Agincare UK Limited

Agincare UK Medway

Inspection report

Nelson Court Care Centre
Nelson Terrace
Chatham
Kent
ME5 7JZ

Tel: 01634405850

Date of inspection visit:
09 May 2018

Date of publication:
17 July 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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

The inspection took place on 9 May 2018. The inspection was announced.

This service is a domiciliary care agency. It provides personal care to any adults who require care and support in their own houses and flats in the community. Not everyone using Agincare UK Medway receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of inspection, although the service supported approximately 250 people in total, only approximately 60 people were receiving personal care in their own homes.

A registered manager was employed at the service by the provider. 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.

At our last inspection on 23 February 2016, the service was rated as 'Good'. At this inspection, we found that there were now areas that required improvement. This is the first time the service has been rated 'Requires Improvement'.

Individual risks were not always identified in order to ensure measures were in place to help keep people safe and prevent harm. Environmental risks inside and outside people's homes were highlighted to keep people, staff and others safe from hazards.

Accidents and incidents were recorded by staff but not always followed up by the registered manager to identify themes and ensure appropriate action had been taken and to learn lessons.

Some areas of the management of people's prescribed medicines needed improvement to ensure people received their medicines in a safe way at all times. Gaps were evident in medicines administration records (MAR). Creams were not always applied as per prescription or with the advice of a healthcare professional. It was not always clear whether staff were expected to sign their name when prompting people with their prescribed medicines.

A safeguarding procedure for staff to follow should they have concerns about people was available to staff. People told us they felt safe and knew who they would talk to if they did not.

The provider and registered manager followed safe recruitment practices to make sure only suitable staff were employed. Enough staff were available to be able to run an effective service and be responsive to people's needs. Most people told us that staff were on time when visiting and always stayed to support them for the whole time they were allocated. Staff had suitable training at induction when they were new as well

as continuing regular updates.

Most staff training was up to date, however, staff did not have their competency checked when administering peoples' prescribed medicines to ensure they continued to carry out this task safely.

People told us they made their own decisions and choices. The registered manager understood the basic principles of the Mental Capacity Act 2005 and made sure their processes upheld people's rights.

People were supported with their nutrition and hydration needs where necessary, although many people did not require this assistance. People and their relatives told us they were happy with the support given by staff.

Many people did not require the assistance of staff to take care of their health care needs as they either managed this themselves or had a relative or friend to help. Where assistance was required, people told us staff were observant and willing to help to refer or make appointments with healthcare professionals.

The caring approach of staff was evidenced by people and their relatives making positive comments about the staff who supported them. People told us they had regular staff providing their care and support who had got to know them well, creating confidence and trust. People were given a service user guide at the commencement of their care and support with the information they would need about the service they should expect.

An initial assessment was undertaken of people's personal care needs so the registered manager could be sure they had the resources and skills available to support people. People had a care plan to detail the individual support they required as guidance for staff, however the information in the care plan was not always consistent with the care given by staff and recorded in the daily records. Care plans had not always been responsive to people's changing needs as reviews had not been carried out regularly to update the plans.

The provider had an up to date complaints procedure and people told us they would know how to make a complaint. Complaints made had not always been followed up by the provider or registered manager to ensure actions were taken and lessons were learnt in order to make improvements. We have made a recommendation about this.

Although the provider had auditing systems in place to monitor the quality and safety of the service, these were not always used effectively to identify where improvements were needed and take action.

The provider sought people's views of the service on an annual basis. Most feedback was positive, however, it was not evident if action had been taken to respond to areas that required improvement. Regular feedback from people during their care plan reviews had not always been pursued, missing an opportunity to act on comments made.

The registered manager had daily meeting with office staff to aid communication and plan the day. These meeting were not documented so an opportunity was missed to evidence this work and to be able to share the information with the wider staff team. We have made a recommendation about this.

We received good feedback from people and their relatives about the running of the service, particularly about their regular care staff.

