Nurse Plus and Carer Plus (UK) Limited

Nurse Plus and Carer Plus (UK) Limited - Ashford

Inspection report

1st Floor, Unit 7
Highpoint Business Village, Henwood
Ashford
Kent
TN24 8DH

Tel: 01233641373
Website: www.nurseplusuk.com

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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**

Summary of findings

Overall summary

Nurse Plus and Carer Plus (UK) Limited Ashford provide care and support to people in their own homes. The service is provided to mainly older people and some younger adults. The service is registered to provide personal care and treatment of disease, disorder or injury. At the time of the inspection there were approximately 360 people receiving support with their personal care and none in receipt of treatment of disease, disorder or injury. The service undertakes visits to provide care and support to people in Ashford, Tenterden, Romney Marsh and surrounding areas. The service can also provide 24 hour support to people.

The service is run by an established 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt their medicines were handled safely. However there were shortfalls in some medicine records and a lack of guidance about some areas of medicine management.

Risks associated with people's care and support had been identified, but not all actions in place were recorded on risk assessments to help ensure people remained safe. People were not fully protected against the risk of infections as there were inconsistencies in staffs use of personal protective equipment.

People were involved in the initial assessment and the planning of their care and support and some had chosen to involve their relatives as well. Most care plans were detailed reflecting people's preferred routines. However not all tasks undertaken by staff were always incorporated into the care plan and not all care plans were up to date reflecting people's current care and support. People told us their independence was encouraged wherever possible, but this was not always supported by the care plan.

People felt most staff were caring and respected their privacy and dignity. However people gave examples where they felt this was not the case.

There were audits and systems in place to monitor that the service ran efficiently. These had been effective in identifying the shortfalls highlighted during this inspection, but were not effective in driving improvements in a timely way. People felt the timing of their visits, continuity of staff that visited them and communication within the service were all areas that required improvement.

New staff underwent an induction programme, which included relevant training and shadowing experienced staff, until they were competent to work on their own. Staff received training appropriate to their role and a high percentage of the staff team had gained qualifications in health and social care or were working towards this.

People felt safe using the service and when staff were in their homes. The service had safeguarding

procedures in place and staff had received training in these. Staff demonstrated an understanding of what constituted abuse and how to report any concerns in order to keep people safe.

People told us their consent was gained at each visit. People were supported to make their own decisions and choices. No one was subject to an order of the Court of Protection although some people had made Lasting Power of Attorney arrangements and others had a Do Not Attempt Resuscitation (DNAR) in place. Some people chose to be supported by family members when making decisions. The Mental Capacity Act provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager understood this process.

People were supported to maintain good health and they told us staff were observant in spotting any concerns with their health and taking appropriate action.

People told us they received person centred care that was individual to them. They felt staff understood their specific needs relating to their age and physical disabilities. Where there was continuity staff had built up relationships with people and were familiar with their personal histories and preferences.

People had opportunities to provide feedback about the service provided. Complaints had been investigated and responded to appropriately.

There was an open and positive atmosphere in the office and staff were receptive to improving services people received. Changes and new systems were being implemented, which should impact on the quality of service people receive.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were shortfalls in some medicine records and a lack of guidance about some areas of medicine management.

Risks associated with people's care had been identified, but there was not always sufficient guidance about how to keep people safe.

People's needs were met by sufficient numbers of staff and these were kept under review. However the timing of visits is an area identified for improvement.

Is the service effective?

Requires Improvement

The service was not always effective.

People's care and support was not always delivered by familiar staff. Staff had received appropriate training and support in order to meet people's needs.

Staff encouraged people to make their own decisions and choices. People's arrangements for decision making and legal powers in place were recorded.

People's health needs were met and staff were observant in spotting concerns and took appropriate action.

Is the service caring?

Requires Improvement

The service was not always caring.

People felt most staff were caring and respected their privacy and dignity. However there were examples where this had not been the case.

People felt their independence was encouraged.

