Care Quality Commission

Superior Care Limited

Superior Care Folkestone

Inspection report

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Date of inspection visit: 21 & 22 May 2015
Date of publication: 03/09/2015

Ratings

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

Overall summary

This inspection took place on 21 and 22 May 2015 and was announced. The provider was given 48 hours' notice of the inspection, as this is our methodology for inspecting domiciliary care agencies, so that we can ensure someone will be available in the office to talk with us and enable us to access records.

Although this is an established service, this was their first inspection since the agency moved to its current location and registered the new location with us on 3 September 2014.

Superior Care Folkestone provides agency staff to other nursing or residential care services; in addition it operates a domiciliary care service providing personal care and support to adults and children in their own homes. The provider operates its services across three locations in Kent and provides personal care to people in Whitstable and surrounding areas, Maidstone and surrounding areas and Folkestone and surrounding areas. The service provides for older people, people with continuing care needs who have complex physical support needs, people with visual impairments, and people with acquired brain injury, and autism.

At the time of inspection the service was providing a personal care service to 19 people.

Summary of findings

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of inspection the registered manager was unavailable. The managing director of the company was present and was able to respond to operational questions and also to queries we had in relation to individual packages of support.

The registered manager was not a visible presence at the office and spent most of their time based at another office some distance away. Some staff were unaware who the registered manager was and commented that it was difficult to keep up with so many changes to staff in the office. The registered provider visited the office often but there was a lack of management oversight. This showed in a number of areas for example, the absence of organised and recorded staff supervisions and competency checks, and the lack of a system for routine site visits to people's homes to seek feedback from them about service quality. Care staff were able to visit the office to raise issues with office staff, but other staff avoided this and said they did not feel listened to, and felt there was a lack of formal opportunities for them to speak together with a manager or on an individual basis.

A number of staff provided support on a regular basis to people with complex needs and they knew the people they supported well. People's levels of satisfaction around the service were highest when speaking about their regular care staff, for whom they had nothing but praise. However there were recurring communication issues between office staff and with people using the service. People and care staff told us that communication needed improvement. Some staff told us that they did not get their rotas until halfway through the week; some people did not receive a rota on a regular basis and had to ring the office to find out who was coming to support them.

Only eight staff had received specific Mental Capacity Act 2005 training, but all staff were given a basic understanding of the principles of the Mental Capacity Act 2005 at induction. Staff demonstrated an understanding of mental capacity issues and where people lacked capacity the service was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interest.

People who required weekend support told us that these were particularly difficult for them because of problems of staff cover. The commented on the difficulty of getting hold of people covering the out of hour's emergency number for the agency. They said that sometimes they could not get through at all or if they left a message, someone responded some hours later and sometimes not at all. There were not many missed calls but due to the complex needs of some people when they did occur they compromised the person and their family's plans for the rest of the day.

The agency had enough staff available to cover leave and sickness, but care staff with the right skills and knowledge to provide dedicated support were not always available. Staff undertaking some of the complex support packages were without back up from other dedicated care staff and so felt unable to take leave or sickness because they knew how much their support meant to people. A staff member said they had been unable to take planned leave for nearly seven months.

All the people we spoke with commented positively about their regular care staff who they described as "fantastic". They felt they ensured their privacy and dignity was respected in the way they delivered support, and people had confidence in their knowledge and skills and trust in them. Some people told us that they did not always feel they could rely on the service. They told us that they were not always kept informed of new care staff that might visit them and had not been introduced to them previously; and often the new care staff had not shadowed the person's usual allocated care staff to learn about how the person's support was delivered. People said they were not always confident about the attitude and skills of some staff sent along by the agency, who had failed to build a rapport with them, which helped if they were undertaking personal care. Two people said they did not always feel comfortable or safe with care staff who were sent and who they had not met previously. One person said they sometimes felt intimidated and made to feel uncomfortable in their own home.

Spot checks of care staff, and visits to people's homes to assess their satisfaction with the service were happening

Summary of findings

infrequently; only some of these visits were recorded. An overall system of assessment and monitoring of service quality was not in use. The provider could not assure themselves that all areas of the service were operating to a good standard, or was sufficiently effective to highlight the shortfalls found by this inspection; some of which have been recurrent.