During this inspection, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version 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.

Individual risks were not always identified to help protect people's safety. Risks to the environment were checked to keep people and staff safe. Accidents and incidents were not always followed up by reviewing people's care to keep them safe.

The administration of people's prescribed medicines within their home was not always safe, some areas needed improvement.

Staff knew how to keep people safe by following the safeguarding procedure and reporting any concerns they had.

Robust recruitment practices were in place to safeguard people from unsuitable staff. Sufficient staff were available to provide the support required.

Is the service effective?

Requires Improvement

The service was not always effective.

People had an initial assessment to determine the care and support they required from staff. Individual care plans that were in place were not reviewed regularly to provide up to date information.

Some staff had received one to one supervision. Observational checks to monitor staff competency had not been carried out regularly. Suitable training was provided to develop staffs' skills appropriately.

People had control over the choices and decisions they wished to make.

Staff provided the support people required with their meals and fluids as well as their health.

Is the service caring?

Good

The service was caring.

People were complimentary about the staff who supported them, finding them kind and caring.

People and their relatives were involved in their assessment and care planning process.

People were given information about the support they received and the standards they could expect from the staff.

People experienced care from staff who respected their privacy, dignity and independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person centred as regular reviews had not been carried out to ensure the support people required and wished for was up to date and in line with their changing circumstances.

The complaints procedure gave people the information they needed to know. Complaints made had been responded to but not always followed up to ensure actions were taken and outcomes were met.

Is the service well-led?

Requires Improvement

The service was not always well led.

Monitoring processes were in place to check the safety and quality of the service. However these had not been effective in identifying areas that required improvement.

Feedback was not always sought according to the providers processes.

Staff meetings were held although these were not always documented to show the discussion made and actions agreed.

Agincare UK Medway

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 May 2018. The inspection was announced. We gave the service 48 hours' notice of the inspection visit because it is a care agency and the registered manager is sometimes out of the office. We needed to be sure that they would be in.

The inspection was carried out by two inspectors and two experts by experience. The experts by experience made telephone calls to people and their relatives to gain their views of the service provided. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

We spoke with 14 people who used the service and four relatives, to gain their views and experience of the service provided. We also spoke to the registered manager, the deputy manager and two staff. We also received feedback from a local authority officer.

We looked at six people's care files, medicine administration records, five staff records including recruitment and training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at surveys returned by people.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with told us they felt safe with the staff who supported them. The comments we received included, "I feel safe with the carers (staff)"; "I have no fear of any of them (staff)"; "They keep me safe and help me to move about without falling"; "I feel very safe with them they know me and I trust them in my home".

Individual risks had not always been identified to ensure staff had the guidance necessary to follow a specific plan to prevent harm. One person told us, "The reason I haven't got bed sores is they look after my skin". However, we found the appropriate records were not in place to ensure all staff knew how to provide safe care. A recognised scoring tool for predicting pressure sores was used to assess people's risk of acquiring pressure sores. One person's score showed they were at 'no risk', however they were prescribed creams for a sore sacral area which was at risk of breaking down. This had not been recognised and therefore a risk assessment to introduce measures to maintain the person's skin integrity was not completed. Another person's circumstances were similar. Staff had assessed the risks to the person using the same scoring tool. Their assessment showed the person was at 'no risk'. However, the person was prescribed two different types of cream that staff applied to their sacral area when assisting with their personal care as they were at risk of becoming sore. Another person, who was cared for in bed was assessed as being at 'high risk', however their assessment had been completed 19 January 2017 and had not been reviewed since that date. An individual risk assessment was not completed to ensure measures were in place to prevent the person's skin breaking down. This meant people were at greater risk of acquiring pressure sores as their specific needs had not been identified or reviewed.