Some people talked about staff that went that extra mile and made a difference to their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans detailed their preferred routines. However they were not all up to date and some tasks undertaken by staff or the details about what people could do for themselves were not always included, to aid consistent care and support.

People had opportunities to feedback their views on the service provided.

People were not socially isolated and some felt staff helped to ensure they were not lonely.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were audits and systems in place to monitor the quality of care people received. However action taken had not driven improvements to ensure compliance and that people received a quality service.

People felt communication with the office was polite and courteous, but felt the timing of their visits, continuity of staff and communication within the service all required improvement.

There was a registered manager who was supported by a team of senior staff team who worked hard to deliver a service to people. The registered manager and senior staff were open and receptive to driving improvements.

Nurse Plus and Carer Plus (UK) Limited - Ashford

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 checked 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 31 October and 1 and 2 November 2016 and was announced with 48 hours' notice. The inspection was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience of caring for a family member. This was the first inspection since the service had moved and registered at the new offices in Highpoint Business Village in February 2015.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed this and other information we held about the service, we looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we reviewed people's records and a variety of documents. These included nine people's care plans and risk assessments, three staff recruitment files, staff training, supervision and appraisal records, visit and rota schedules, medicine and quality assurance records.

We spoke with 21 people who were using the service, four of which we visited in their own homes, we spoke with eight relatives, the registered manager, a member of the provider's compliance team and 12 members of staff.

Before the inspection we sent surveys to people who used the service, relatives, professionals who had had involvement with the service and staff. We received feedback from 16 people who used the service, five relatives and 15 staff.

Before and after the inspection we received feedback from six health and social care professionals who had had recent contact with the service.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt safe when staff were in their homes and when they provided care and support. Comments included, "At first there were a few blips because I have to have food before my tablets, but it's all ironed out and can't complain at all now". "When they're in my home, they're very polite". "Yes, I do feel safe". "Oh yes, I do yes. They know what all my needs are and the girls are all clued up to keep me safe".

The registered manager told us staff handled medicines for approximately 260 people. People told us they felt they received their medicines when they should and staff handled them safely. One person said, "They're (tablets) just left out for me because I can't open the packaging and that's actually highlighted in my care plan". Another person told us, "They turn them out for me and make sure I take them". However people were not fully protected against the risks associated with medicine management.

There was a medicines policy in place, which had been recently reviewed. Staff had received training in the management of medicines and their competency was checked by senior staff. The registered manager told us that the training had been changed to include practical examples and experience of administration and recording to increase staffs competency and confidence.

A medicines risk assessment had been undertaken for each person. This identified whether staff were involved with people's medicines and to what degree. People had consented to the arrangements in place by signing their risk assessment.

Medication Administration Record (MAR) charts were in place where staff were involved in the administration of medicines in most cases, but not all. For example, one person's daily reports made by staff showed they had 'applied cream', but there was no MAR chart in place so we were unable to ascertain what had been applied or why. In other cases MAR charts did not always reflected that medicines had been administered or a code entered as to the reason they were not, so we were unable to ascertain whether people had received their medicines. In some cases daily reports made by staff showed that topical medicines had been applied, but the MAR chart had not been signed. One person was prescribed a medicine with a variable dose (one or two tablets), but staff were not recording how many tablets they had administered so we were unable to ascertain exactly what medicine had been administered.

Where people were prescribed medicines on a 'when required' or 'as directed' basis, for example, to manage pain or skin conditions, there was not always clear individual guidance for staff on the circumstances in which these medicines were to be used safely, where (for topical medicines), when (they should be given or applied) and when they should seek professional advice on their continued use. In some cases there were body maps in place showing where creams should be applied, but this was not consistent and not all the creams were always detailed on the body map. This could result in people not receiving the medicine consistently or safely.

