Care Quality Commission

Nightingale Homecare and Community Support Services Ltd

Nightingale Homecare and Community Support Services Ltd

Inspection report

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Ratings

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

Overall summary

The inspection visit took place at the agency's domiciliary care office on 4 February 2015. On the 5 February 2015 we visited people who used the agency in their own homes.

Nightingale Homecare and Community Support Services Ltd are registered to provide personal care to people, living in their own homes in the community. The support

Summary of findings

hours varied from one to four calls a day and start at 15 minute calls, with some people requiring two members of staff at each call. The agency office is based in a business park on the outskirts of Canterbury. The agency offer support and care to people in Canterbury, Whitstable, Herne Bay, Faversham and surrounding areas. They provide care and support to a wide range of people including, older people and people living with dementia and mental health needs.

Concerns had recently been identified by the Care Quality Commission (CQC) about the overall management of the agencies run by this provider. Since the last inspection of February 2014 the agency had expanded and now provided care and support to 130 people in the local area. The agency had not managed the rapid increase in the number of people and this had resulted in concerns being raised.

At the time of the inspection the agency had a registered manager in post. 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.

There were varied views from the people and staff about care planning, late and missed calls and communications between people, office staff and the management of the agency. Some people told us the agency involved them in assessing and planning their care. They said calls were usually on time and that the office staff communicated with them to let them know if there were any problems. Other people had a different experience and felt the agency could improve. People did tell us that when the staff arrived at their homes they received the care and support that they needed. Several people said that the staff who visited them 'go over and above what they needed to do'. Comments were, "goes out of her way", "excellent", "very happy" and "no complaints".

People told us they felt safe when staff were supporting them with their care. In some people's care plans there was information and guidance to inform staff how to care and support people in a way that kept them as safe as possible and kept any risks to a minimum. There was guidance for staff in some care plans about how to move people safely or how to provide people with the individual personalised care and support that they needed. In other people's care plans the amount of details was limited. There was little or no information about what care and support people needed to meet their needs and keep them safe.

People were not always involved in the assessment and the planning of their care. Some people told us they were not asked about the care and support that they needed. The amount of detail in some care plans was limited and the information recorded in the daily notes was not always reflected in the care plans. People were at risk of not receiving the care they needed because their needs had not been planned and reviewed. Senior staff from the agency had not visited people to make sure the care they were receiving was meeting their changing needs. Any relevant changes to their care were not recorded. People said staff were caring and treated them with dignity and respect and were kind and polite. They said that staff listened to them and gave them the care and support in the way they preferred.

People were not always responded to when they needed help and advice. There was an on-call system covered by senior staff in the office for people to use in an emergency or for staff to use for support. Staff said the communication between the staff who delivered the care and the office staff who organised the care was inconsistent and 'depended on who you talked to'. Staff told us that office staff did not always respond to them and any queries they raised were not sorted out. They said that they were not listened to. People said that when they called the office, especially at weekends, no-one answered the phone and if they left a message it was not responded to in a timely way. They said that often messages did not get passed on.

On occasions there were missed calls to people and staff were sometimes late to calls. Missed calls and late calls were logged and investigated to reduce the risk of reoccurrence. A new system for staff was being implemented to record their arrival and departure of the call. People told us that the staff did arrive close to the time they were supposed to. Sometimes they were a bit late but people said they did not mind. They said usually the agency office staff rang to let them know if the staff were going to be late. People did not receive the care and support that they needed because sometimes calls were missed. This was usually due to people being missed

Summary of findings

from the list staff had received from the office of the visits they were supposed to do. People said that staff stayed for the duration of their call and if necessary they stayed longer. On the whole they said that they received care from a consistent team of staff but sometimes new carers came who they had not been introduced too and they did not like this.

Staff had not received regular one to one meetings with a senior member of staff. They did not have the opportunity to privately discuss any issues or talk about their training and development needs. Staff competencies were not checked to make sure they were competent and safe when caring for people. A system of recruitment checks were in place to ensure that the staff employed to support people were fit to do so. Some of these checks had not been fully completed to make sure staff were suitable to work with people in their own homes.

There was enough staff employed to give people the care and support that they needed usually at the times they wanted and in a way that they preferred. 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. Staff had made appropriate referrals and worked with health care professionals, such as community nurses and doctors, to ensure that people received the treatment and support they needed.