A moving and handling assessment was completed with each person to detail the areas of support required when moving around their home and what equipment they required. The risks associated with moving around were identified and measures put in place to keep people and staff safe. However, the assessment was not always reviewed regularly to make sure staff were aware if any changes were required when they were assisting people. One person was cared for in bed at all times. A moving and handling assessment was in place dated 13 January 2017 and the assessment had not been reviewed since then to show if any changes were necessary to the guidance given at that time.

People who were at risk of falling over were assessed, this included their history of falls, if they lived alone and the type of support they needed. The assessment helped to determine the level of risk and how to put prevention measures in place. However, some people's assessments had not led to the appropriate measures needed to prevent further falls. One person's records showed they had four falls in the last six months. The guidance when this amount of falls had occurred according to the provider's falls risk assessment was to refer to the GP for a falls assessment or referral to a falls clinic. We could not find evidence that this had happened or reasons why the guidance was not followed.

Accidents and incidents were not always followed up by the registered manager or office staff. Staff had completed a wound assessment for one person on 6 March 2018 as they had found many small blisters that had 'popped' on their left leg. A body map showing the area affected had been completed by the staff

member. The staff member recorded in the daily notes they had asked the person's family member to request a GP appointment. The staff member recorded in the daily notes the next day that the family member had told them they had arranged a GP appointment. However, there were no further records made regarding the person's condition and if the GP had advised any treatment. An incident record showed another person had caught their leg in their bed base sustaining a cut to their leg which was bleeding. The incident was reported and recorded appropriately by staff. No changes were made to the care plan or risk assessment, which could have helped to prevent a repeat of the incident and keep the person safe. We saw three further significant incident records relating to people that staff had completed, however, care plans and risk assessments had not been reviewed or updated following any of these incidents. This meant that staff may not always have the information they needed to support people appropriately and make sure they were safe.

The failure to ensure records are updated so people receive care that is safe is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people who were at risk of falls but had not actually fallen over had suitable risk assessments in place. One person tended to 'stumble' and was therefore at risk of falls although had not fallen. The person was independently mobile in and around their home, however a risk assessment ensured staff were aware of the possibilities of them falling over while staff were visiting them at home. Another person had a weakness down the left side of their body which meant they could not always stand independently. The person also suffered anxiety attacks. These were clearly identified as risks when the person was being assisted to move around.

A health and safety risk assessment of the environment inside and outside of people's homes was completed before the person's care and support was commenced. The assessor checked the inside environment such as electrical sockets and equipment used, floors, stairs and surfaces and fire safety measures such as smoke detectors. The outside of the environment was checked for uneven pathways, poor lighting and if the property was situated in an isolated area.

People were not always protected from the risks associated with the management of medicines. Not every person required assistance with taking their prescribed medicines as some people could administer themselves or a family member or friend assisted them. Those who did require the assistance of staff had a care plan, however, these did not always include the detailed information needed to enable staff to administer people's medicines in the way they wanted and needed. One person's care plan stated, 'To assist with medicines' and no further guidance was provided. Gaps were found on some people's medicines administration record (MAR). One person's medicines had not been signed for by staff on 16 April 2018. The person should have been administered Atarvastatin, regularly used to help lower cholesterol; Citalopram, used to treat depression; Lansoprazole, used to treat acid reflux disease. There was no explanation recorded why the medicines had not been administered by using a code on the back of the MAR as indicated.

Staff applied creams without signing for them on a MAR. Some creams were applied by staff and there was no record who had advised them to use a particular cream. Staff had recorded in the daily records they had applied pro shield cream to the sacral area of one person on 3 September 2017 and stated there was no MAR available to record this. On 2 August 2017 staff had recorded in the daily record they had applied Anusol cream, however this had not been recorded anywhere within the care plan as being a cream staff should be administering. Daily records showed that staff were applying cream to another person's legs, however there was no record in the care plan that this was part of the person's routine and a care task that staff had been asked to assist with or why they were applying the cream.

