Kensington Community Care (Gloucester) Ltd

Kensington Community Care Birmingham

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 September 2016. This was an announced inspection.

At the time of our last inspection in August 2014, Kensington Community Care Services Birmingham was found to require improvement in three out of the five areas that we inspected them against, including treating people with respect and involving them in their care, providing care, treatment and support that meets people's needs and the quality and suitability of management. We found that some improvements had been made in these areas.

Kensington Community Care Birmingham provides a domiciliary care service to people living in their own homes. At the time of our inspection, 93 people were receiving the regulated activity, personal care, from the provider.

There was a registered manager in post at the time of our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not always effective because people received care from staff who had not always received adequate training and did not always have the knowledge and skills they required to do their job effectively.

The service was not always responsive because care was not always planned in a person centred way that took in to consideration people's individual care needs and health related risks.

The service was not always well led because the provider had some quality monitoring processes in place to monitor the safety and quality of the service. However, these had not identified the shortfalls found during the inspection.

The service was safe because people were protected from the risk of abuse and avoidable harm and staff were aware of the processes they needed to follow. People were supported by enough members of staff who knew them well enough to ensure their needs were met. We also found that people received their prescribed medicines as required.

People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration and they had food they enjoyed. People were also supported to maintain good health because staff worked closely with other health and social care professionals when necessary.

The service was caring because people were supported by staff that were friendly, caring and supportive. People received the care they wanted based on their personal preferences and likes and dislikes because staff took the time to get to know people well. People were also cared for by staff who respected their

privacy and dignity.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

People received care and support with their consent, where possible and people's rights were protected because key processes had been fully followed to ensure people were not unlawfully restricted.

People and their relatives felt involved in the planning and review of their care because staff communicated with them in ways they could understand. People were also encouraged to offer feedback on the quality of the service and knew how to complain.

Staff felt supported and appreciated in their work and reported Kensington Community Care Birmingham to have an open and honest leadership culture.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse and avoidable harm because staff were aware of the processes they needed to follow.

People were supported by enough members of staff to meet their needs.

People received their prescribed medicines as required.

Is the service effective?

Requires Improvement

The service was not always effective

People received care from staff who had not always received adequate training and did not always have the knowledge and skills they required to do their job confidently.

People received care and support with their consent, where possible, and people's rights were protected because key processes had been fully followed to ensure people were not unlawfully restricted.

People received care and support to maintain a healthy diet and had food that they enjoyed.

People were supported to maintain good health because they were supported to access health and social care services when required.

Is the service caring?

Good

The service was caring.

People were supported by staff that were friendly, caring and supportive.

People received the care they wanted based on their personal preferences and dislikes because staff were dedicated and committed to getting to know people.

People were cared for by staff who respected their privacy and dignity

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not always planned in a person-centred way that reflected people's individual care needs and health related risks.

People and their relatives felt involved in the planning and review of their care

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had some quality monitoring processes in place to monitor the safety and quality of the service. However, these had not identified the shortfalls found during the inspection.

Everyone we spoke with were consistently positive about the registered manager and staff felt supported and appreciated in their work.

Staff reported Kensington Community Services Birmingham to have an open and honest leadership culture.

Kensington Community Care Birmingham

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 was an announced inspection. We gave the provider 48 hours' notice to let them know we would be visiting the service, because we needed to ensure someone would be available at the office. The inspection took place on 1 September 2016 and was conducted by one inspector.

Before the inspection, the provider completed a Provider Information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

As part of the inspection we looked at the information that we hold about the service prior to visiting the location. This included notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also received feedback from the local authority with their views about the service provided to people by the provider.

During our inspection, we visited the office location and spoke with the registered manager. We also reviewed the care records of seven people, to see how their care was planned and recorded. We also looked at training records for all of the staff that worked for the provider and at three staff files to look at recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including feedback surveys, compliments and complaints as well as the policies and procedures for the service.

After the site visit, we conducted telephone interviews with eight people who used the service and three

relatives to see what they thought of the care and support they were receiving. We also spoke with two health and social care professionals and five members of staff including the registered manager, three care staff and a care co-ordinator.

Good

Is the service safe?

Our findings

Most of the people we spoke with told us that they were happy with the care that people who used the service received from the provider and they were satisfied that people were safe. One person told us, "They [staff] are very good, they look after me well". Another person said, "I only have them [staff] because I am afraid of falling, they reassure me, I know I am safe when they are here". A third person said, "I feel happy and safe with them". A relative we spoke with told us that they were relieved to have the care package in place, especially after having met some of the care staff; they know their parents are safe.

