

Kent Social Care Professionals Limited

Kent Social Care

Professionals Domiciliary

Service

Inspection report

2 Woodville Road
Maidstone
ME15 7BS

Tel: 01622764014
Website: www.kentscp.com

Date of inspection visit:
31 August 2021

Date of publication:
21 October 2021

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service responsive?

Inspected but not rated

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Kent Social Care Professionals Domiciliary Service is a care at home service providing personal care to 230 people within their own homes, at the time of the inspection.

Not everyone who used the service received personal care. The Care Quality Commission (CQC) only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found

Risks to people were not always recorded in their risk assessments or care plans and these records were not always personalised. This put people at potential risk of harm and at risk of receiving inconsistent care. We have made a recommendation in this area.

Feedback from people about staff deployment from the service was negative. People told us calls were often late and sometimes missed. People did not always receive information about this from the office which impacted on people emotionally and physically. A relative told us, "I would say there is a shortage of staff, there are delays in the morning visit. Today carers didn't get [loved one] up till 11.30am. The target time is 9.00am... It impacts on [loved one's] diet, like a late breakfast and [they] might not then eat lunch."

Accidents and incidents were not consistently recorded. Despite this, where accidents or incidents were recorded, action was taken to make people safe and lessons were shared.

Staffing level challenges had had an impact on people receiving timely support and the management of the service. The provider was in the process of implementing new strategies at the time of our inspection to try and increase recruitment and continued to do so following the inspection.

Audits had not taken place regularly in the months prior to the inspection. Risk assessments and care plans were not up to date and did not reflect the care that people were currently receiving. Actions were not consistently taken from the audits that had previously been completed. We did not see evidence of trends analysis to further aid learning and drive improvements.

Feedback from people was negative about communication from the office. Although, staff said they received necessary updates from the office and a recent survey had been sent out to people at the time of our inspection.

Feedback from people about the care they received during visits, from regular carers, was positive. People told us they felt safe. One person said, "I have a trio of lovely [carers] who look after me and I trust them with my life." Staff knew the signs and symptoms of abuse and how to report any concerns. Safeguarding

concerns were reported to external agencies.

Risks from the spread of infections such as COVID-19 had been considered. Staff knew how to prevent the spread of infections for example by wearing personal protective equipment.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests and systems in the service supported this practice.

There was no one receiving end of life care at the time of the inspection, however staff had received training regarding care at the end of people's lives and preferences around this were included in care planning.

The service worked in partnership with healthcare professionals and other external agencies.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was Good (published 26 July 2018).

Why we inspected

We received concerns in relation to staffing levels, the quality of care provided and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led. We carried out a targeted inspection in the key question responsive to look at concerns in relation to end of life care.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

The provider had been aware of the concerns the inspection identified prior to the site visit. They had a plan to increase recruitment which would allow for better service delivery. This was being implemented during our inspection and therefore we cannot comment on the effectiveness of these plans.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service

We have identified breaches in relation to ineffective staff deployment and ineffective quality assurance systems and processes at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service responsive?

At our last inspection we rated this key question good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Inspected but not rated

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Kent Social Care Professionals Domiciliary Service

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

This inspection was carried out by two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

This service is a domiciliary care agency. It provides personal care to people living in their own homes.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 31 August 2021 and ended on 02 September 2021. We visited the office location on 31 August 2021.

What we did before the inspection

The provider was in the process of completing the Provider Information Return at the time of our inspection. This is information providers are required to send us with key information about the service, what it does well and improvements they plan to make. Therefore, we were unable to take this into account when making our judgements in this report. We reviewed information we had received since the last inspection.

We used all of this information to plan our inspection.