Staff were provided with a classroom based interactive training programme to ensure they had all the essential skills they needed to support people's everyday basic needs. Some staff had received additional training in respect of specialist support, for example tracheostomy care. This was either provided by a lead nurse employed by the agency or by other professionals in the community.

Staff had received safeguarding training in respect of adults and children and understood their responsibility to raise concerns if they found them. They were aware of being able to raise alerts with other organisations, for example Social Services if they felt action was not being taken by the agency.

Environmental risk assessments and some individual risk information in regards to moving and handling and medicines were completed but these were not always dated. Individual risk assessments in respect of the specialist needs some people had for example, pressure ulcers, were not in place to show how risks were reduced.

People's needs were assessed prior to a service beginning. Everyone had a care plan and these were developed from this assessment and were individualised. Some people described how well their regular care staff understood the important details of their care whether small or big that added to their feeling of comfort and reassurance when staff left them, for example putting a lamp on, drawing the curtains, making sure things were within easy reach for them when there was no one else around. The importance of these small details cannot be over stressed in ensuring that people have a good experience of care, However, this was not reflected within the support plans that informed staff about what they needed to do; new staff would not have this knowledge to hand and this would impact on how people felt about the care they received.

People were informed about their right to make a complaint and those spoken with said they would feel confident about raising issues with staff at the office if needed. Most said they had not felt the need to formally complain but others who described numerous occasions when they had not been satisfied with the service, said they had discussed this with the office but it was unclear from records viewed whether staff recorded these issues as complaints.

There was a recruitment process that ensured that staff were interviewed and appropriate checks of their suitability to undertake their role were carried out, including criminal record and conduct in employment checks. Minor improvement was needed to ensure that full employment histories were recorded and gaps explored with applicants.

People told us they received their medicines as prescribed. Staff had received the necessary training to administer medicines and there was a clear medicine policy that detailed staff roles and responsibilities.

Staff showed an awareness of people's health needs and whilst not responsible for this aspect of people's wellbeing liaised appropriately with health professionals and relatives when appropriate to ensure interventions were arranged if people were seen to be unwell.

We found a number of 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 the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People felt safe with known care staff but expressed concern at the awareness and understanding of some staff who did not know them well. Poor communication sometimes led to calls not being covered.

Risks that people may be subject to were not made clear to staff or the measures in place to reduce harm occurring. There were enough staff hours but the deployment of the right staff with the right skills to support some packages was an ongoing issue.

Medicines were managed well. Appropriate recruitment checks were made of new staff.

Is the service effective?

Requires improvement

The service was not always effective

The support structures for staff such as staff meetings, supervisions and appraisals were provided inconsistently.

Staff received a good induction that provided them with the basic skills to undertake their role, but there was lack of evidence to record how competency was assessed. Refresher training was provided each year. Access to specialist training to support the needs of some people was encouraged but its delivery was inconsistent.

Staff were given a basic understanding of the principles of the Mental Capacity Act 2005 and were aware of actions to take if people's capacity changed. Staff monitored people's healthcare and alerted and involved others appropriately to ensure any health concerns were addressed.

Is the service caring?

Requires improvement

The service was not always caring.

People did not always have confidence in the skills and understanding of new care staff and some people felt uncomfortable in their homes with the attitudes of some staff. People said they did not always feel listened to when they rang the office and did not always get feedback.

People said the out of hour's service was not always effective and they sometimes could not get through or did not receive call backs. There was no travel time for some half hour calls and this meant staff were usually late.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

People had care plans but these were not always kept updated to provide an accurate picture of the person's current needs. Care plans did not always contain the level of detail that reflected the small things that usual staff did to make people's lives easier and comfortable.

People knew how to make complaints and felt confident of raising concerns if they needed to. Records showed that the service took action in response to people's concerns, but was not always good at feeding this back to people.

Is the service well-led?

Requires improvement 

The service was not consistently well led

The quality assurance system was ineffective and did not provide assurance that all aspects of the service were delivered to a good standard. There were recurring issues with communication between staff and between staff and people using the service.

There was a lack of consistent management oversight and some staff were unable to tell us who the manager was. She did not have a visible presence in the office or with staff. The provider had failed to return a Provider Information Return that we had requested prior to inspection.