New staff had induction training which included shadowing experienced staff, until they were competent to work on their own. Other staff who had worked at the service for over a year had received training to make sure they had the continued competencies, skills and knowledge to do their jobs effectively and safely. All the topics were covered in a one day refresher course. The agency had recognised that this was not enough time to cover the topics in the depth that staff needed. They were reviewing how they delivered the refresher training to make sure staff had more time and support to get up to date.

Staff did not have a full understanding of current guidance to support people to make decisions and consent to care and support. 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, at a certain time. Staff had some knowledge of the Mental Capacity Act but could not relate it to how they cared and supported people.

People's medicines were not always handled and managed as safely as they could be. There was no guidance for staff to tell them how to give people their medicines safely and in a way that they preferred and suited them best. Some medicine records were not clear and were not accurate. There was a lack of detailed guidance for medicine needed on a 'when needed' basis

The agency had a complaints procedure and people told us they did know how to complain. People and their relatives told us that they did complain when they had any concerns. They felt that they were listened to and the agency tried to resolve the issues. The registered manager told us that they did respond to complaints which were normally about late or missed calls. Complaints were recorded but there was no information about what action was taken and the outcome of the complaints.

The systems in place to monitor the safety and quality of the service were not effective and were not improving the service. When shortfalls and concerns had been highlighted no action had been taken to make improvements. Staff were unaware of the values and vision of the agency and were not involved in the development of the service.

People were supported with their nutritional needs. People told us that they chose what they wanted to eat. Staff prepared meals or supported people to cook.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?

Inadequate

The service was not safe.

People were not protected from avoidable harm. Not all risks to people were assessed and guidance was not available to make sure all staff knew what action to take to keep people as safe as possible.

The provider had not followed their recruitment policy. Some of the staff employed were not fully checked to make sure they were safe to work with people.

People's medicines were not always managed safely.

There were mixed views from people about the reliability of the service. Some people told us that sometimes calls were late and on occasions had been missed. Other people said the staff arrived more or less on time. Staff generally stayed the full duration of the call.

Staff knew how to protect and keep people safe. They could identify the signs of abuse and knew the correct procedures to follow if they thought someone was being abused.

There were sufficient numbers of staff available to make sure people got the care and support they needed when they needed it.

Is the service effective?

Inadequate

The service was not effective

Staff did not have regular one to one meetings with the manager or a senior member of staff to support them in their learning and development.

The staff did not understand their responsibilities under the Mental Capacity Act 2005. People's mental capacity to consent to care or treatment was not assessed and recorded.

A training programme had been developed and implemented for staff. The programme did not contain all the specialist topics needed to make sure people were receiving effective and safe care and support.

The communication with the office staff was not always effective to meet people's needs. The office staff did not always respond to telephone calls or ring people back promptly.

Staff responded to people's health care needs. People were supported to have suitable range of nutritious food and drink.

Is the service caring?

Requires improvement

The service was caring.

Summary of findings

Sometimes people received their care from staff they did not know and had not been introduced to.

People told us they were treated with kindness and staff respected their privacy and dignity.

People liked the staff and looked forward to them coming to support them. People told us the staff were 'great' and said staff treated them with kindness and compassion.

Care was personalised with people's choices and preferences and people were involved in making decisions about their care.

Is the service responsive?

Inadequate 

The service was not responsive.

People's care and support was not always assessed and planned. People did not have all the information needed in their care plan to give staff the guidance to give the care and support that people needed. Care plans had not been reviewed and updated.

The communication with the office staff was not always responsive to people's needs. The office staff did not respond to telephone calls or ring people back promptly. This also applied to the out of hour's service.

People and their relatives said they would be able to raise any concerns or complaints with the staff and manager, who would listen and take any action if required.

Is the service well-led?

Inadequate 

The service was not well-led.

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

People were at risk because systems for monitoring the quality of care provided were not effective. Records were not suitably detailed, or accurately maintained.

Roles and responsibilities within the agency were clear and the staff knew who they were accountable to and what they were accountable for.

Nightingale Homecare and Community Support Services Ltd

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 4 and 5 February 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. On the 4 February 2015 we went to the agency's office and looked at care plans, staff files, audits and other records. On the 5 February 2015 we visited and talked with people in their own homes.