A medicines risk assessment was completed with each person who required staff support to take their prescribed medicines. The risk assessment was detailed, providing the information needed to assess the risks associated, including the numbers of medicines taken, the person's mental state, their vision, social circumstance and physical condition. One person's risk assessment showed although they took a number of prescribed medicines, they knew all the medicines they were taking, when they should take them and why they were taking them which meant the risk was reduced. Where people administered their own medicines or had a family member who supported with this, a list of the medicines they were prescribed were included in their care plan. This was meant to ensure staff had access to this information in case concerns arose such as people suffering side effects or requiring hospital admission. However, some of the lists of people's medicines had not been kept up to date. One person's medicines list was dated August 2017 and had not been reviewed. This meant that staff may have access to out of date information which may be used if people were unwell to inaccurately inform health care professionals.

There was some confusion amongst staff when they should sign a medicines administration record (MAR) for people's prescribed medicines. Staff visited one person once a day. The person took their medicines four times a day. When staff were visiting during the morning they reminded and prompted the person to take their morning medicines, staff did not administer them. The rest of the day the person continued to take their medicines themselves. Some staff were signing a MAR that the person had taken their medicines and some staff were not signing the MAR. We spoke to the deputy manager about this and they agreed this could create confusion and as staff did not administer the medicines a MAR should not be in place so it was clear to staff.

The provider and registered manager had failed to manage medicines in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. Safe care and treatment.

There was an up to date safeguarding policy in place which included information on how to report safeguarding concerns and the local authority safeguarding process. An up to date whistle blowing policy gave staff the information they would need if they wished to raise concerns about staff conduct within the service externally. The registered manager had appropriately made referrals to the local authority safeguarding teams when concerns had been brought to their attention.

People told us staff were usually on time, except on some occasions due to traffic or public transport issues. People told us, "They (staff) are on time most of the time. They may leave a bit early if they are in a rush"; "They (staff) are on time and stay as long as they should"; "The majority of carers (staff) are on time. Those who have to walk are often late because of relying on buses"; "Carers (staff) are on time and stay their time"; "Usually on time but not always depends who it is". People had mixed experiences of whether they had regular staff supporting them. Some people said they did not have the same staff at one time but this had now changed and they felt better as it made them anxious having different staff coming in to their home. Others told us they still had different staff coming in to their home to support them. People told us, "Last week I got the same ones (staff) all week. It makes such a difference but this week I've had all different (staff) again"; "All the time they send new ones I have to show them what to do"; "I do get different people but I don't mind that".

There were sufficient staff to provide people's assessed care and support needs as people did not tell us they had no staff turning up at any time. Staff usually had sufficient travel time between their care visits to be able to travel from one person's home to the next. Occasionally this had not been calculated correctly, However, most people did not have any complaints about staff being consistently late. The registered manager shared with us that recruiting staff was often a problem. Although they were recruiting new staff

and this was a continuous process, the recruitment coordinator kept on top of it which meant they had enough staff to provide the care and support people needed. The recruitment co-ordinator told us the service worked in partnership with local employment support centres to identify new potential recruits.

The service was following safe recruitment policies and guidance when employing new staff to the service. The service had safe practices to ensure that the staff employed were suitable. Checks had been made against the Disclosure and Barring Service (DBS). A DBS check highlights any issues there may be about staff having criminal convictions or if they are barred from working with people who need safeguarding. Potential new staff provided their full employment history and photographic identification had been checked. The provider had checked two references before new staff commenced employment.

The office was staffed from 08.00 to 18.00 Monday to Friday. Outside of office hours there was an on-call system. The out of hours system was staffed by one staff member who was on duty using a rota system. This meant staff could be contacted when necessary. There was a business continuity plan in place. The plan identified risks and mitigations and listed the contact details for senior staff within the organisation. People's contact details and staff details were recorded in the on-call file which was kept away from the office by the staff member on-call.

Requires Improvement

Is the service effective?

