it when assisting them.

Accidents and incidents were managed in a way which protected people from the likelihood of the incident reoccurring. Staff understood their responsibilities to raise concerns and report incidents. Staff completed detailed incident reports and recorded any action taken. This helped to ensure the provider learned from incidents and put processes in place to reduce the risk of them happening again.

## Is the service effective?

### Our findings

People's needs were assessed before they received a service, and in line with current legislation and good practice. Senior staff were responsible for carrying out initial assessments, and care plan reviews following this. The initial assessment included meeting with the person, and their loved ones to discuss the person's needs, and what they were able to do for themselves. The assessment considered people's protected characteristics under the Equalities Act, such as their ethnicity, culture and faith. This helped ensure there was no discrimination when making decisions about people's care. This information was then used by staff to create a care plan, which was reviewed and amended as and when people's needs changed.

People were supported by a staff team that had received training and support to enable them to carry out their roles effectively. Staff had completed an induction programme, which reflected the Skills for Care Certificate induction. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. This included attending training courses, completing a workbook and shadowing experienced staff until they were signed off as competent to work alone. During our inspection, a number of staff were undergoing their induction. Support was available out of hours, with an on-call system covered by two staff with coordinators and the registered manager on a rota to offer support and guidance for staff.

Following their induction staff received regular refresher training including moving and handling, health and safety, equality and diversity and emergency first aid. Staff also received training in subjects specific to people's needs, such as pressure area care, catheter, stoma and convene care, diabetes and dementia care. In addition, staff had access a training portal on the provider's website at any time, for further guidance and information. The registered manager told us the Stoma Nurse had delivered an additional training workshop on stoma care, which 15 staff attended. The local authority safeguarding team had also delivered a workshop to staff about the safeguarding process and investigations. Staff felt the training they received was good and enabled them to meet people's needs. Three staff had been nominated for Kent Integrated Care Alliance (KiCA) awards during 2018 and one had been awarded runner up in the dementia friends category. One person told us, "They all seem to be most intelligent people I would say. I am most confident with their abilities."

Staff had opportunities to discuss their learning and development through team meetings, observational and one to one supervisions and an annual appraisal. Observational supervision was completed by the senior staff, during visits to people. During these observations staff practices were checked against good practice.

Since our last inspection, the service had introduced a checklist for people leaving the service. The document aimed to provide the best transition from one service to another for people. Prior to implementing of the document, the registered manager trialled it within another service to ensure it was fit for purpose and iron out any teething errors. Feedback had been requested from people regarding the effectiveness of the document. People had information they were able to take with them, should they be admitted into hospital. This included the medicines they were taking and a brief overview of the care they

received to promote continuity of care.

People who received support from the service with eating and drinking, were supported safely. People's care plans had prompts for staff to remind people to drink sufficient amounts, especially in the warm weather. Staff were aware of people's preferences around food and drink for example if someone preferred a hot or cold drink, or if they liked squash or water. One person told us "They do leave me a nice bit of lunch and will always help if I'm hungry or would like a nice cup of tea." We observed that when staff supported people with food and drink they did so appropriately, using the correct PPE, and allowing people the time to make a decision about what they would like. One person told us "They will always support me I feel. If I want a sandwich, they will make me one, if I want a newspaper, they will get me one and if I want a wash, they will give me one. I don't feel anything is too much trouble for them."

Staff worked closely with a range of healthcare professionals, including district nurses, to ensure that people's health needs were met. Staff organised for healthcare professionals to visit the extra care housing units, and invited all people using their service to give talks on different subjects to support people to live healthier lives. This included healthcare professionals such as nurses sharing information on living with diabetes and how to remain well in the winter. People were supported to maintain good health. Staff were observant in spotting any concerns with people's health. A relative had praised the staff when on a visit, they had realised how unwell their relative was and staff acted quickly to call the paramedics, which led to the person being admitted to hospital.

Staff were trained in Mental Capacity Act (MCA) 2005. The registered manager told us that no one was subject to an order of the Court of Protection at the time of the inspection although some people had Lasting Powers of Attorney arrangements in place and/or a Do Not Attempt Resuscitation (DNAR) in place.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision was made involving people who know the person well and other professionals, where relevant. Discussions and records identified that one person's medicines were locked away and this decision had been made in the person's best interest and with the involvement of their family. The registered manager told us they had recently been involved in a best interest meeting about the future arrangements of a person's care and support. The decision-making had involved the person, the community nurse and care manager. They demonstrated they understood the process to be followed.

## Is the service caring?

### Our findings

We observed people being treated with kindness, respect and compassion. "Staff are kind, they are caring, and they are incredibly patient with me." A relative told us, "They are little angels these girls, they are so kind and caring. They will always make absolutely sure my loved one is comfortable and tucked in. They give them a good meal and a wash."

People told us they received care from a regular staff team, which enabled them to form meaningful relationships. Staff told us they knew people well, and recognised subtle differences in them, for example if they were down or needed their spirits lifting. One relative told us "They always make my relative laugh, which I can tell you is quite something nowadays."