Risks associated with people's care and support had been identified. For example, risks in relation to

people's environment, falls, skin integrity and moving and handling people. The provider had introduced a 'TILE (Task Individual Load Environment) assessment' and these described the personalised way to move the person safely. Where health professionals had been involved in the assessments they had developed guidance, which was also included in the care plan. One person had a catheter in place. However actions taken by the staff to mitigate the risks in relation to this were not all recorded in the assessment, such as monitoring the output and colour of urine. Also there were no details about when staff changed the catheter day or night bag.

People were not fully protected against the risk of infections. Eight people felt the staff did not do all they could to prevent and control infection, for example, by wearing gloves and aprons. Some of those people felt staff wore gloves, but not aprons. During the inspection we observed two staff arrive to undertake a personal care visit, which involved toileting the person, both staff told us they did not have any aprons with them and this was their normal practice for this visit. When we spoke to other staff later we found that the use of gloves and aprons was not consistent and not always in line with the staff training or the provider's policy.

The provider had failed to have proper and safe management of medicines. The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. The provider had failed to mitigate risks in the prevention and control of infections. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had a risk assessment in place in the event of emergencies that might affect the service. These included bad weather measures, such as access to 4x4 vehicles and staff working locally to where they lived, to ensure people would still be visited and kept safe.

People were protected by robust recruitment procedures. We looked at three recruitment files of staff that had been recently recruited. Recruitment records included the required pre-employment checks to make sure staff were suitable and of good character.

People had their needs met by sufficient numbers of staff. Staff felt there was sufficient staff to meet people's needs. The registered manager kept staffing numbers under review and had an ongoing recruitment programme in place and turnover of staff was low. The registered manager told us approximately 70 percent of people's visits were allocated permanently to staff schedules and these were only then changed when staff were on leave or sick. The other 30 percent were scheduled each week, which may impact on the timing of people's visits and also on the continuity of staff undertaking the visits. Staff told us they usually worked in one geographical area. Records showed that staffing numbers had steadily increased month on month since February 2016. There was an on-call system covered by senior staff, which had the support of management.

People had very mixed opinions about whether staff arrived on time. Some people told us that staff "on the whole" arrived when they were expected barring emergencies. Some people said, that when their "regular" (staff member) was off or at weekends things "tend to go to pot". However 13 out of 50 people and relatives felt that staff did not arrive on time. Comments included, "I don't bother phoning (when they are late) because I try to be independent, so by the time they get here I don't need them anymore". "The weekend carers can be very late, up to two hours on a Sunday. They just turn up when they do". "That's something (arriving on time) I have problems with. Every third Monday out of the month I go out to a club with my (family member). I'm picked up by transport, but sometimes if the carers are late coming, they're rushing to get me ready". "They're a lot better now 'cos I think they've been getting extra staff". People also had mixed opinions about whether they were advised if staff were running late. Some people told us they felt a lack of

travel time on staff schedules was responsible for them being late and some staff agreed with this. A high number of people contacted were not satisfied that staff arrived on time and this is an area we have identified that the provider could make improvements. Most people said staff "usually" stayed the full time or did all the tasks required. One relative told us staff did not stay the full time; records confirmed this to be the case and the registered manager agreed to look into this.

People were protected from harm or abuse by staff. There was a safeguarding policy in place. Staff had received training in safeguarding adults; they were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. The registered manager was familiar with the process to follow if any abuse was suspected; and knew the local Kent and Medway safeguarding protocols and how to contact the Kent County Council's safeguarding team. Where the safeguarding had related to poor practice by staff the registered manager had taken appropriate action to protect people, including monitoring staff closely and further training for staff.

Requires Improvement

Is the service effective?

Our findings

Most people and their relatives were satisfied with the care and support they received, although some people felt "some staff are better than others". Comments included "I am very satisfied". "Yes, they do pretty well". "I'm satisfied with how things are. It's a great help to me". "The service I'm getting is quite adequate; they're quite good". "They're extremely professional; we have no complaints at all".