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

We normally ask the provider to complete 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. On this occasion we did not ask the provider to do this as we were responding at short notice to information and concerns that had been raised at another location run by this provider. We wanted to check whether similar concerns were happening at Nightingale Homecare and Community Support Services Ltd Canterbury. We reviewed information we received since the last inspection, including notifications. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we visited and spoke with nine people in their own homes. We spoke with the registered manager, the branch manager, two co-ordinators who organises the work for the staff and three members of staff.

We reviewed people's records and a variety of documents. These included six people's care plans and risk assessments, four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys.

After the inspection the expert by experience contacted 19 people by telephone. We also contacted four members of staff by telephone to gain their views and feedback on the service.

We received feedback from two professionals who had recent contact with the service.

At the previous inspection on the 4 February 2014 there were no concerns.

Inadequate

Is the service safe?

Our findings

People said that they felt safe when staff were caring for and supporting them. There were systems in place to identify, assess and manage risks relating to the health, welfare and safety of people but these had not been consistently followed. Staff did not have the guidance and information they needed to make sure the person received the care and support that they needed in the way that was safest for them. There was a lack of risk assessments in care plans relating to moving and transferring people safely, administering their medicines and reducing the risks of pressure sores developing. When people had medical conditions like diabetes there was no information for staff to help them recognise the signs that might indicate their condition was becoming unstable and what action they had to take. There were no risk assessments carried out in relation to staff delivering the regulated activity of personal care in the community on their own.

People were at risk of receiving inappropriate or unsafe care as risks had not been identified, assessed and managed. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always recruited safely. The provider had policies and procedures when new staff were recruited but these were not always followed. All the relevant safety checks had not been completed before staff started work. Some application forms did not show a full employment history and one file did not contain sufficient information with regard to the person's conduct from their previous employment. Prospective employees did complete an application form, provided forms of identity and had a formal interview as part of their recruitment. Notes were made during interviews so there was a record of how staff responded to questions when they were being interviewed.

The provider did not make sure all staff were safe to work with people. This was a breach of Regulation 21of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive their medicines in a safe way. There were policies and procedure in place but they were not easily accessible to staff. It was not documented in any of the care plans what level and type of support people needed with their medicines. All of the care plans recorded that 'people needed prompting with their medication'. There was no other information in the care plans to detail what support was needed to meet specific and individual requirements relating to obtaining, administering, handling, recording and disposal of people's medicines. Staff told us that they administered and gave some people full support with their medicines. They said that there was no individual direction or guidance for staff on how to give people their medicines in a way that was safe and suited them best. Staff told us that they sometimes left medicines in pots for people to take at a later time. They said that they then signed the medicines record even though they had not witnessed the person taking the medicines. There was no risk assessment or guidance in place for staff to follow to make sure that this was appropriate or that people were taking their medicines safely. Some people needed medicines on a 'when required' basis, like medicines for pain. There was no guidance or direction for staff on when to give these medicines safely. Staff had received training in medicine administration and but their practice was not checked to make sure they were still competent and safe to give people their medicines.

Some people were prescribed creams. Staff told us that there was no recorded information about where and how people's creams should be applied. When staff applied creams this was not recorded in the medicine record sheets and there was no information to tell staff where the cream was to be applied. 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 and on time. This was a breach of Regulation 13 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were missed calls to people and staff were sometimes late to calls. This was usually due to the list of people staff had to visit not containing the correct information or staff misreading the list of people they had to visit. People said calls were occasionally late but that they did not mind as it was usually only by about ten

Is the service safe?

minutes. They said sometimes the office staff contacted them to let them know but sometimes they did not. The registered manager was dealing with each of the missed or late calls and was taking action to improve rotas and the communication between people and the office staff. Missed calls were logged and investigated to reduce the risk of reoccurrence and a new system for staff was being implemented to record when staff arrived and left the call. There was an on-call system covered by senior staff for people to use in an emergency or staff to use for support. There were plans in place in case of emergencies such as bad weather when staff may not get to calls.

People and their relatives told us there were enough staff. They said staff took their time and gave all the care and support that was needed. People told us that the staff were flexible and if they needed to stay longer on a call then they did. One relative told us, "The staff are great. Nothing is too much trouble. They always make sure my relative gets everything they need. They never leave until everything is sorted out".