People were encouraged to be as independent as possible. People's care plans contained information regarding what people could do for themselves, such as washing their face and back, and how much support staff should offer. People told us staff supported them to be as independent as possible. One person told us they struggled to use their television. Staff tried to support the person to learn how to use the television but the person told us they kept forgetting. The person told us that staff then made a handbook for them to follow, in easy to follow steps so the person was able to use the television without assistance in between calls.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Some people's first language was not English. The registered manager was able to recruit staff members who were fluent in other languages, to support people to be actively involved in the decisions about their care.

People told us they were able to express their views. People were asked how they wanted their care to be delivered and this was regularly reviewed. One person told us, "The carers all listen to me and help me get the exact care that's right for me which the office has always been most helpful to do also." Another person told us, "They sit down for a chat and make sure I am heard. I really feel that they actually listen to me unlike some of the youngsters today."

The registered manager told us at the time of the inspection most people did not require support to help them with decisions about their care and support. People 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. More than half of staff were dementia friends. A dementia friend is a national government funded initiative to improve the general public's understanding of dementia.

People told us they were treated with dignity and respect. People told us, and we observed staff knocking on doors before entering, and following the instructions detailed in people's care plans, such as prompts for staff to remember to ask for consent prior to carrying out a task. Staff told us one person was unable to

answer the door, but ask staff to ring the bell, and wait for them to ask staff to enter. Another person told us that staff wore shoe covers when entering their house, at their request. Staff made referrals to the local authority, with people's agreement, for adaptations to their homes to make them more accessible. Staff told us this was important to people as it supported them to stay in their own home.

The service had received many compliments and thank you cards about the care and support provided. Comments received during October 2018 included 'keep up the good work, a lot of people look forward to your visit each day' and 'The carers I have had so far are terrific. I was unsure about asking for help, but now I am pleased I have'. Others detailed; 'I would like to say a very big thank you to you all for caring for my loved one in such a kind and friendly manner. You always treat her gently and with respect.'

## Is the service responsive?

### Our findings

People received an individualised service, specific to their needs. People and their relatives were involved in creating a care plan which was person centred and detailed what the person could do for themselves and the support the person needed from staff. Care plans detailed people's routines, such as how they like staff to enter their house, where staff will find them and how they like to be supported. Preferences such as if the person would want to self-direct the care they received on a daily basis or if they wanted staff to follow a routine were clearly detailed. Staff were aware of people's preferences around food and drink, for example the cups people liked to drink out of. We observed staff supporting one person with their evening meal. Staff asked the person what they wanted, and then cooked the meal to the individual preference of the person, including asking if they wanted the meal seasoned. The person was asked if they wanted any condiments, and staff made suggestions of what would go well with the meal. Staff checked that the person was satisfied with the meal, and the person told us that the staff that supported them were great cooks, and always cooked them good meals.

The registered manager was in the process of trialling and implementing a 'this is me' document. This contained person centred information about people, that staff could use as a brief guide on how to support someone. People's goals and personal outcomes were detailed in their files. These included details such as the person wanting to stay at home and be as independent as possible. One person's goals included for staff to support their family to enable them to stay at home as long as possible. People told us of the importance of them to stay in their homes, where they told us they felt safe and happy.

People told us, and records confirmed that staff visited people frequently to review the care they received. After the first call provided, staff called the person for feedback to ensure they were happy with the service. Following this, there was a four week telephone check, and six and nine monthly quality reviews which were completed both face to face and via telephone. During the reviews people were asked what they would like to change about the service and what could improve. One person told us "I wasn't happy when I was sent a male carer and I phoned straight away, it wasn't that he wasn't nice because he was, I just didn't feel comfortable and they never sent him again, so they must listen and respond I would say."

People were supported to maintain and follow their spiritual beliefs. One person had their calls scheduled around their prayer times, which was important to them. Other people were supported at specific times of the day, to ensure they could get to an activity or day centre. People told us staff had time to speak with them, and engage in meaningful conversations.

The provider had implemented an electronic call system. Each staff member had a smart phone, which held relevant information. The system informed staff of the calls they were scheduled, and which staff would be supporting, if the person required assistance from two staff members. People's care plans were available on the device to ensure that staff had as much information about the person they were supporting before visiting them, and to enable them to check any information on the go. Staff told us this was useful if they picked up additional calls, or to check if anything had changed since they last visited the person.

Complaints and concerns were documented and responded to effectively. The registered manager kept a log of all complaints received. People received a copy of the complaints procedure, which included timescale for responding, which included details of the local government ombudsman and the Care Quality Commission (CQC). The complaints folder showed that eight complaints had been received this year to date. Some were still showing as open with the investigations on going. Each complaint was recorded on an individual complaints form and there was a summary in the front of the folder. Complaints included staff running late and care practice issues. Complaints had been investigated and responded to within appropriate timescales. Where poor practices had been identified management had taken appropriate action, such as disciplinary action or booking further training. People and their relatives knew how to raise concerns. One person told us "I have never had the need to make a complaint nor can I envisage needing to do so, but I would not think twice about calling the office."