Superior Care 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 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 21 & 22 May 2015, and was announced. We gave the provider 48 hours' notice of our inspection. The inspection was carried out by one inspector.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This form asks the provider to give key information about their service to tell us what the service does well and improvements they plan to make. The provider did not return the PIR when requested to.

Prior to the inspection, we looked at information about the registration of the service and notifications we had received about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law. We contacted ten people that received a service and were able to speak with six directly and with the relatives of three others. Two of the people we spoke with we visited in their homes.

We spoke with two staff at inspection and contacted a further eight of whom we were able to speak with four. We briefly observed a staff training course, and spoke with two office staff and the provider and another director of the company. There was a registered manager in post for this service but they were not available at inspection.

During the inspection we viewed a number of records including three care plans and daily notes, three staff recruitment records, staff training and induction information. We looked at arrangements for staff support, and policy and procedure information including the staff handbook available to staff. We looked at incident and accident information and complaints and compliments. We also looked at arrangements for spot checks of service quality and audits undertaken by senior managers.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us that they had confidence in their regular staff who delivered their care.

People and staff told us that before a service was offered an initial assessment of a person's needs was undertaken and this included an assessment of the environment to ensure this did not pose any hazards for the person or staff. Each person's file viewed showed a completed environmental risk assessment and this was reviewed annually or sooner if changes in the environment were highlighted by staff. Staff understood that some people used equipment to minimise the risk of falls and used equipment to help reduce the risk of pressure ulcers developing. Systems were in place to ensure that equipment was checked annually to ensure it had been serviced. Records showed that moving and handling assessments were not always dated and it was unclear therefore if they were an accurate reflection of current need.

Some people were at risk from pressure ulcers, had catheters, or were at risk of poor nutrition and hydration, individual assessments to look at the level of risk to each person with these needs had not been developed. Staff knew about risks in peoples care but this had not been incorporated into information recorded about individual risk. For example a staff member explained that the person they supported spent all day in their bed or a chair and was at risk of pressure ulcers, the care plan stated there was no need for staff involvement, but involvement from health professionals indicated the level of risk was such that staff also needed to be using prescribed creams to reduce the level of risk of pressure ulcers. Although recorded and therefore administered according to the medicine administration record there was not a separate risk assessment in place for this or the setting on the air mattress to ensure staff understood the importance of these measures.

There was a failure to show how the agency had assessed potential risks to people's individual safety, and what steps and actions staff were responsible for, to help minimise the potential for risks to occur. This is a breach of Regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The agency used between 200-300 staffing hours to cover the calls for the people using the service. If necessary they were able to support additional hours if needed from a pool of agency staff that were usually placed to cover shifts in care and nursing homes. Most people said they were satisfied with the length and pace of the support offered to them and did not feel rushed in any way. They said on the whole staff arrived on time and stayed the full session they were booked for.

Staff said there was not a problem with ensuring two staff covered calls where a hoist needed to be used. However, there were some issues with continuity in staffing for some people who said they always had different staff providing support. For staff undertaking half hourly calls, rotas showed no travel time between calls; this meant that they were always likely to be late for their next and successive calls. An example given by a staff member was of "If I am in Hythe and my call finishes at 9:30 my next call may be Folkestone and starts at 9:30 am, it is therefore impossible to achieve these times".

People told us that they did not think there were always enough suitable staff and that the agency had not always provided the dedicated staff members it had promised them, even where the agency had a long period of notice to recruit specific care staff with the right skills. Staff allocated to work with specific people showed concern for their wellbeing and were concerned about how their care would be covered if they took leave. They told us that because of the lack of suitable care staff available they sometimes found it difficult to take leave. A staff member told us that there were several occasions where they had given advance notice of their annual leave dates, but had found themselves still on the rota for those dates and had to remind the office staff that they would be unavailable, and to ensure their calls were covered in their absence. Feedback from some of the people receiving the service showed that they had experienced missed calls when their usual carer was unavailable and had not been informed.

People who had refused to have some staff said they had been listened to and these staff were allocated elsewhere but they had not always been offered an alternative staff member. Another person told us that someone had been sent to their home the previous day for the first time, who they had never met. The staff member had not been given the correct address, and the person did not feel that the agency had done enough to prepare the staff member for

the range of tasks they were being asked to undertake. The person receiving care felt this was unfair to them and the new staff member and said that they felt stressed when this happened.