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of care hours people needed to fully meet their needs The service had an on-going recruitment process, so that they would be able to cover the service in times of sickness or annual leave. Staff told us that they did not get paid for travel time unless they travelled outside of their usual patch. The registered manager told us that travel time was taken into account and rotas were worked out geographically to reduce travel time between calls. People's calls were covered as close as possible to their agreed times. Staff told us that they had permanent people to visit each day including weekends, and that if possible they took on additional calls to cover in times of sickness and annual leave.

Staff who had worked for the agency for a period of time had received up to date training in protecting people from abuse. Staff recently employed by the agency had completed induction training to support people safely, recognise and report abuse, and knew the actions to take, such as reporting issues to their manager and other agencies like the local authority safeguarding team.

Staff knew how to report accidents or incidents that occurred. The manager investigated and carried out any required actions to help ensure people remained safe and to reduce the risk of further occurrences. Forms were used to record when accidents or incidents occurred. The registered manager analysed incidents and accidents to look for any trends or patterns. This helped reduce the risk of them happening again.

Inadequate

Is the service effective?

Our findings

People were satisfied with the care and support they received. People said, "They all (staff) seem qualified and know what I want; they just get on with it." I am very happy with the staff. I treat them like one of the family". "They all know how to move me safely: even the new ones. They are all so helpful".

Staff told us that sometimes there were training opportunities and they received a yearly update on all the main areas like moving and handling, infection control, medicines and protecting people from abuse. Staff training was recorded on a computer system which alerted the agency trainer when their training needed to be refreshed. Refresher training was provided by a one day face to face training session with the agency trainer. All necessary training topics were covered in the one day. Staff said there was not enough time to cover the topics like fire training, infection control, health and safety and the Mental Capacity Act in any depth. The agency trainer was in the process of reviewing this to make sure it was over a longer period of time and more in depth. They were also developing a training record so that an additional check could be made to ensure that staff remained up with all the training that they required.

There was a lack of specialist training to meet people's individual needs. The agency trainer was aware that staff had not undertaken specialist training. The agency provided care and support to people with a learning disability, but the training department told us they had not provided training for staff in how to support people to be independent who had a learning disability. They said that specialist training was being developed in supporting people with a learning disability, challenging behaviour, diabetes and epilepsy, but this training was not currently being provided.

Some staff received regular one to one meetings from a senior member of staff or the manager. These processes gave staff an opportunity to discuss their performance and identify any further training or development they required. However, other staff told us that they had had not received supervision from senior staff or the manager. All staff had not received an appraisal to discuss their development and individual training needs. The registered manager told us that appraisals were being planned for April 2015. Staff told us when they had requested further training to develop their skills and knowledge they were told that they would receive this training but this had not happened.

There were mixed views from the staff about the support they received from the office staff. They said it 'depends on who picks up the phone'. Staff said that some office staff were very supportive and made sure that any problems or issues, like people needing more medicines or if they were going to be late for a call, were responded to quickly and effectively. At other times they said when they needed support and help they were not listened to and their requests were not acted on.

The provider did not ensure that staff were properly supported, trained and supervised to meet all people's individual needs. This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The key requirements of the Mental Capacity Act 2005 were not fully understood despite staff attending training. People and their relatives said they were always asked by staff if it was alright to give care and support. Staff did have an understanding that people had the right to make their own decisions but were not able to explain how they would put this into practice on a daily basis. Care plans did not contain information to explain to staff how to best facilitate people's decision making, such as explaining choices. Senior staff had not completed mental capacity assessments to find out if people had capacity to consent to the care and support staff were going to give.

The provider did not have a system to assess people's capacity to make specific decisions and act, with others, in people's best interests. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When staff started to work for the agency they received a formal induction which consisted of a four day programme delivered by one of the agency's trainers. This included staff's duties and responsibilities, practical sessions on how to support people with their personal care and what to do if people refused care. There were sessions on skin care,

Inadequate

Is the service effective?

catheter care, communication, emergency procedures, safeguarding, whistle blowing and complaints, food hygiene, infection control, fire safety, first aid, medication, the Mental Capacity Act 2005, and dementia awareness. There was a whole day practical session on moving and handling people safely. Staff were given a staff handbook and information leaflets on topics covered during the training. Staff told us that they thought the induction training was good but was too much to take in, in four days. Following the induction programme new staff shadowed senior staff, and completed a probationary period before becoming permanent staff.