During the inspection

We spoke with seventeen people who used the service and eighteen relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, service delivery manager, co-ordinator and care workers.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, reports, policies and procedures were reviewed.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- People were not supported by sufficient numbers of effectively deployed staff. The registered manager told us the COVID-19 pandemic had had an impact on staffing levels. There were several staff vacancies, sickness and annual leave which was affecting the deployment of staff and impacting on the service. The provider had been actively recruiting and implementing new strategies to increase recruitment prior to our inspection and continued to do so.
- The service had had to operate using their contingency plan in recent months due to the staffing crisis. Each person was assessed for their dependency and urgency of their care calls. Those who were assessed as able to manage without support had some of their calls cancelled due to staffing level challenges. Insufficient staff deployment to meet people's needs meant some people who would usually receive support from the service had to rely on family or friends instead.
- Staff did not always attend people's care calls at their scheduled times, or for the duration of the allocated time and there had been some instances of missed calls to people. Records we reviewed confirmed this. This impacted on people physically and psychologically due to not receiving the care they needed in a timely manner. A person told us, "I was still waiting for my morning call...The carer arrived at 2pm...I hadn't wanted to sit in the cold waiting for help so had really struggled and managed to do a lot myself, so [the carer] was in and out in minutes for what should be a 30-minute call."
- Staff rostering records showed staff were not always given enough time to travel in-between the calls, which impacted on their ability to arrive promptly or stay the full allocated time with people. Some care staff told us that sometimes they had to leave calls early to ensure they got to the next call on time. For example, some calls were scheduled to start at the same time as the previous call finishes, leaving no travel time or consideration of distance to travel.

The provider failed to deploy sufficient numbers of staff to meet people's needs. Scheduled visits were not always on time and staff did not always spend the full allocated time with people, this impacted on people's physical and psychological wellbeing. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were recruited safely. The registered manager had completed relevant pre-employment checks including Disclosure and Barring Service checks, full employment history and references. These checks ensured the provider that staff were suitable to provide care and support to people before they started work.

Assessing risk, safety monitoring and management

- Risks to people had not always been fully documented. Guidance was not always in place for staff to

follow to ensure safe, consistent care delivery and logs of care provided, completed by staff, often differed from the care plans. For example, one person's care plan noted they were fully continent however visit logs showed staff were providing catheter care. There was no guidance around this or the risks associated with catheter care leaving potential for risks such as infection not being managed safely. The registered manager took action following the inspection and documented risk management for the person's catheter care.

- Where risks had been identified, there was not always guidance for staff to follow in how to monitor or manage those risks. Where people had emotional or psychological risks identified in their risk assessments or care plans there was not always information on how to support people should they become anxious or distressed. Similarly, people with physical health needs such as people living with epilepsy or diabetes did not have personalised information about what it might look like if that person was to become unwell.
- Information about what staff should do to support a person if they became unwell was within fact sheets about each condition however these were not personalised and did not link to identifying particular indicators for each person and how to escalate those concerns.
- There had been no harm as a result of a lack of information in risk assessments and care plans. However, without guidance for staff to follow there was a risk that staff might not know how to support people and that care being delivered may not be consistent across all staff.

We recommend the provider consult nationally recognised guidance about delivering safe care and treatment through risk management and implement this as appropriate.

- Despite the issues identified in risk assessments and care planning, people and their relatives told us regular carers knew people well and could meet their needs. One person told us, "They all know what to do and just get on with the job in hand." A relative said, "The carers are excellent. The standard of care is high. They are well trained."

Learning lessons when things go wrong

- Accidents and incidents were not consistently recorded. Incident records of missed calls for the month of July 2021 suggested there was one, however, the registered manager shared a report of missed visits for July 2021 which listed three instances.
- Where accidents or incidents were recorded action was taken to make people safe and lessons were shared.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe. One person said, "I have a trio of lovely [carers] who look after me and I trust them with my life." Another person told us, "I do feel safe when [carer] is with me as I know I won't have a fall."
- Staff knew the signs and symptoms that might suggest a person was experiencing abuse. Staff felt confident to raise concerns and that these would be acted on.
- The registered manager reported relevant safeguarding concerns to the local authority and to CQC.

Using medicines safely

- People received their medicines safely from staff who were trained to administer them. Records indicated the level of support people needed to take their medicines whether that was prompting by staff or being administered by staff.
- Medicines administered were recorded on the providers electronic system with guidance on the system for staff to follow about how people required their medicines. Missed medicines were reported to the office by carers and these were recorded as incidents.
- Carers communicated changes to people's medicines to the office.