There was a failure to ensure that staff deployed had the necessary skills and competencies and this is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for staff employed at the service who worked on the domiciliary care part of the service. One out of three files did not evidence that a full employment history had been obtained; interview notes did not record whether gaps in the employment history had been explored with the applicant at interview. All other records showed staff recruitment records contained all the required documentation. Each staff file viewed contained an application form and conduct in employment references, evidence of personal identity and a criminal record check through the Disclosure and Barring Service.

All staff irrespective of whether they were British citizens or not had Employers 'Right to work' checks undertaken to confirm that all relevant paper work was in place to judge they were suitable to undertake their role. Applicants were asked to complete a health questionnaire and gave consent for their GP to be contacted if necessary. There was evidence on application forms of people being asked to comment on their reasons for leaving previous roles including care roles, and where issues were highlighted these were discussed with the applicant.

There was a failure to ensure that a full employment history was obtained for each new staff member and this a breach of Regulation 19 (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with told us that they received their medicines as prescribed and in accordance with their wishes. Staff had received training and there was a medicines policy to inform staff practice. Staff were provided with classroom based training regarding the administration of medicines and we sat in on one such course and found this provided an interactive training experience for staff, where they were provided with real life scenarios they might be faced with and asked to explain how they would respond and the action they needed to take. The agency had a policy of only administering prescribed medicines but the trainer discussed with staff the actions they might take if asked to give non-prescription over the counter medicines, supplements or creams.

Staff who administered medicines told us that their competency was assessed before they could administer even though they had completed training. Staff records showed evidence of medicine competency assessments. One staff member told us they had their competency reassessed following a medicines error to ensure they were still safe to administer. People we spoke with also confirmed that a senior member of staff from the office had visited to assess staff competency with medicines.

Some people told us that they felt confident in allowing the care staff to administer medicines to their relative because they had personally observed them doing so and were satisfied they understood the specific process for their relative. The agency employed a lead nurse who undertook to provide specialist training to staff in areas and this included the administration of medicines through a Percutaneous Endoscopy Gastronomy tube (PEG) (this is a plastic tube which passes into the persons stomach, and is most commonly used to provide a means of feeding or administration of medicines where this cannot be done orally).

We spoke with two people in their home about how they were supported with their medicines. Their descriptions matched the medicine support routine detailed in their care plan. Each care plan contained a complete list of prescribed oral medicines and creams, and these were recorded on the medicine administration record (MAR). The agency provided a range of support to people with their medicines and a medicine assessment detailed how much support the person needed. Both people we spoke with were assessed as needing full support in this area but were able to describe their medicine routine and how staff supported them.

Staff knew what action to take if a person refused to take their medicines, recording this in the daily log and reporting this to the office where it was recorded as an event and alerted to other health professionals if necessary. The agency had established a system of quality monitoring of Medicine Administration Records (MAR) to ensure these were completed properly. This process had

Is the service safe?

highlighted examples of recording errors and the actions taken to address these shortfalls. We looked at a sample of MAR sheets and found these had been completed appropriately.

Staff had received training in safeguarding adults and children from abuse. The agency had a safeguarding policy which made clear to staff the types of abuse that people could experience, and their responsibility to report their concerns to their manager. The manager had responsibility to ensure they alerted the local authority where this was appropriate to do so. Staff received copies of policies in their staff handbook and signed to state they had received and read this. Staff also completed a child and adult protection training course. Staff were very familiar with the needs of the people they supported and felt they would recognise issues of abuse and raise the alert with the office, and would check to ensure this had been actioned.

The provider and registered manager had contact details for the local authority safeguarding staff. They could demonstrate that they were alerting concerns where these were identified. Feedback from the local authority showed they were satisfied with the manner in which the service undertook some investigations to inform local authority responses.

Staff spoken with said they were aware of the whistleblowing policy and some had used this in the past; they felt confident of raising concerns about other staff practice and that this this would be treated confidentially within the management team. Other staff said they had been open with staff they had expressed concerns about.

Staff were aware of the reporting processes for any accidents or incidents that occurred. Accident and incident information was recorded by staff on site and alerted to the registered manager or other office support staff. This information was added to an electronic records system. This allowed the provider to analyse incident and accident frequencies, and other possible trends and patterns that could be identified. Incident and accident information was reviewed. A business continuity plan was in place and this would take account of bad weather that would impact on business as usual practice.