People and their relatives thought that the staff had the right skills and knowledge to give them the care and support that they needed. They said the staff were very good, kind and considerate. People told us they had regular staff for most of their visits and the staff knew how to meet their individual care needs. They said they trusted the staff and knew they would do anything that they asked. They said staff listened to what they said and supported them in the way they wanted. The staff knew how people wanted to be cared for and supported. People told us that sometimes staff arrived that they did not know but they knew what to do.

People told us that the staff supported them with their health care needs. They told us that staff were attentive and knew when they were unwell or may need a doctor's appointment. People said: "The staff always act quickly". "I was very unwell recently and my carer called the doctor. She stayed with me until someone arrived. A relative said, "The staff always seem to know what to do". The staff did monitor people's health and care needs. Staff found out about people's health and monitored them to make sure they stayed as well as possible. When people needed a doctor or a district nurse the staff contacted the office staff and this was arranged.

People's needs in relation to support with eating and drinking had been identified when they first started receiving care from the agency. Most people required minimal support with their meals and drinks. People told us that the staff supported them to prepare food and drinks and made sure that they had what they wanted. People told us that the staff always left drinks out for them before they completed their calls. They said that the staff made them sandwiches of their choice and others said they had a hot meal of their choice at lunch time.

Requires improvement

Is the service caring?

Our findings

People told us when they first started using the agency they were not initially introduced to the staff who would be visiting them. Staff were not given the time they needed to get to know people who were new to the agency. Staff said sometimes there were no adequate care plans or risk assessments in place to give them the information they needed to give the care and support to people in a way that was safe and suited the person. Staff said, 'we are just expected to get on with it'.

People said that on the whole they had the same team of staff. Sometimes different staff came who they did not know. Some people told us they were contacted by the office staff to let them know this was going to happen, others said that they were not informed that a different staff would be coming. One person said, "Sometimes very young girls come who have not been introduced and have not been here before. I am not very happy about this".

There was some information available to let staff know about people's history, likes preferences and needs. On the whole people said they received consistent, individual care and support because the staff knew them well. They were involved in identifying their needs, choices and preferences and how these were met. They said that staff explained things to them and waited for them to respond.

People told us that they were always given choices and told us that the staff responded to their wishes. They said: "Staff do whatever I ask; they listen to what I say". A relative said: "The staff often stay longer than they are supposed to. "They go out of their way to help". "They always ask what else they can do for us before they go".

A person told us about a staff member who had called to check that a new heater was working in their own time, as they were worried about it. People told us about staff 'going out of their way' to buy them things that needed. Another person said "They are so lovely".

People told us the staff who visited them were kind, caring and respectful. They said that they received the care and support they needed and in the way they preferred. People said some staff knew them and their routines well. People had been asked if they preferred a male or female member of staff to support them with their personal care and this was respected. They said they were called by their preferred names. People told us that they were given choices and told us that the staff responded to their wishes.

People told us they were involved and were always asked about the care and support they wanted to receive. People talked about their care with the staff. Staff said they worked together to make sure people got everything they needed. Relatives told us they were involved in the care for their family member.

Staff members talked with feeling about people, it was evident that they cared for the people they supported. One member of staff spoke in detail about a person they visited. They told us that they had contacted the person's family to help them get to know the person better. They had a good knowledge about the person's background, current needs, what they could do for themselves, how they communicated and when they needed help and encouragement. Staff members valued the people they supported.

Staff explained how they made sure people received help with their personal care in a way which promoted their dignity and privacy. They told us about covering people with a towel or a sheet when they were receiving personal care. People said the staff always knocked on the door and waited to be invited in. They said staff encouraged them to do things for themselves so that their independence was maintained as much as it could be.

Inadequate

Is the service responsive?

Our findings

There were mixed views from people about how their care was assessed and planned. When people first started receiving care from the agency they were supposed to have an assessment to identify what care and support they needed. Some people told us that they had been visited by a staff member before their care with the agency started; others told us they had not. Some people told us that they had been involved in planning their care and others said they had not. How people's care was assessed and planned was inconsistent and people were at risk of not receiving the care and support that they needed.