People did not always receive continuity of staff providing their care and support. Some people told us they did have regular staff on the whole, but others told us "We have a lot of different ones. There are a lot of new ones coming". Other people commented when their regular staff member was on a day off or on leave they "had all different ones" and did not like that. Records confirmed that some people did not receive good continuity. One person who required two staff on each visit and had four visits a day (eight visits a day) had had eight different staff in a day. Another person had 42 visits a week and 17 different staff and a third person had 28 visits in a week by 18 different staff. Two health care professionals also felt that continuity needed to improve and better continuity would result in people receiving a better service. Continuity is an area we have identified as requiring improvement. Some people who had requested received a copy of their schedule of visits in advance. People told us when they had not been happy with a particular staff member there had been no problem with changing.

Care plans contained information about how a person communicated and what support was required to enable good communication, such as 'carers must look at (person) when speaking' or 'information may need to be repeated'.

People had signed their care plans and risk assessments as a sign of their consent. People said their consent was also achieved by staff discussing and asking about the tasks they were about to undertake. One person told us, "Yes I make all my own decisions".

Staff were trained in the Mental Capacity Act (MCA) 2005. The registered manager told us that no one was subject to an order of the Court of Protection although 21 people did have Lasting Powers of Attorney arrangements in place and 24 people had a Do Not Attempt Resuscitation (DNAR) order. Information about people's arrangements was recorded during the needs assessment, to ensure people's wishes would be followed and staff acted legally. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager had been involved in best interest decision making and understood the process to be followed.

Most people and relatives felt staff had the right skills and knowledge to provide care and support that met people's needs. Comments included, "Some are excellent". "On Saturday I had (description of staff member); she was lovely and knew what she was doing".

Staff understood their roles and responsibilities. Staff had completed an induction programme, which

included reading policies, attending training courses and undertaking knowledge competency tests and staff also received a staff handbook. In addition staff also undertook shadowing of experienced senior staff until they were signed off as competent in a variety of tasks. The induction training had been increased to ensure it met the Skills for Care Care Certificate, which was introduced in April 2015. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life.

Records showed that after induction staff received an annual update over two days, during this training any staff that had not originally undertaken induction to meet the Care Certificate would receive the additional training to ensure they met the 15 standards. Training included enablement, stoma and catheter care, nutrition and hydration, health and safety, moving and handling, fire safety awareness, emergency first aid, infection control and basic food hygiene. Staff received some specialist training, such as dementia care including dealing with challenging behaviour and diabetes.

The service had approximately 110 staff and 70 had achieved or were undertaking a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard. Staff felt the training they received was adequate for their role and enabled them to meet people's needs.

Staff told us they had opportunities to discuss their learning and development through team meetings, unannounced spot checks, supervision (one to one meeting) and an annual appraisal. Unannounced spot checks were undertaken by the senior staff, these were unannounced, whilst staff were undertaking visits to people. During these observations staff practice was checked against good practice. Team meetings for staff were held. Staff were able to discuss any issues and policies and procedures were reiterated. Staff said they felt well supported.

People's needs in relation to support with eating and drinking had been assessed and were recorded. Most people required minimal support with their meals and drinks if any. People that were at risk of poor nutrition or hydration had food and fluid intake charts in place so this could be closely monitored. Staff talked about one person they supported to eat their meal as this encouraged a better appetite. Staff usually prepared a meal from what people had in their home. Special diets were supported including diabetic diets. People said staff encouraged them to drink and eat enough and would leave a snack or drinks for later. Some people used special cups or a straw, which enabled them to be more independently. People told us and care plans showed that staff left food and drinks to promote a healthy diet and sufficient fluid intake.