Our findings

The people we spoke with told us that staff supporting them knew what they wanted and how to support them. The comments we received included, "I know they're coming and what they're doing. They get on with it"; "Carers (staff) asked how I liked things at first, but now they know what I want as well as I do"; "I think they (staff) know what they are doing. They tell me they have ongoing training"; "They (staff) do all seem well trained, they know how to speak to me and how to ask if its ok when I'm in the shower"; "Sometimes they (staff) will shower me and wash my hair, I have choices it's up to me"; "The regular ones (staff) I have seem to know what they are doing, they are experienced". A relative said, "I would say they are well trained from what I see, they seem to know what they are doing anyway".

A brief summary of the care and support people were assessed as needing and how they wanted it was recorded in their care plan. However, the records did not always provide the guidance and detail staff would need to support people consistently. This meant that what staff recorded in daily records was not consistent with the information in the care plan. For example, one person's daily plan, documenting the support they needed each day and the times staff visited said, 'Assist with washing and dressing' every day. The person's personal care plan stated, 'I am independent but may require assistance'. No further guidance was given for staff to describe what assistance may be needed and when or how they would know if assistance was needed. The person's plan also stated, 'To prepare food and drink'. No further instruction or guidance was given to enable staff to provide the appropriate support as required. This meant that new staff may not have the information needed to support people appropriately with their assessed needs.

Staff wrote in one person's daily records more than once that they were concerned the person had been eating chocolate or sweets. However, the reasons for their concerns were not clear as their initial assessment documented they were 'borderline diabetic'. No further reference was made throughout the care plan of the care the person needed to take with their diet and the signs to watch out for if their health changed. The risks associated with diabetes were not identified in a risk assessment to provide the guidance for staff to support the person with the measures they needed to take to prevent a deterioration in their health. The person's assessment recorded they required assistance with eating and drinking but did not give any guidance for staff regarding the diet they should be encouraged to follow. Staff did have concerns around the person's diet as they often recorded in the daily records that the person was eating breakfast cereal on the arrival of staff at tea time. However, no further action was recorded as having been taken such as suggesting a referral to a healthcare professional for advice. Another person's daily records showed they had refused their care visit five times in April 2018 as they were in severe pain. Staff had made reference to the person being in pain when they did visit at other times through April. No record was made of any action taken by staff regarding this concern. For example, records did not show that the information had been passed to the registered manager or deputy manager, or if discussions had been held with the person's main care giver or a health or social care professional. Staff were recording in one person's daily record that they had an incontinence pad in place or that staff had supported the person to change their pad. However, there was no record in their care plan that they required continence care and staff were required to support them with this. Their care plan stated, 'I am independent' with reference to continence care. This meant that people may not get the appropriate support to meet their needs as records were not consistent in providing

the information staff needed to follow.

The failure to ensure people's care documents are accurately recorded in order to provide consistent care that meets their needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although most staff training was up to date, one staff member who was a field supervisor and responsible for observing staff to assess their competency when carrying out medicines administration and moving and handling had not updated both of these training sessions themselves. This meant they may not be competent to assess other staff's safety. The provider could not demonstrate that they had systems to ensure that staff were competent to administer people's prescribed medicines or undertake manual handling safely. The provider's policy stated they undertook competency assessments for medicines administration and manual handling every three months. Records were not clear that assessments undertaken with staff were an observation of staff carrying out the task. Observations were not always scheduled at a time when staff were undertaking the specific task they were to be observed for, such as administering medicines. Where a competency assessment could not be undertaken as an observation the registered manager told us that the assessor discussed manual handling or medicines administration with the staff and awarded a basic competency level. This meant staff may not have the level of practical competence required to carry out these important tasks safely. On 18 April 2017 one staff member had an extra coaching session for medicines administration due to errors they had made being spotted in the medicines audit. We noted the staff member completed annual medicines training on 1 March 2017 and 2 March 2018. However, no observation had been carried out to ensure their training had been successful in increasing their competence. Their last observation when administering medicines was 18 January 2017. The registered manager and deputy manager told us that they relied on information from competency assessments and MAR audits to identify where further training or coaching was needed. However, competency assessments were not undertaken regularly for the registered manager to be assured of the safe administration of people's medicines. This meant that people may not be administered their prescribed medicines by staff who were deemed competent to do so.