All of the staff we spoke with felt that the provider promoted the safety of people. Staff we spoke with knew what action to take to keep people safe from the risk of abuse and avoidable harm. One member of staff told us, "We have safeguarding training, which covers the different types of abuse a person may be at risk of like physical, financial and neglect and it covers what signs we should look out for like bruises or a person not seeming themselves, being withdrawn or quiet; if I suspected anything, I would report it to the office straight away and if I was still concerned I would call the safeguarding team myself". Another staff member said, "We have training on safeguarding and we are checked on our knowledge during supervision". Records showed that staff had received safeguarding training and they were knowledgeable in recognising signs of potential abuse; staff knew how to escalate concerns about people's safety to the provider and other external agencies. The registered manager was also aware of their roles and responsibilities in raising and reporting any safeguarding concerns. Information we hold about the provider showed us that where a safeguarding concern had been raised, this had been reported appropriately and fully investigated by the relevant authorities.

Staff we spoke with knew what action they needed to take in an emergency. One member of staff told us, "I am confident that I know what to do in an emergency, we have training". Another member of staff also gave us an example of a time when they had to react in an emergency situation. They said, "I found a lady on the floor once, so I had to call for an ambulance because we are trained not to move a person in case you cause more injuries to them or to yourself; I put a pillow under her head though to make sure she was comfortable as she kept trying to sit up and put a blanket over her to keep her warm…I sat with her and reassured her until the ambulance arrived". Information we received from the provider in the Provider Information Return (PIR) pack and records we looked at as part of the inspection, showed that staff received training on basic life support. We also saw that people had 'Emergency Client Information' sheets in their log books, which staff are advised to give to any emergency personnel to ensure that they have all of the information they require about a person. This included information on their past medical history, their medications and who they would like to be informed in the event of an emergency, such as their next of kin.

Staff we spoke with and records we looked at showed that people had some generic risk assessments in their care files such as environmental and manual handling risk assessments. We saw that these were reviewed regularly. However, we did not find any risk assessments or care plans that were specific to people's individual care needs or their health related conditions, such as diabetes. We fed this back to the registered manager at the time of our inspection, who acknowledged that more individualised risk assessments would be useful to inform staff of the potential health related risks that people may be living

with.

Everyone we spoke with told us they thought there was always enough staff available to meet people's needs. One person told us, "They are usually on time unless they have had to deal with an emergency, but I have never had a missed call". Another person said, "They always turn up and stay the full amount of time". A relative we spoke with told us, "She [person] needs two carers at all times and two always turn up, which is more than I can say for the last care agency we had, so it [Kensington Community Care Birmingham] is much better". Staff we spoke with did not raise any concerns about the staffing levels within the service and the registered manager told us that were continuously recruiting to make sure they can always meet the needs of people. They said, "It can be difficult at this time of year because some carers leave to go to university or cannot do as many hours, so I always make sure we are recruiting and have enough staff available at all times". When we visited the office location on the day of our inspection, we saw three people had come to the office for an interview as part of the on-going recruitment drive. We also saw that the service used an electronic call monitoring system which alerted the management team of any missed or late calls, to ensure people received the care they required, when they required it.
Staff we spoke with and records we looked at showed that the provider was fulfilling their roles and responsibilities associated with the safe recruitment of staff. We saw the provider had a recruitment policy in place and staff had been appropriately recruited via a formal interview, references, and a Disclosure and Barring check. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care. Staff we spoke with told us they had completed a range of pre-employment checks before working unsupervised. This corroborated the information that had been shared with us by the provider in PIR.

We were told that some of the people receiving support from the provider required assistance to take their medication and that all staff had received training on the safe administration and management of medicines. One person we spoke with told us, "They help me with my tablets because I find the packets a bit fiddly". Another person said, "I sort my own medication out but I know they would help me if I needed them to".

Requires Improvement

Is the service effective?

Our findings

People, relatives and staff we spoke with felt that more training and coaching was required for new members of staff. One person told us, "They [staff] do their best but new carers don't always know what they are doing; I don't think they are very well trained". Another person we spoke with said, "I had to show the one girl [staff] what to do". A relative we spoke with said, "They [staff] are all lovely people but I think they need more training when they first start or they should at least be paired up (for double up calls) with experienced members of staff; instead it's like the blind leading the blind, with us having to guide them; it doesn't fill you with much confidence". One member of staff we spoke with said, "When we first start we have to complete a workbook which is very detailed and I did learn a lot from it but I think we need more practical training like the use of different equipment. I have had to learn as I go along and muddle through, usually with the person telling me what to do, it's embarrassing and makes you feel incompetent and it can't make them [people] feel very good either, after all this is their lives".