People were supported to maintain good health. People told us staff were observant in spotting any concerns with their health. One person talked about when they "passed out" and staff rang the doctor. Staff talked about when they had come across situations when people had been unwell. A staff member had found a person had fallen to the floor when they arrived, they had already pressed their lifeline, but the staff member called them again and was advised an ambulance was on its way, but would take some time, the staff member stayed with the person to reassure them until the ambulance arrived. Another staff member talked about a time when a person was presenting with signs of a water infection so they called 111 and then an ambulance. Some people were diabetics and there was guidance in place about what action should be taken to ensure the person remained healthy. One health professional felt staff were good at making appropriate referrals or contacting them for advice and guidance. Although another felt staff did not always identify issues with equipment when it was no longer suitable for the person. The provider had recently worked with health professionals, such as occupational therapists where people using hoists had been reassessed to ensure they had the most suitable equipment in place.

Requires Improvement

Is the service caring?

Our findings

People were relaxed in the company of staff and told us staff listened to them and acted on what they said. One person said, "Oh yes, they listen totally to what I say".

People felt staff were kind and caring. Comments included, "Yes, I think most of them are. They're all different in little ways, but at the moment they're all kind and helpful". "Oh yeah, especially the one who comes regular; she's only too willing to help". "Yes, they are. But some of them are so much better than others". "Can't fault any of them, all very good". "I can't give them enough praise". "They are nice girls". "The girls are all very good; they take their time, but do an immaculate job". "They're very polite". "They're all pretty caring you know". "The girls that come here I find very obliging".

Two people talked about two isolated incidents where staff had not demonstrated a caring attitude. The registered manager was aware of both these incidents and action had been taken at the time to address this with the staff.

Some people, relatives and a health professional told us how staff complained to them about the organisation of the service and their work or traveling they had to do, which was not professional and these conversations might put people under pressure that staff needed to leave quickly. One person told us, "I've had one girl that gives me the impression she has to be in and out as quickly as possible, but the other girls take their time and do the necessary".

People felt staff treated them with dignity and respect. However one health care professional told us about recent visits they had made to people whilst staff were present and undertaking personal care. They felt staff did not always uphold people's privacy and dignity. For example, not covering a person to ensure their dignity during their personal care routine and transfers and two staff talking about tasks in a way that did not respect the person's dignity and another member of staff that had not respected a person's privacy during their visit.

The provider had failed to ensure that people were always treated with dignity and respect. This is a breach of Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people talked about staff that "Went that extra mile". One person told us, (Staff member) is so caring and understands me. She laughs with me; we get on like a house on fire". A relative talked about a staff member who had "been with us for a few months now and her personality suits, she really encourages (family member). She is brilliant and has got such patience". Another person said, "The one I've got at the moment, she's very, very caring and friendly with it". A relative told us, "One of the carers is an angel; she can get him to do anything".

Two health and social care professionals felt many staff were very caring and the majority had a good rapport with people.

During the inspection the registered manager took the time to listen to feedback and answer people's questions. When people raised concerns or wanted to make changes to better suit them, the registered manager listened, looked at the daily report book to check information and explained what options may be available to improve things for them. We observed two members of staff arrive at a person's home, come in and greet the person one holding their hand for reassurance; we saw the person was relaxed in the company of the staff.

People told us they had their privacy respected. One person told us, "If I'm on the phone, they'll walk out of the room". People told us staff did not speak about other people they visited and they trusted that staff did not speak about them outside of their home. Information within the service user guide confirmed to people that information about them would be treated confidentially. The service user guide was a booklet that was given to each person at the start of using the service, so they knew what to expect.

People told us they received person centred care that was individual to them. People felt staff understood their specific needs relating to their age and physical disabilities. Where staff visited people regularly they had built up relationships with them and were familiar with their life histories and preferences. Care plans contained details of people's preferences, such as their preferred name and information about their personal histories. During the inspection staff talked about people in a caring and meaningful way.

People told us their independence was encouraged wherever possible. Comments included, "Yes. I think the idea is for me to do as much as I can myself and they're there all the time to assist me." "I do as much as I can. I am a very independent person, anything I can do I do myself I want to do". "I think I do as much as I can for myself with them in attendance".