The failure to ensure staff have the skills and competence to undertake their role in providing safe care is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that new staff had a period of shadowing more experienced staff before they carried out tasks on their own. During the induction period, staff had two appraisals before the end of the probation period to check they were coping well with their new role and were competent to complete their probation and become a permanent member of staff. On completion of the probationary period, staff were able to apply to complete a National Vocational Qualification (NVQ). An NVQ is a work based qualification which recognises the skills and knowledge a person needs to do a job by demonstrating and proving their competency.

The Mental Capacity Act 2005 (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 people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People gave their consent to the care agreed with the service and to the care plan and risk assessments undertaken. People signed to confirm their consent. Where people were thought not to have the capacity to consent to all or some parts of their care, a mental capacity assessment was undertaken. This meant that discussions and decisions about people's care were taken in their best interests.

Many people did not need the assistance of staff to support them with their healthcare, such as making and attending appointments as they managed this themselves or a family member or friend assisted them. However, people told us that staff did check them and help when needed. One person told us, "If I'm unwell, they always keep an eye on me. I couldn't be without them". Another person said, "I had an ulcer on my leg and the carer (staff) noticed it and went to my surgery and asked the nurse to come out and take a look".

Many people could either made their own meals and drinks or had a family member or friend who helped them. Some people required the support of staff to assist with their nutrition and hydration. Where this was the case, people told us they were happy with the support from staff. One person said, "Carers (staff) cook whatever I want". Another person told us, "I don't like microwave meals so the carers (staff) cook something fresh, for example, mash with something. The carer (staff) found some meatballs in the freezer and some sauce today and I am going to have those for a change. They (staff) encourage me to eat and suggest meals".

Good

Is the service caring?

Our findings

People were very complimentary about the staff supporting them and how kind they were. The comments people made included, "I have never met such a nice bunch of people"; "I have been astonished how well I get on with them (staff)"; "They are lovely and so caring"; "The ladies (staff) that come here, even if not the permanent one, are kind and know what they're doing, they don't waste time and they always have time to chat. This is very important because I get depressed"; "There is chat all the time with the carers (staff) as they do their work"; "I've got a lovely bunch of girls (staff), I'm quite happy, really happy with my carers (staff). I can't speak highly enough of them"; "Now I get the same ones it's like my family coming, they know me and my funny ways".

People's relatives told us they were pleased with the staff who cared for their loved ones. One relative said, "The carers are kind. They will make him a cup of tea and have a chat". Another relative told us, "Her regular one is like a family member. She knows mum well, all her likes and dislikes. For instance, they don't have to ask how she likes her tea or how she likes her veg cooked. I hear them chatting to mum and telling her what they are doing".

We heard conversations on the telephone between office staff and people who were receiving care and support in their own homes. The staff were caring in their approach and respectful and courteous while dealing with enquiries on the telephone. We heard the office staff discussing their concerns around one person's manual handling assessment with the registered manager. The conversation was caring in nature about the person and the registered manager suggested advising a second opinion if the person was not happy with their assessment.

Staff supported people to remain as independent as possible in their own homes by helping them to continue to do as much as they could. People told us this was the case and that this was important to them as they wanted to remain in their own home. One person said, "They (staff) allow me to do as much as I can myself" and another person told us," When it comes to washing, I do as much as I can and the carer (staff) does the bits I can't do".

People told us that staff respected their privacy and respected their home when they visited. One person told us, "Yes they have towels ready for me and they close the door, yes they do speak nicely to me I feel respected". Another person told us staff do not talk between themselves when visiting, they said, "Yes they are all very kind and speak respectfully and treat me as a person, they don't talk about themselves they are interested in me".