There were arrangements to help protect people from the risk of financial abuse. The care of one person we visited involved care staff handling finances. Staff showed us the records they kept and receipts they collected; a balance of the person's available finances was maintained and staff knew who to contact if this was running low. The person told us that the care staff always checked with them what they wanted them to purchase and always provided them with the receipt and showed them the change they had left

Requires improvement

Is the service effective?

Our findings

Two people we spoke with told us they could not fault their regular care staff who they described as “fantastic”, “attentive”, “a godsend for me”, “fabulous”. They sometimes received new staff that they did not feel had the right knowledge and skills to do the job, they felt this was because they had not shadowed more experienced staff with their support package and had not been provided with necessary information about the tasks they would be expected to do. Two people told us that they felt new staff sometimes lacked the right attitude and awareness to provide support they felt safe with.

Staff told us that they were provided with an appropriate programme of induction within the first week of employment that ensured they had received the correct essential training in moving and handling, fire safety, food hygiene, moving and handling and first aid. This training was completed before they worked on shift alone. Three days of the induction were office based and staff attended their essential training and gained knowledge of the agency policies and procedures.

Records showed certificates gained through induction although there was an absence of recording around how staff were assessed and signed off as competent. The provider told us that they were reviewing the effectiveness of the office based training and were considering other options that included mixing this with live training on the job, but this was still under discussion. A staff member told us that they enjoyed the work they did and felt the move to the agency had opened up more opportunities for them to develop more skills.

Staff received updates for all their essential training at intervals specified by the trainers. Some staff told us that they were reminded when training was due and were given a selection of dates when they could attend. This was not the same experience for other staff, as one told us that one of their essential courses had been out of date for a month before they were reminded. They said that they were then given short notice of training dates which they were unable to do because these fell on dates when they were providing support to someone.

Some staff told us that they had received specialist training for example, where they needed to provide specialist support to people who were at risk from pressure ulcers or had PEG (Percutaneous Endoscopic Gastronomy) tubes fitted (this is a plastic tube which passes into the persons stomach, and is most commonly used to provide a means of feeding or administration of medicines where this cannot be done orally). This training had been provided by a lead nurse employed by the provider, who also undertook medication competency checks for staff. However this was not the experience of all staff.

There seemed to be a mismatch sometimes between what support staff were trained to provide and what they were asked to do. For example, one staff member told us that they worked with someone with a PEG and also another person who was at risk of pressure ulcers. This was not a problem as they had received appropriate training from working alongside health professionals who also visited the person. However, no specific support training for these areas had been provided by the agency. Another staff member said that whilst they had in fact been trained by the agency to care for people with PEG care or tracheostomy care needs, they did not support anyone with these needs currently. They did however, from time to time support people with palliative needs but had not received training in this. They felt it was important that they received this training to improve their awareness and this would have been helpful to their work.

People told us that they thought that staff were appropriately trained and had the skills to provide the necessary support, however some staff needed additional support to raise their awareness and understanding of people with very complex needs. One person told us they had found having the staff member around helpful and confidence boosting as they had shown them how to use a piece of equipment they had not been confident of using themselves. A relative told us that they worked with staff to ensure they had the right level of awareness and competency to assure them that they were safe to leave their relative in their care. However other people expressed concern that although they found their allocated staff member “excellent” and “fantastic” there was an absence of back up care staff to provide the same standard of support should the main care worker not be available. Some staff commented that there was an absence of shadowing for new staff. They said that this was important if they were to work with people with complex needs so they understood all aspects of the person’s care and could take over if needed.

Requires improvement

Is the service effective?

There was limited evidence of observations of staff practice and unannounced site visits by a manager or senior to assess and check staff performance and competency in areas other than medicines. We noted there was some attempt to reinstate home visits and also to undertake observations of staff competency beyond that of medicines. Diary entries for the lead nurse showed that they had undertaken a number of observations and medicines competency assessments since January 2015, The findings from these visits were not documented; there was no assurance that observations and site visits had been conducted to a set format, or that shortfalls if found, were recorded and the actions taken to address them.