Some people told us about their care plans and how they had been involved with decisions about their care. One person felt the format of their care plan was poor. It lacked detailed information and they felt the documentation was 'totally inadequate'. Another person said: "I know everything in my care plan" and have regular reviews to discuss if anything has changed.

Some people said that they were unsure what a care plan was but that the staff did look in a book and they had to sign in a book. They had no recollection of it being reviewed by senior staff. People said senior staff from the office visited when they first joined the agency but not since. Other people said that no one from the agency office had called on them to review their care. One person said, "In eight months of care I have had no care plan and no visit from senior staff. Luckily I can tell the girls what to do when they arrive". People's care and support was not fully documented in their care plan to make sure staff knew how to deliver individual care in a way that best suited the person. Staff told us that some care plans did not contain the information they needed to give people the care and support that they needed. They said that some care plans 'were better than others'. One staff member said "I have been visiting a client for eight months and they still do not have a care plan. I have contacted the staff at the office a few times but there is still no care plan".

People had not been involved in the development and review of their care plans in a meaningful way. People were not all receiving the care and support that they needed. People's care needs were not reassessed regularly and this resulted in their care plan being out of date and not reflecting their current needs.

Some people needed a lot of support and equipment to move and transfer around their homes. In some of the care plans there was detailed direction on how to safely move and handle people explaining what equipment to use and how to use it. In other plans there was no information. One plan stated, 'Hoist to bathroom. Hoist to bed, Hoist to chair'. This did not give staff the specific individual guidance and direction they needed. People were at risk of not being moved safely and comfortably.

Care plans did not identify that some people needed care and support to keep their skin healthy and intact. There was no information in any of the care plans to inform staff on how to deliver care to people whose skin may be at risk of breaking down. There was no information about what signs to look for if sores were developing and what action staff should take, like contacting the doctor or district nurse. There was information in the daily records to indicate that staff were applying creams to people's skin but there was no direction where it should be applied and what cream should be used. When people did have pressure sores the local district nurses were visiting to support them.

The care plans did not contain the information needed to make sure people received care and support that was specific to their individual needs. One care plan stated, 'Apply pressure area creams', 'Has a catheter follow procedure', 'Diabetic'. There was no further information on what staff had to do to help support the person with these care needs and there was no procedure available. There was no information about what level of personal care they needed. There was no direction on how people needed or preferred to have their personal care delivered. Staff told us they had got to know the people they visited and how they preferred to be cared for.

Some people had weaknesses on one side of their body because they had suffered from a 'stroke'; because of this they needed specific support with personal care. There was nothing recorded in the care plans about how to give the right support. The care plans had a general comment 'assist with personal care'. Staff had no guidelines to follow about how to give the support that the condition required. People were at risk of receiving inappropriate unsafe care.

Some people had dementia and were confused and disorientated. There was no information or guidance in their care plans about the individual care and support to make sure staff knew how to keep them as safe as possible.

Inadequate

Is the service responsive?

The provider had failed to plan people's care to protect them from the risks of receiving care which was inappropriate or unsafe. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

People told us that they would and had complained to the agency. They said their complaints were taken seriously and acted on. One relative said they had complained about a member of staff who had not acted professionally. The agency took action. They responded to the complaint and the member of staff did not return. The agency had policies and procedures in place to explain how they would respond and act on any complaints that they received. When people started to use the agency they were given a copy of the complaints procedure that explained to them what they had to do. This was not written in a format that everyone who used the agency would be able to read or understand. Information and records about complaints and compliments were kept by the agency. Records showed that the detail of any complaint was recorded together with the action taken to resolve it to the satisfaction of the complainant. There were complaints about missed and late calls and the agency had responded to these in writing and had told people how they were going to address them.

Inadequate

Is the service well-led?

Our findings

There were mixed views about whether or not the agency was well led. People said that recently there had been a high turnover of staff in the office and they were not sure who was in charge now and there was only one person they knew who was still there. They did add that it was not a problem as they were all nice and had dealt with it well. One person said, "They can be a bit random in who you speak to in the office there has been a big turnover but it's been better lately"

People were very positive and complimentary about the staff who visited them in their homes but felt the organisation lacked clear leadership. They said that there was a lack of communication and action taken at management level to improve the service. One person said, "I receive fantastic care from the staff despite the poor management of the organisation". Staff told us that the management did not always respond when they needed support.