The service had received some compliments letters about the care and support provided. Comments in these included, "I wish to thank your care staff for all their kindness, sensitivity and support shown to my (family member) during the last few weeks of her life, in particular (staff member) and (staff member) contributed so much to her comfort during this sad time". "He was always pleased to see you all". "I would like to thank you all very much for all your help and for all you have done for me". "Thank you so much for all your patience and sensitivity when caring for my (family member). We as a family are very grateful for all that you did over the period of time". "You are a great team, so keep you the good work". "…one of your carers that attended me today. I found she gave exemplary care and I do tend to be fussy".

People told us they were involved in the initial assessments of their care and support needs and planning their care. Some people had also involved their relatives. People told us that senior staff visited periodically to talk about their care and support and discuss any changes required or review their care plan. People felt care plans reflected the care and support they received. The registered manager told us at the time of the inspection most people did not require support to help them with decisions about their care and support, but if they chose were supported by their families or their care manager, and no one had needed to access any advocacy services. Details about how to contact an advocate were available within the service.

Eleven staff were dignity champions and seven staff were dementia friends. Signing staff up as a dementia friend is a national government funded initiative to improve the general public's understanding of dementia. The dignity in care campaign was launched in November 2006 and aims to put dignity and respect at the heart of care services. Dignity champions are staff that believe passionately that being treated with dignity is a basic human right and not an optional extra.

Requires Improvement

Is the service responsive?

Our findings

People told us they were involved in the initial assessment of their care and support needs and in planning their care. Some people told us their relatives had been involved in these discussions. One relative had written a compliment to the service following their assessment commenting, "Thank you very much for visiting my (family member) this morning to discuss (family member's) needs. We really appreciated the time that you took and found the conversation with you very helpful". One person told us, "Yes, somebody came out to discuss all my needs".

The assessment template had been reviewed and updated in April 2016. Assessments were undertaken by senior staff, which included details of other health and social care professionals involved in the person's care and support. People had signed records showing their consent for care and support to be delivered in line with their assessment and care plan.

People felt their care plans reflected the care and support that was delivered. Care plans were developed from discussions with people, observations and the assessment. Care plans should have contained a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. Most care plans we saw contained a good level of detail about people's routine on each visit although reading daily notes by staff there were some tasks undertaken by staff that were not detailed in the care plan. For example, records for one person showed staff were managing the person's catheter care, supporting with oral hygiene and brushing a person's hair, getting the person breakfast or snack and drink, but this was not detailed in the care plan.

In four care plans it stated the people were able to 'assist' with some of their personal care, but did not say how to ensure their independence was maintained. In some cases there was no mention or the 'assistance' required with drying and dressing was not recorded.

When people were supported with continence management there was a lack of detail about people's preferences of their personal care at this time.

Information in the assessment and care plan at times contradicted each other. For example, one record stated the person was a 'diabetic type 1' and in and another was 'diabetic type 2'. Another record stated a person had a stoma, but other records showed they did not.

One person had had their visits increased to include an additional lunch call, but the care plan had not been updated, to show the routine for this visit as it was not the same as the weekend lunch visits they received. Another person had decreased their visits so the teatime routine had changed, but the care plan had not been updated. One person had changed their routine and was having a shower instead of a wash, although the care plan review was booked for the following day. The routine in two people's care plans required review as one appeared to say the person would have their nighty put on whilst suspended in the hoist sling and it was not clear the other person returned to the bedroom from the wet room and was supported to dry and dress on the bed and not in the wet room.

This meant that people would have to explain the changes to their preferred routine to any new staff that visited or would not receive consistent and safe care particularly when a regular staff member did not visit.

The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were not socially isolated. Some people said they looked forward to the staff visits each day and told us this in itself sometimes ensured they were not lonely. One senior member of staff had recently worked with two people to access day care for one person in order to give the other a break from caring. Another relative talked about how they could have a break when the staff visited. Other people had good family support or visitors or were able to get out and about in the community.