Staff said they could ring office staff or the management team if they needed support. They also said that if they wanted one to one time with a manager they could ask for this. There was no formal support structure that included individual supervision sessions, spot checks and annual appraisal to assess individual staff performance, and provide assurance that staff were delivering support to a good standard.

The failure to ensure that systems were in place for the supervision, competency assessment and appraisal of staff performance and this is a breach of Regulation 18 (2) (a) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff if they knew about the Mental Capacity Act 2005 which makes provision for what should happen if a person cannot make decisions for themselves. This could be because of an illness such as dementia or through having a learning disability. Staff were provided with a basic understanding of the principles of the Mental Capacity Act 2005. When we spoke with them they demonstrated that they had a working knowledge of this and used their understanding of the person's needs to be sure they were able to consent. People we spoke with said that staff always checked with them first before undertaking tasks or support and staff said they would always report to the office if they considered someone was no longer able to make some decisions, or if they refused consent, for example for medicines.

Some staff were responsible for preparing and cooking meals for people they supported. People told us that staff always offered them choices and asked them what they preferred. People said they were happy with the support they received around meal taking. When we visited one person the member of staff was in the process of preparing lunch and we noted that they were wearing gloves to ensure there was no cross infection in the food preparation. We looked at care files in people's homes and saw that food and fluid monitoring was recorded for some people to ensure they were eating and drinking enough, and completion of these records was monitored by senior staff at the office.

Although staff were not responsible for people's health care staff spoken with demonstrated an understanding of the importance of alerting health professionals appropriately to seek interventions. A staff member told us that they had noted a pressure sore developing on the foot of someone they supported, and they had contacted the community nurse and informed the office of the actions they had taken to ensure the person received support in a timely way from health staff to minimise the impact. Another staff member told us of an incident where they had to call an out of hours GP service and had to wait with the person until the early hours of the morning so that they had company until they were taken to hospital by ambulance.

Requires improvement

Is the service caring?

Our findings

People's satisfaction was highest when talking about their specific care staff who knew them well and about whom they spoke positively. Only one person raised concern about the attitudes of some staff that were sometimes sent along without introduction. They said they personally felt that some of these new staff made little or no attempt to build a rapport with them; although they were supporting them with intimate personal care. They said they sometimes felt rushed by these staff and felt these staff conveyed a 'can't be bothered' attitude.

This was not a view shared by other people, the majority of whom felt their privacy and dignity was respected by all staff. Some people said they felt sorry for new care staff who they said were often sent along to them with very little awareness or understanding of what tasks they might be asked to perform.

Overall dissatisfaction with care staff was low and was reserved for what people saw as a lack of organisation and communication from the office based staff and management.

Some people who had needed to use the out of hour's number felt it was ineffective. One person told us that some of the staff covering the phone said they lived in poor signal areas and could not always receive calls. This was not acceptable for an out of hour's duty number, some people said staff did not always respond to messages left on the out of hours' phone and this service was not reliable.

There was a failure to provide an effective out of hour's service and this is a breach of Regulation 12 (2) (b) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with a rota to inform them who would be undertaking their calls. Staff received their rotas on a monthly basis. We spoke with some staff that had picked up additional calls and received a supplementary rota for these; they told us that they sometimes did not receive their new rota until after they had undertaken a number of shifts. Other staff said they were given their regular rotas in good time and this was not a problem. People with larger support packages had more consistency in the care staff they received because their care staff needed to have specialist knowledge of their needs. Other people who received short half hour calls said they did not always know who was coming.

When we looked at the rotas for people who received half hour calls we noted there was no travel time between calls. This meant that after the first call staff were always trying to catch up because they were going to arrive late for the next call. Staff said people were often annoyed at their arriving later because they had been given expectations of times when staff would arrive. They understood that some relatives were dependent on staff arriving on time so that they could leave for work or other appointments. This meant people were not receiving care that met their specific needs. The provider said at inspection that they would review some of these calls and ensure travel time was introduced.

There was a failure to ensure that the present system for informing people and staff about changes to the rota was implemented effectively, and that there is appropriate time built into staff rotas to enable them to provide person centred care. This is a breach of Regulation 9 (1) (a-c) (3) (b) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people commented that they did not always feel listened to by the office or that their comments were acted upon because the same issues arose from time to time, or they were never given feedback about issues they raised. A few people said they had received the odd visit from senior staff to reassess their needs or check they were satisfied with the service; but this was rare.