We were also told that new staff only had the opportunity to shadow an experienced member of staff for one day before being deployed to provide care independently, and that they had not had any 'monitoring' to check their competencies within the first few weeks of employment. We fed this back to the management team at the time of our inspection with the recommendation that they improve the induction training programme for new members of staff.

The registered manager told us that all of the staff received on-going training and supervision to make sure they keep up to date with the training that they require to do their jobs effectively. They also told us that they carried out observations and spot checks on staff performance to ensure care was delivered to a high standard and as required. Staff we spoke with who had been working for the provider for a longer period of time, confirmed that they received regular training updates and felt that they were supported by the provider to maintain and update their knowledge and skills. One member of staff told us, "I think the training is very good and very comprehensive, in comparison to the previous companies I have worked for". They said, "Since being here [Kensington Community Care Birmingham] I have had more specialised training like dementia care, palliative care, and intense medication training… I think it is very good, and we have regular supervision which covers any outstanding training". We saw that records of staff training were kept within each staff members' personal file, which were up to date and reviewed during supervision. The provider also kept a record of annual refresher training to ensure all staff were kept up to date.

We were told and records showed us that the provider offered regular supervision to staff and that staff felt supported in their jobs. One member of staff told us, "I feel very supported; [registered manager's name] is so good at making sure we are ok and that the people we care for are ok… she goes out of her way to make time for us as well, in between booked one to one sessions, if we need to speak to her we can just pop in the office or call her". Another member of staff said, "It is a supportive place to work, we have regular contact with the co-ordinators or [registered manager's name]". This corroborated the information that had been shared with us by the provider in the Provider Information Return form (PIR).

It was evident when speaking to the registered manager and the staff they had an understanding of the

Mental Capacity Act 2005 (MCA). The MCA 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff we spoke with confirmed they had received training on the Mental Capacity Act (2005) and were able to give examples of how they worked within these legal parameters and protected people's rights and the need for consent. One member of staff told us, "We always give people choices". Another member of staff said, "I like to help people to stay as independent as possible and I think you can do this by giving them more control in their care, by encouraging them to make choices and decisions for themselves, I always ask them what they want me to do".

However, it was not always clear from the records we looked at that the provider had taken in to consideration people's capacity to make decisions and the processes they had followed to make decisions on behalf of people in their best interests. For example, in one person's care plan we saw that their next of kin had signed the consent form for the care package on their behalf, despite the fact that their records stated they had capacity to make their own decisions. There was no explanation as to why this person's relative had signed on their behalf or whether they had been involved in the process. We also saw that in one person's care file it stated, "[person's name] may not make the 'right' decision", which does not adhere to principle three of the MCA 2005 code of practice which states that a person is not to be treated as unable to make a decision merely because they make an 'unwise' decision. We discussed this with the registered manager at the time of our inspection and they assured us that all paper work and processes relating to the MCA 2005 will be reviewed.

The MCA (2005) also requires providers to identify people in their care who may lack the mental capacity to consent to care and treatment and to notify the local authority, who will in turn submit an application to a 'supervisory body' (Court of Protection) for the authority to deprive of a person's of their liberty in order to keep them safe, for example. The provider was able to articulate their understanding of the legislation relating to the deprivation of liberty and was aware of their responsibilities within a community service.

Some of the people we spoke with told us that they received support from staff with their dietary needs. One person said, "They [staff] help me to prepare my breakfast and they will also prepare me a sandwich and wrap it up for me to have later; they are good, they ask me what I want and it's my choice what I eat". We saw that people had care plans relating to their dietary needs; however these did not always include information about their likes, dislikes and preferences. For example, in one person's care file we saw that their initial social work assessment stated that they were a vegetarian and preferred Asian food. However, this had not been included in their care plan. Furthermore, we saw that this person required a 'soft diet' because they were at risk of choking. However, their care plan or risk assessment did not give any additional details of what was meant by a 'soft diet' with regards to the types of food or consistency of the food that staff should be preparing. We fed this back to the registered manager at the time of our inspection. They acknowledged the lack of information identified and agreed that more person-centred care plans and risks assessments were required to improve the quality and safety of the care being provided to people in relation to their dietary needs.