People and their relatives told us they were involved in their initial assessment and the writing of their care plan. One person told us, "Yes my care plan was done at the assessment at the start and it was updated by a senior member recently, we made a few changes". A relative told us about their involvement, "She does have a care plan which is up to date and I am involved in. I'm quite happy with that". Another relative said, "They did an assessment at the start and we all got together as a family and had our input".

The provider had developed a service user guide which was given to people when they began to receive support from Agincare UK Medway, to provide them with the information they would need about the service and their rights. Information included what they could expect from staff, contact numbers and how to make a complaint.

Requires Improvement

Is the service responsive?

Our findings

People told us staff provided their care and support in the way they wanted. One person said, "They look at the whole of me". Another person commented, "They do things the way I like". A relative told us, "I think they do know what is important to mum, over time they have got to know by her body language if she is unhappy with something".

However, people were not always provided with person centred care and support through an individual care plan that took account of their preferences and wishes. Although people had a care plan to document the care and support they required and at what times of the day, the care plan did not always provide personal and individual information relating to people's needs. Although people were happy with the care and support provided by the regular staff they had, people felt that other staff did not always know their needs. One person told us, "All the time they send new ones I have to show them what to do". One person's care plan relating to their personal care needs recorded they needed assistance having a strip wash and getting dressed in the morning. No further guidance was included for staff, for example, how the person liked their care and support delivered and any preferences they had to ensure staff knew how to support them in the way they wanted.

Care plans had not been reviewed regularly to take account of any changes in circumstances or to check if people wanted to change their support. We spoke to the deputy manager who told us care plans were reviewed once a year unless changes in people's assessed care needs or circumstances changed. One person told us their care plan had not been reviewed, "Last year my sister made a complaint that my care plan was not up to date and a number of things in the folder were incorrect. They did come and do it then". One person's care plan had been reviewed on 28 April 2017, however the review form had not been fully completed. The review document was formatted to enable the staff member completing the review to record the outcomes of the review and if changes had been requested and made, to each section of the care plan. All areas were blank, no outcomes were recorded, for example, boxes intended to be ticked were left blank, such as, 'care is to continue as planned' or, 'a new care plan is to be written'. This meant it was unclear if people's needs had changed or if they had requested changes be made as documents were not completed correctly as intended. We found that people's needs had changed and this had not resulted in a change to their care plan. Staff had recorded in one person's daily record on 11 April 2018 that the GP had visited to assess for the early stages of dementia. No further record was made regarding the outcome of this assessment or when to expect an outcome. Care plans had not been reviewed to reflect the change in the person's circumstances. The registered manager told us they were aware care plan reviews were not up to date and said they were trying to catch up with these since coming in to post.

Staff did review another person's care plan, on 6 February 2018 which stated, 'Legs have changed position and are now unable to move them back, making (incontinence) pad change hard'(sic). The review record stated no change to other areas. A tick box at the back of the record stated 'Care is to continue as planned', and another tick, 'No change required'. However, there was clearly a significant change that affected many parts of the person's care. Staff had recorded in the person's daily records on 29 December 2017, 'Is in pain in a locked position'. Later that day, staff recorded, 'Same position as morning, she was in a locked position'

and 'Same curled position'. However, the care plan review did not take place until 6 February 2018. Daily records after the review on 6 February made no mention of the significant changes following the review to evidence staff had noted the change and were following a new plan when undertaking personal care.

The failure to ensure people's care documents are kept up to date in order to provide consistent care that meets their needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Key information about each person was included in a pen profile so staff had information about people's background and what was important to them. One person had various careers before becoming ill, including managing a public house and training as a hairdresser. This meant staff could engage in conversation and gain an understanding of each individual they supported. Due to the nature of the service provided, most people did not require staff support to attend to their religious and cultural needs. However, this was addressed in their care plan so that staff had an understanding of their needs and could offer support if necessary.