Most people told us they knew how to make a complaint and if they had complained previously most felt the service had responded well to concerns raised. The complaints procedure was contained within the service user guide, which people had received a copy of. Folders had started to be introduced in June 2016, which would be located within people's homes containing all their Nurse Plus care records and the service user guide to ensure this information was to hand for people. Records showed there had been 19 complaints since the start of the year, which had been investigated and responded to. Complaints had been about staff conduct and not following the care plan, missed and late calls, continuity and communication with the office and the provider had taken action including further supervision and training and introducing new systems to try and resolve these.

People had opportunities to provide feedback about the service provided. People were asked informally for their feedback during their care plan review visit and also during staff spot check visits. Some people told us they were also telephoned for feedback. Quality assurance questionnaires were sent out annually by head office and at the time of the inspection had recently been sent out. The results would then be collated by head office and cascaded to the registered manager. Once this happened an action plan would be put together to address any negative comments and areas that required improvement.

Requires Improvement

Is the service well-led?

Our findings

Most people would recommend this service to a family member or another person although five people told us they would not.

People told us although they did not have any real complaints they felt the organisation of the service, continuity of care and communication were areas that required improvement. Comments included, "The only complaint I have really is communication; it's not there". "The only complaint I've got is the lateness of the carers when I'm waiting to go out on the transport. My regular carer is very good about that". "The only thing I would like pushed forward…I do like this consistency of care. I think the same carer should be given to the same person". "The only complaint I've got is they don't have enough time to get from one to the other; they don't get travelling time and so they've got to cut corners to try and make up, but mine don't". Most staff told us they did not feel sufficient travel time was incorporated into their schedules.

People said that when they phoned the office staff were polite and courteous. However comments included, "They don't always listen to me". "I sometimes feel that the office don't really bother". "Quite a few times I've rung the office about (timing of specific visits). My opinion is that they write it down on a notepad in front of them, but don't take it any further or it may be OK for a couple of weeks, but then it goes back to how it was and I get late carers again on (specific visit)". Staff also told us they would inform the office they were running late, but the message did not always get passed onto the person concerned.

People and/or their relatives completed quality assurance questionnaires to give feedback about the services provided. Questionnaires had recently been sent out by the provider and would be collated by head office. The survey in 2015 showed 93 people responded to surveys sent out by the provider. An average of 76 people rated the areas relating to care staff as good or very good. This averaged dropped when people rated the office staff with an average of 62 rating areas relating to office staff as good or very good. Seventy people rated the overall level of service provided as good or very good. Negative comments related communication, staff not arriving on time and continuity of care.

Health and social care professionals were mixed about the communication within the service. They said senior staff were polite and courteous, but felt the communication between office staff and care workers was poor. For example, when arranging joint visits with the office, care workers were not made aware and as a consequence had started the person's routine that the professional had come to observe. One social care professional felt staff did respond timely to any requests.

Staff felt there was "room for improvement" when it came to whether the service was well-led and well organised. Comments included, "It's not perfect". "Communication and listening to us and service users (are areas for improvement)". "Could be better communication". "Yes it's alright, travel time and backwards and forwards to calls could be better". "Informing the service user when I'm running late could be better".

The system for returning the MAR charts to the office for audit was not always effective. During the inspection we found that some files did not contain MAR charts so we were unable to ascertain whether

some people were receiving their medicines appropriately.

The registered manager told us that the new computer system (people planner) had been implemented. People's visits had been transferred onto the new system and scheduling had been undertaken using this system for the previous three weeks. However although visits had been transferred travel time between visits had not been input onto the system. Most staff also told us that the previous system had not allowed sufficient travel time between visits making them late for visits. The registered manager advised that travel time would be the next step of the implementation and would be in place by the end of November.

Senior management received reports from the registered manager regarding accidents, incidents, assessments, spot checks, care plan reviews, recruitment, training, supervisions, team meetings and appraisals.