The registered manager kept a log of compliments the service received. These included feedback from other healthcare professionals relating to staff and stated they 'came across as very professional and knowledgeable regarding [supporting the person with transferring].' Compliments received from people using the service and relatives included; 'keep up the good work, a lot of people look forward to your visit each day' and 'I would like to say a very big thank you to you all for caring for my Mum in such a kind and friendly manner. You always treat her gently and with respect'

People at the end of their lives had been supported to have a comfortable, pain free death. People who were at the end of their lives had a comprehensive care plan in place which gave staff guidance on how best to support people. This gave staff detailed guidance on how best to support the person with food and fluid intake, and monitor the person's skin for any breakdown, as well as monitoring for signs of deterioration. Contact information was available for staff, for example if someone was involved with the palliative care team, or if someone needed support from the district nurse or GP. Staff discussed people's end of life wishes during the assessment process, and detailed that not everyone was willing to have discussions with them around this.

## Is the service well-led?

### Our findings

Although we found people were complimentary about the service, we found that the registered manager did not have sufficient oversight of the service. For example, the registered manager and senior staff checked paperwork completed by care staff including MAR. However, there was no deadline in place for these checks to be completed. Checks were often delayed and had not picked up the issues we identified at this inspection. As a result of the delay people were at risk of harm for extended periods of time.

On the day of our inspection, the registered manager took action regarding the poor medicines records. They reminded all staff that the administration of prescribed creams must be recorded on a MAR chart. An alert was put on the computer system to tighten the process for returning completed MAR charts and daily logbooks so more timely audits could take place.

The provider's systems had not been effective in monitoring and improving the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Audits and checks were undertaken in order to monitor the service. For example, late and missed visits, continuity and medicine management. Where issues had been identified, such as missed signatures on MAR, the registered manager had organised training and competency checks for the staff member. The registered manager attended the provider's regular manager and senior manager meetings where these results were monitored and discussed to enable any further learning.

The provider's website states their values were to work within a culture of continuous improvement. Their priority was always centred on the quality of the service they provide. This ethos was carried through the organisation from recruitment, training and monitoring of the staff teams, to delivery, review of service and evaluation of customer satisfaction. We found these values to be reflected during our inspection. We saw that the management team worked together with great passion and commitment and demonstrated the values of working for continuous improvement. Staff we spoke with shared the values of the service. Comments we received from people included "I believe the service must be well managed or we wouldn't get such a good set up would we," and "I have not had a problem for the 3 years I've been using the service and doubt I ever will, so they are obviously doing a grand job of managing things in the office."

The registered manager led this service and another owned by the same provider. They were supported by a branch manager, and a team of senior staff. In addition, there was a training manager who worked across the two locations managed by the registered manager. The coordinators/assessors, team leaders and care workers all worked in geographical areas or an individual extra care housing units to aid consistency and effective working.

The provider was a member of the Kent Integrated Care Alliance (KiCA) and the United Kingdom Home Care Association (UKHCA). The registered manager kept their own knowledge up to date by attending managers' meetings within the service and working in partnership with other stakeholders, such as social services, the

borough council and the housing associations. The Kent Integrated Care Alliance (KiCA) holds an awards competition each year and in 2017 the registered manager won the category of registered manager and the trainer manager came runner up in her category for exceptional leadership and training delivery. The training manager also won the Great British Care Awards regional trainer category.

Recently the service had participated in a national scheme and joined forces with healthcare professionals to raise awareness of a short-term complication of diabetes, hypoglycaemia, in a drive to improve staff knowledge and people's care. As part of this scheme training events were held, and leaflets and guidelines were used to raise awareness.

People and their relatives completed quality assurance surveys to give feedback about the services provided. Where people had made negative comments, if the survey had given their name, the registered manager had contacted the person to discuss the concerns and make improvements where possible. In addition, people had the opportunity to share their views on the service during quality assurance visits and telephone calls and care plan review meetings. In the provider's quality assurance from 2018, comments about the staff included, 'Have a good sense of humour from different carers. Makes you feel at ease if I was a bit upset of anything at the time' and 'The girls are very good, I couldn't wish for better.' Other comments included 'All the girls are friendly and nice and work very hard' and 'Extremely good at their jobs and very caring and helpful, they do not rush me.' The majority of people and their relatives rated staff timekeeping as acceptable to excellent.

Staff told us their feedback was sought. Team meetings for staff were held regularly. Staff were able to discuss any issues and policies and procedures were reiterated, such as infection control and the use of personal protective equipment. Staff told us they felt well supported in their roles.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This ensures that CQC can then check that appropriate action had been taken. The provider had notified the Care Quality Commission of important events as required. The registered manager was aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. Services are required to prominently display their CQC performance rating. The service had yet to be formally rated, but the registered manager had a good awareness of the need to display the rating in the office as well as on the providers website.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The provider and registered manager had failed to ensure that medicines were managed safely.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The provider's systems had not been effective in monitoring and improving the quality and safety of the service.