Preventing and controlling infection

- There were risk assessments in place to assess and mitigate the risk from infection of COVID-19 for people, staff and the office. Risk assessments included actions taken such as proper use of personal protective equipment (PPE).
- People told us staff wore PPE and disposed of this appropriately. One person said, "[Carers] are always changing their gloves and washing their hands and then drying them with paper towels. I feel very safe with them here." Staff also confirmed they knew how to reduce the risk of spreading infection through proper PPE use and regular hand washing.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check a specific concern we had about staffing levels and the quality of care including end of life care as well as the management of the service. We will assess all of the key question at the next comprehensive inspection of the service.

End of life care and support

- There was no one at the service receiving end of life care at the time of the inspection. However, end of life preferences were recorded in people's care plans.
- Training records showed that training in this area was completed when staff first joined the service.
- Staff told us they had supported people at the end of their life and felt end of life care provided by the service was adequate. However, some staff felt additional training would better support their ability to meet the specific needs people at the end of their life might have. We fed this back to the provider at the end of the inspection.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Care records for people were not up to date. For example, one person's care records were unclear whether they were independently mobile or required support from staff. Staff told us the person was cared for in bed and received support with repositioning. There was no guidance for staff to follow in delivering this care or risk assessments associated with this care need.
- Systems and processes to monitor the quality of the service had not been consistently applied such as spot checks on the quality of the service delivered by staff and audits. Issues we found at this inspection such as care records not being up to date could have been picked up through effective use of the provider's quality assurance system.
- The registered manager told us staff shortages due to the COVID-19 pandemic had had an impact on the running of the service. The registered manager told us their plans to move forward in getting records up to date and audits happening regularly again as new office staff were due to start following the inspection.
- We requested to see actions plans from previous audits to check actions were taken. The registered manager said they would share these with us during and after the inspection, however, they did not show us them. We could not be assured actions were consistently taken from the audits that had been completed. We followed up on some issues identified and found these had not been addressed in full. Some staff told us they had raised concerns with the registered manager and office staff which had not been resolved. For example, staff not being allocated travel time between calls.
- We did not see evidence of trends analysis which further aid learning and drive improvements.

Systems and processes to monitor the quality and safety of the service had not been consistently applied to ensure the quality of the service and reduce risks. The governance system had not always effectively identified issues found at this inspection and had not always driven improvement and continuous learning. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

- The registered manager was open during the inspection about the challenge they had been experiencing with staffing levels affecting call scheduling and the impact this had on the running of the service. This

corresponded with the feedback that we received from people. One person said, "I would give the [carers] 10 out of 10 and five or six out of 10 for the office."

- The majority of people and their relatives told us they experienced late calls. They fed back the office did not always consistently inform people about these issues which impacted on people and meant they did not always experience good outcomes. One person said, "It can be very frustrating as they don't tell you if they are running late or there is a staffing issue, you just find out on the day. I organise...around the sessions, so it is very inconvenient sometimes." Another person said, "They are often an hour late and recently the person on the phone said we were hoping you would be able to manage...I have had office staff turn up before now at weekends, but you feel like a number. It's very impersonal."
- Feedback from people about their engagement with the service and their care was mixed, some people said they recently had care reviews, while others said they had never had a review.
- A recent survey had been sent out by the provider and results were being collected for analysis at the time of our inspection. The previous annual survey was not carried out due to COVID-19.
- Despite the recent challenges, people were generally positive about the care they received from their regular carers. Staff were knowledgeable about the people they were supporting. Feedback from staff was that they aimed to do their best for people despite the current staffing challenges.
- Staff told us they felt supported by the manager and received regular updates of information that they needed to know.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider understood the duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative. The registered manager advised us there had been no incidents requiring the duty of candour to be applied. However, the principles of being open and transparent with people had not been consistently applied where calls had been late or missed.

Working in partnership with others

- The service worked in partnership with healthcare professionals and other external agencies. Referrals had been made to relevant healthcare professionals such as district nurses where people's needs had changed, or risks had been identified.
- People told us carers were observant and took appropriate action to ensure their needs were met. One person said, "There was one time when [carer] noticed that [they] had gone very red and they called the GP...and they were not happy to leave without doing something. I know they have my best interests at heart."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor the quality and safety of the service had not been consistently applied to ensure the quality of the service and reduce risks.
Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of staff to meet people's needs.