Other people said they had never received a visit to their home from agency staff to check the care plan was still accurate or their level of satisfaction, or as a spot check on staff. The service provider told us that only people in receipt of a service for one year would receive a formal review of their care needs. People were randomly selected for satisfaction surveys but we were not provided with analysis from these, and actions taken.

There was a failure to fully implement systems to gather people's views, and to analyse and act upon their feedback to make improvements to the service. This is a breach of Regulation 17 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

People told us that someone came to assess what their support needs were before a bespoke support package was provided.

The provider told us that people's care needs were reassessed on a regular basis. Although records viewed did not show when this took place, electronic records were maintained that showed when this was completed. People provided conflicting information as to whether they did or did not receive visits to reassess their needs and check their satisfaction. Some people thought that someone had visited the previous year but could not recall if this was to review their plan of care, and another person told us that they had recently been contacted about someone coming out to reassess them, but had not been given a date yet.

Staff told us that if any changes occurred to someone's care needs this would be reported and updates to the care plan would be made eventually. However, one staff member told us that someone they supported had needed their care plan updated for months which they had made the office aware of but someone was still to come out and reassess although there had been a lot of changes to the person's support needs.

There was a failure to ensure that formal arrangements were in place for the review and reassessment of people's needs, this could place them at risk of unsafe or inappropriate care if staff are working with out of date or inaccurate information. This is a breach of regulation 12 (1) (a) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans although not written from the person's point of view did reflect their specific support needs. Two people felt their own care plans failed to include the exact details of the tasks staff might be asked to do, and what their usual staff member did, that made them feel comfortable and positive about their experience of care. This could sometimes mean that new staff were unprepared or lacked confidence, for example taking the person to appointments outside the local area and understanding the transport arrangements that needed to be implemented in order to achieve this. The lack of confidence and preparedness for some new care staff meant this became a stressful experience for the person being supported.

Another person told us that when some new care staff came to their house they told them where the care plan was kept but these staff never looked at it. They said that the care plan did not take into account all the small things that the regular care staff did such as pulling the blinds before they left, which made them feel secure and comfortable for the rest of the day.

A copy of each person's care plan was kept at the office and also in their home as a reference for staff. Most people spoken with said they had not read their plan but knew where it was kept. They were aware that staff always wrote in their part of the file and completed medicine administration forms and other monitoring records for example, food, fluid and bowel charts. Some people also had repositioning records to reduce the risk of pressure sores, and knew that staff monitored their skin integrity.

People told us that they knew how to complain and this was made clear in documentation within their home file. We asked people whether they had ever complained about the service, everyone we spoke with said they had no reason to complain about their usual care staff, but felt confident about raising issues if they needed to with office staff. Peoples expressions of dissatisfaction were recorded as incidents but it was unclear if every phone call from a person expressing a concern was in fact recorded in this way

Two people said that although they had not made formal complaints they had telephoned the office on a number of occasions when they were dissatisfied with the service. They said that although they felt able to ring the office and were always told their concerns would be corrected, they felt this did not always result in improvements. A lack of confidence had developed in the way they believed their concerns were handled because they felt that they did not always receive call backs or visits to discuss their concerns. We tracked one recent incident for one of the people who had raised these concerns and noted that their concern had been recorded and that office staff had taken action to investigate and had reported back their findings to the person within one day.

There was a failure to implement an effective complaints process that people using the service had confidence in. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

People with more complex packages were complimentary about the usual staff that visited but felt that improvements needed to be made in the way agency staff communicated with them and with each other.

It is a condition of the registration of Superior Care Folkestone that a registered manager is in post. The registered manager who was registered for this office also had management responsibility for another office in Maidstone where she was permanently based. The manager was contactable to staff by phone but was not a visible presence at the Folkestone office and some staff were not aware of whom she was or that she was now the registered manager.

The office had a small number of staff responsible for scheduling and recruitment, but there was no one specifically available to provide management oversight or support to care staff. A lead nurse employed by the company had been given the role for staff competency assessment in regard to medicines. Diary dates provided by the provider for the lead nurse showed that her role had expanded to include some spot checks and some reassessment of needs but there was not an established or effective system in place to ensure spot checks were regularly undertaken or to ensure that care reassessments were undertaken quickly to ensure care plans were kept up to date.