We found that people were supported to maintain good health because the provider liaised with external health and social care professionals to ensure that people's physical and mental health needs were met. Records we looked at including the PIR showed that the provider had liaised with social workers, occupational therapists, and GP's to ensure people received the care and support they required. The registered manager told us, "In one instance we had to co-ordinate everything with the relevant health care professionals to get a person a profiling bed because they family did not speak any English". This meant that

the provider was also acting in response to a personal equality and diverse needs.

Good

Is the service caring?

Our findings

Everyone we spoke with were consistently positive about the caring approach of the service and the individual staff members. One person we spoke with said, "I love the carers!" They said, "They [staff] are lovely girls, they look after me and are very nice to me, they don't rush me, they are very kind and caring". Another person said, "They [staff] are nice and friendly; very good". A relative we spoke with told us, "They [staff] are really good with dad, they have a nice way about them and he responds really well to them; they even get him to have a shower when no-one else can!". They said, "Dad looks forward to seeing them which is a good sign that he likes them… even when they have just been he'll ask when he will see them again".

Relatives we spoke with told us that this kind and caring approach extended to their contact with the staff too and that they had also felt supported by the care staff. One relative told us, "Neither mom or dad are getting any younger and it offers peace of mind to mom, knowing they are there to help her care for dad, as much or as little as she needs".

Staff we spoke with had a good understanding of people's needs and we found that people received their care and support from staff that took the time to get to know and understand their history, likes, preferences and needs. They said, "We get to know people really well but if someone is unable to speak with us themselves, we will make sure we get enough information as we can from the care plan or from people that know the person well like friends and family". Another member of staff said, "We always talk to people to get to know them more, some people have had really interesting lives, we always ask people what they want and what they like to give them choices, but for people who are unable to tell us, we show them options and they may pick one or sometimes its trial and error; we will offer them something if they eat it, we know they like it, if they don't, we will try something else… we always make a note of it as well so other staff know what they like".

Everyone we spoke with told us that staff ensured that people were involved in making choices and decisions about their care and that where possible, care was provided to people with their consent. One person said, "They [staff] leave it up to me what I want, I make my own decisions". Another person said, "I have a book which has everything in and tells them what to do, but they [staff] always talk to me and ask me what I want doing, out of courtesy I suppose or encase anything has changed maybe?". A third person told us, "I see the same girls [staff] regularly, so they have got to know me by now, but they always check if there is anything else I'd like". We saw that people were encouraged to offer their feedback on the service they were receiving and to make any suggestions or changes to their care.

Everyone we spoke with told us that staff supported them to remain as independent as possible and they received the help they needed, when they needed it, in the way they wanted it. One person said, "I am able to do a lot for myself, so they just help me with the bits I can't manage, like washing and drying my back". Another person told us, "They [staff] are good, they do the jobs I need them to and let me get on with the rest… they always ask if there is anything else I need too which is good". Staff we spoke with told us of how they supported people to maintain their everyday skills as much as possible. This corroborated the information we received in the PIR which stated that provider was dedicated to supporting people to

achieve further or maintain their independence.

We found that people were treated with dignity and respect. One person said, "I find them [staff] very respectful". Another person told us, "They are very good (with regards to protecting the person's privacy), they do all the bits I can't reach, but I always do my private areas myself, but if they had to, I know they would be dignified about it". One member of staff said, "We are very mindful of people's privacy, like close doors and windows during personal care and encourage people to do as much as they can for themselves". Another member of staff told us, "I treat people how I would want to be treated, or how I would want my parents to be treated and that is with dignity and respect".

Requires Improvement

Is the service responsive?

Our findings

We found that care plans were not always person centred or individualised to the needs of people. This meant that people were at risk of not receiving the care they required to meet their specific care needs or that staff were not always informed of some of the risks or potential management plans associated specifically to people's health conditions such as dementia, Parkinson's Disease and Schizophrenia. For example, we saw that where a person had a history of suicidal ideation due to an on-going mental health condition. The provider had not included a specific care plan or risk assessment to inform the staff of what this meant for the person, what support they required with this illness or any information to enable the care staff to identify any 'early warning signs' of a potential relapse in this person's mental health and the potential associated risk of suicidal ideation. We fed this back to the registered manager at the time of our inspection and they acknowledged that this was an area in need of improvement.