A thorough quarterly audit was undertaken by the provider's compliance team. Reports showed the last visit had been during October 2016. This audit looked at records relating to people and staff, staff survey results and complaints. Five people were also telephoned to gain their feedback. The report was based on a traffic light system, when the service had not reached green, action was required and an action plan put together, which was monitored until the next audit.

In addition the service had to submit a quarterly return to the local authority that they contract with to enable them to measure the service quality. The return dated June to August showed there had been a small number of missed and late visits. A social care professional told us there were systems in place to monitor the quality of care, however there had issues around these systems as missed visits had occurred signalling systems were not working. However they felt staff had been working with the local authority to ensure that these risks were reduced and had taken on board concerns raised around the quality of care that was being delivered.

Systems and audits had been effective in identifying the shortfalls, but were not effective in driving improvements through in a timely way to ensure compliance and people receive a quality service.

The provider has failed to ensure that systems and processes were operated effectively to ensure compliance with requirements and people received a quality service. The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The new computer system would in the future be able to identify when staff were running late and had not undertaken a visit within half an hour of the correct start time, helping to reduce the risk of missed and late visits. In the interim, during out of office hours, a system had been put in place where staff telephoned to inform the senior staff on call that a person's visit had been completed where people were unlikely to telephone to say their visit was late to try and help reduce risks.

The registered manager was supported by three field care supervisors and another who was at the time of the inspection was still receiving their training. Field care supervisors undertook initial assessments, care planning and care plan reviews. There were four full time coordinators who scheduled people's visits and undertook the care workers supervisions. In addition the office was supported by a recruitment administrator who also arranged training and a trainer. There were six senior care workers who were shadaowed by any new staff. Coordinators and care workers all worked in geographical areas to aid consistency and effective working.

People spoke well of the registered manager. Comments included, "She's quite good and will get things

done". "Extremely decent. She certainly knows her job". A social care professional told us when they had had dealings with the registered manager and office staff they were polite and appeared to have a good understanding of the person (they were discussing). The registered manager had recently been awarded the Kent Homecare Registered Managers award for 2016.

Staff generally spoke well of the senior staff team and said they listened and dealt effectively with any concerns. Comments included, "They are very good, very approachable", "Most of the time they are approachable, but sometimes they are under pressure and then not so". "This is one of the best care companies and they do try their hardest". "I'm very happy with Nurse Plus". "They are available, listen and understand".

The provider had signed up to the Social Care Commitment. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. It is a Department of Health initiative that has been developed by the sector, so it is fit for purpose and makes a real difference to those who sign up. Made up of seven statements, with associated 'I will' tasks that address the minimum standards required when working in care, the commitment aims to both increase public confidence in the care sector and raise workforce quality in adult social care.

The provider was a member of the Kent Integrated Care Association, the Contractors Health & Safety Scheme (CHAS) and the Recruitment and Employment Confederation (REC). These memberships, the internet and attending managers' meeting within the service and meetings with other stakeholders, such as social services was how the registered manager remained up-to-date with changes and best practice.

The provider's values were included in the service user guide and staff handbook. Staff were not aware of the actual values of the service, but told us the service promoted good quality care, privacy and dignity and respect and independence. Staff felt the changes that were being implemented were for the better. Staff said they understood their role and responsibilities and felt they were well supported. There were systems in place to monitor that staff received up to date training, had regular team meetings, spot checks, supervision meetings and appraisals, when they could raise any concerns and were kept informed about the service, people's changing needs and any risks or concerns.

Staff had access to policies and procedures via the office or their staff handbook. These were reviewed and kept up to date. Records were stored securely and there were minutes of meetings held so that staff would be aware of up to date issues within the service.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. Regulation 9(3)(b)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were always treated with dignity and respect. Regulation 10(1)(2)(a)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to have proper and safe management of medicines. The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. The provider had failed to mitigate risks in the prevention and control of infections.. Regulation 12(2)(b)(g)(h)