Before the inspection we had sent a provider information return (PIR) to the registered manager but this had not been completed and returned as required.

There was a quality assurance policy. The provider told us that they visited the Folkestone office at least weekly to ensure things were running smoothly, they spoke with office staff, and also with care staff that came to the office. The provider also undertook a review of documentation. During the inspection the provider made available a number of reports that showed a limited range of audits were undertaken, these monitored areas such as incidents and accidents, medication records, fluid, food and bowel charts and log entries.

The auditing of documentation provided assurance that staff were completing records and highlighted any omissions in recording where improvement was needed. However the system was not robust. There was a lack of evidence that people or staff were routinely asked for their views about the service. The present system did not monitor all aspects of the service to ensure it was operating effectively and which could include checks of staff training and competencies, staff appraisal, spot checks and home visits to people using the service. There was no evidence that the agency had undertaken a thorough self-assessment of the service provided, to identify what worked well and what did not, and develop an action plan to address those areas for improvement.

There was a failure to ensure that the system of assessment and quality monitoring in place was effective and this is a breach of Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were happy working for Superior Care but wanted change to improve the service. Most felt they received a good induction and access to a regular programme of basic training that ensured they could undertake the everyday care needs of people. Some care staff said that if they identified training they thought was important to the support they provided, for example palliative care they could put their name forward for this, whilst some staff had received specialist training others felt that although they were encouraged to request it, it never came to fruition.

Most staff spoken with told us that they could call into the office any time to pass on information or be informed about any changes. They all commented that one of the improvements they would like to see was with communication; everyone had problems with this to varying degrees. For example, some staff reported issues with changes to rotas that they were not told about, some said information passed to office staff was not always acted on, some staff felt the responses they received from office staff were not always helpful.

Staff were unaware of who the current registered manager was and several said there had been “A lot of changes up at the office”. The provider showed us their business continuity plan but staff were unaware of this and did not know how calls would be covered in the event of an emergency such as bad weather. This could place people at risk if staff did not know what emergency arrangements were to be made in respect of prioritising calls, how staff would be contacted, how arrangements would be made to get staff to and from calls by using vehicles that could cope with bad weather, or changing rotas so staff undertook calls closest to them where possible.

Requires improvement

Is the service well-led?

There was no structure in place for staff to receive formal supervisions, annual appraisal or to look at their personal development, training needs and work performance. The provider was therefore unable to assure themselves that they had a full understanding of staff concerns and aspirations. They could not show that shortfalls in staff performance and practice were appropriately documented with actions recorded of how staff would be supported to improve or achieve the necessary training and competence.

Records showed that one staff meeting had been held in March 2014, but staff spoken with had generally not attended staff meetings since commencing work or may have attended one in a number of years. Staff said they were not made aware through minutes of what was discussed at staff meetings and did not have opportunities to put things on the agenda.

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 9 HSCA (RA) Regulations 2014 Person-centred care There was a failure to ensure that people and staff were kept informed about rota changes and that there was appropriate time built into staff rotas to enable staff to provide person centred care. Regulation 9 (1) (a-c) (3) (b)(h)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The failure to provide an effective out of hour's service to protect people from harm and ensure they receive appropriate care is a breach of Regulation 12 (2)(b) There was a failure to ensure that formal arrangements were in place for the review and reassessment of people's needs, this could place them at risk of unsafe or inappropriate care if staff are working with out of date or inaccurate information. Regulation 12 (1) (a) The failure to provide individual assessment records of how to keep people safe from risk of harm is a breach of Regulation 12 (1) (2) (a)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints There was a failure to implement an effective complaints process that people using the service had confidence in. Regulation 16.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The failure to implement systems to ensure people were satisfied with the care they received and to undertake analysis of their feedback. 17 (2) (e) There was a failure to ensure that the system of assessment and quality monitoring in place was effective and this is a breach of Regulation 17 (1) (2) (a)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was a failure to ensure that systems were in place for the supervision, competency assessment and appraisal of staff performance. Regulation 18 (2) (a) There was a failure to deploy staff that have the necessary skills and competencies. Regulation 18 (1)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed There was a failure to ensure that a full employment history was obtained for each new staff member, or that gaps in employment histories were explored and documented. Regualtion19 (3) (a)