We found that people and/or their representatives were consulted about their care; this ensured that people received the care they needed in the way they wanted it. One person we spoke with said, "When I first joined, they asked me everything and they wrote it all down; it's in the book for the carers to read; they call me to see how things are going". Another person told us, "I had a review a few months ago to see if I was satisfied with the carers and if anything needed changing". A relative we spoke with said, "Unfortunately, the social worker got the times wrong during their assessment and the care agency took on the care package based on those times but we needed an earlier call, we have called the office and they are trying their best to change things for us, so they are responsive". Another relative told us that their loved one had experienced deterioration in their physical health and that Kensington Care Service Birmingham had been responsive to their changing needs. We saw that staff had spoken to people about the service and engaged in conversations about whether they were happy or if they wanted anything in their care plans to be changed, which were then updated.

Everyone we spoke with and records showed that the provider often asked for feedback on the quality of the service and people were given the opportunity to suggest improvements. One person said, "We have reviews, where they ask us what we think and if we are happy". We also found that the management team facilitated 'spot checks' with the care staff, which involved them asking the service users for their feedback on the quality of the care and support they received. This corroborated the information that had been shared with us by the provider in the PIR.

During our inspection, we saw that the provider had a complaints procedure in place and the registered manager was aware of their roles and responsibilities in managing complaints. Everyone we spoke with told us that they knew how to complain and were confident that any issues would be dealt with quickly and effectively. One person said, "I have never had any reason to complain, but all of the information I need is in the book". Another person told us, "I haven't complained as such, I have called them to raise an issue and things have been dealt with very quickly". The registered manager told us that there were no outstanding complaints at the time of our inspection and we saw that where complaints had been made, these had been dealt with efficiently and appropriately.

Requires Improvement

Is the service well-led?

Our findings

The service was required to have a registered manager in place as part of the conditions of registration. There was a registered manager in post at the time of our visit. Information we hold about the service showed us that the registered manager was meeting the registration requirements of CQC. The provider had ensured that information that they were legally obliged to tell us, and other external organisations, such as the local authority, was passed on. We also found that the provider was working collaboratively with other external agencies, such as social services.

Before the inspection, the registered manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. The information provided within the PIR was corroborated throughout the inspection by the observations we made and by what people told us.

It was evident from speaking with the registered manager, the staff and with people who use the services, as well as from the records we looked at including the PIR, that the provider had some quality monitoring systems in place such as audits of safeguarding, complaints and records as well as quality assurance surveys, which they had analysed and used to inform them of their strengths and areas for development. The registered manager had devised an action plan of improvements they intended to make. This had been developed collaboratively with the operational manager and there was evidence of cross-learning and shared practice with the providers other location in Bristol.

However, we found that these systems had not always identified the shortfalls highlighted during the inspection, such as the need for more person-centred and individualised care plans and risk assessments, as well as outstanding training needs for new members of staff. We fed this back to the registered manager at the time of our inspection and they assured us that these areas for development will be added to the improvement plan and actioned as a matter or priority.

We saw that there was a clear leadership structure within the service which had developed a supportive, open and transparent leadership culture. Everyone we spoke with told us that the registered manager and the deputy manager were 'supportive' and 'approachable'. One person we spoke with said, "They [management staff] have always been very helpful and approachable; they are good at getting things sorted". Staff we spoke with told us that the registered manager had consistently supported. One member of staff said, "It's a really nice company to work for, [registered manager's name] genuinely cares about us and the clients [people], they pay a genuine interest in asking how we are and how the clients are; it is very supportive". Another member of staff said, "We can pop in to the office or call her [registered manager] at any time and we know she will make time to speak to us". A health care professional we spoke with told us about how responsive the registered manager had been to urgent requests for care packages and how their co-operative, helpful and organised manner had enabled them to ensure people's needs were met in the event of a crisis.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-

blowing and that they were actively encouraged to raise any concerns. They told us that they felt comfortable raising concerns with their manager and would contact external agencies if they needed to, including CQC. One member of staff told us, "I know [registered manager's name] would address anything we told them like safeguarding or complaints, but if I needed to, I know I can call CQC or social services". The registered manager told us that they were confident that staff would feel comfortable to raise any concerns with them but they also ensured that all staff were aware of the whistle-blowing policy that was in place. Information we hold about the service showed that no whistle-blowing concerns had been raised.

We asked the registered manager to tell us about their understanding of the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. The registered manager was able to tell us their understanding of this regulation and records we looked at showed us how they reflected this within their practice, in their response to complaints, for example.