The registered manager of the service had recently taken on extra responsibilities within the organisation and did not spend much time in the Canterbury office. A branch manager had been appointed and they were starting to make changes at the agency with the support of the registered manager and the provider.

There was a culture of mistrust and lack of openness amongst the staff, which meant some staff had left the agency and others were unhappy. Staff working with people felt it was 'hit and miss' whether they trusted the office staff. They said, 'it depends on who answers the phone'. They said that if the registered manager was around they took action but the registered manager was not at the office on a regular basis. Staff sometimes felt they were not listened to and did not get the support that they needed. They said they did not have any confidence that some of the office staff would take the appropriate action when they needed support and help. Staff felt their views were not sought and valued. They said that the organisation did not invest in the staff. The manager had started meetings to improve the communication and relationships between staff. The agency was also making links with other domiciliary care organisations to seek advice and discuss the challenges providing of domiciliary care.

The management structure of the organisation had been reviewed and additional staff experienced in providing domiciliary care had been appointed. In addition the office staff had been re-organised to clearly define roles and responsibilities so staff knew who they were accountable to and what they were accountable for. When calls were late or missed the management took action to address the issues with the individual staff members.

People were not protected against the risks of inappropriate or unsafe care as there are no established effective systems in place to monitor the quality of the services provided or to identify, assess and manage risks to the health, safety and welfare of people. The agency had recently employed a quality assurance manager who was in the process of developing systems to check the quality of the service the agency provided. At the time of the inspection these systems had not been in place long enough to have had a positive impact and improve the service provided.

There were systems in place to make sure that investigations were carried out to improve staff practice, however in one case the outcome had not been followed up. Records showed that a member of staff was to receive 'spot checks' weekly, as calls had been missed. There was no evidence to confirm that this had taken place to reduce the risk of it happening again. There was no record of any spot checks being carried out to check on staff's performance or to check the service was appropriate and safe. Staff confirmed that they had not been observed in practice or been the subject of any spot check.

People were at risk of receiving inappropriate or unsafe care because the provider did not regularly assess and monitor the quality of the service. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a system in place to ask people for their views. Some people had received phone calls from the quality assurance manager asking for their opinion about the service they received. Surveys had been sent to people in December 2014. Relatives, staff and health professionals were not included in the quality monitoring of the agency. Returned surveys showed that most people were satisfied

Inadequate

Is the service well-led?

with the service but felt the organisation could improve communication. One person had commented on their form, "I could not wish for better care with lovely carers, I am very happy".

Staff meetings had been held so that staff could discuss any issues or concerns. They also discussed ways that the agency could improve. Minutes of the meetings were available for staff if they were unable to attend.

The agency had started audits of records including care plans and medicine records to ensure records were accurate, up to date and reflected people's needs. The agency had recognised that care plans and risk assessments were not accurate and were not fit for purpose. They did not contain the information to make sure people received the care and support that they needed to keep them as safe as possible. The management were in the process of introducing new documentation to make sure people received consistent and safe care and support.

The provider did not keep accurate records in respect of people using the service. This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The registered person had not taken proper steps to ensure that each service user's care and treatment was provided in a safe way and risks were kept to a minimum. The registered person had not protected service users against the risks associated with unsafe use and management of medicines. Regulation 12(2)(a)(b)(f)(g)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person had failed carry all the necessary safety checks to make sure all the staff were of good character and were safe to work with service users. Regulation 19(1)(a)(b)(c)(3)(a).

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 11(1)(3)(4)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have suitable arrangements in place to ensure that the persons employed were appropriately trained, supervised and appraised. Regulation 18 (1)(2)(a)
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person was not protecting service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of health and safety and quality monitoring systems. The registered person did not ensure that records were accurate, or available, They were not up to date or in good order. Regulation 17(2)(a)(b)(c)
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had failed to plan people's care to protect them from the risks of receiving care which was inappropriate or unsafe. Regulation 9(1)(a)(b)(c) (3)(a)(d)