The provider had a complaints procedure that gave the information people or their relatives needed to be able to make a complaint if they wished to. People told us they knew how to make a complaint if they needed to. One person said, "I have had no complaints. It's been fine" and another person told us, "I don't know who the manager is but if I had a complaint I would ask to speak to them". Another person told us they had made a complaint and it had been dealt with to their satisfaction and the matter had been addressed. Two formal complaints had been made since the last inspection. The first, raised by a family member in January 2017 showed that although action had been taken to ensure a member of staff who the complaint was raised about did not return to the person's home to provide their care, no further action was seen to be taken to ensure the opportunity to learn lessons. The second complaint, in January 2018 was again from a family member as their loved one had not been visited during bad weather. The person had not been prioritised for a visit within the emergency plan when they should have been. A meeting had been held with the complainant and a number of actions resulted from the meeting, all to be completed 'As soon as possible'. However, there was no follow up recording made to ensure the actions had been taken.

We recommend the provider and registered manager uses information from a reputable source to review how they fully complete the complaints process and ensure the learning from complaints received is shared with staff.

Compliments had also been sent to the provider by people or their relatives about the care they received from staff. These included the comments, '[Name] is a brilliant carer. So thorough and knowledgeable'; 'The office is very accommodating and we are always told if someone is running late'; [Name] is a fantastic care worker, very bubbly and has a knack of making everyone feel calm and relaxed'.

Requires Improvement

Is the service well-led?

Our findings

Most people thought the service was well run. Although a few people had some concerns about the running of the service these were isolated incidents that other people had not experienced. Most people had not met the registered manager, as the service is large with over 250 people to support. However, many had spoken to the registered manager on the telephone and knew who they were. Most people said that if they had a problem they would have no hesitation in contacting the office or the registered manager. The comments we received from people included, "That [Staff member's name] in the office is very efficient"; "They have stepped up, they are listening and are making a difference now"; "If they could do something better it would be to have the continuity of the same person more often"; "I do know most of the office staff, they do listen and will try to sort out any problems but it's not easy when carers are late or don't turn up".

The registered manager had recently taken up their post, in January 2018. They told us they were still working through a plan of action to address areas they had identified as requiring improvement. The provider had also recently appointed a new regional manager whose responsibilities included the Medway area where the service was situated and was therefore the new line manager of the registered manager. Office staff, including a deputy manager, a recruitment and training manager, two care coordinators and two supervisors supported the running of the service, all of whom had been in their positions for some time. The registered manager told us they had a good support network from the provider's other services and managers across the South East region, attending regular manager's meetings and contact by telephone and email.

An effective system for monitoring the quality and safety of the service provided was not in use. Although some regular audits were being undertaken, these had not been successful in identifying the areas for improvement that we found during our inspection. Care plans were audited every month by a member of office staff. A selection was sampled each month. Although each section was checked to make sure the information was available and correct, very few areas were identified as requiring action. For example, the audits only identified records found to be missing and needed adding to the care plan file, for instance, 'Needs a signed agreement'; 'Needs a file checklist; 'Copy of Lasting Power of Attorney (LPA) needed'. The audit did not check if care plans or risk assessments had been reviewed or if changes were made when necessary.

A medicines audit was undertaken each month. A sample of about 10 MAR were looked at each time. In the November 2017 and February and March 2018 audits gaps were found in MAR charts. Many gaps were noted and action was recorded as taken to identify extra coaching for those staff who had not recorded in the MAR correctly. However, no further records were made to evidence the training had been completed for those staff. A memo from the deputy manager dated 24 April 2018 asked the provider's training department to add four members of staff to the training due to gaps found in MAR's. This meant that although concerns had been identified between November 2017 and March 2018, training was not requested at the time. Records did not show if staff had their competency to administer medicines checked following their training and regularly thereafter. We found concerns with the recording of MAR charts at this inspection so it was unclear if the appropriate action had been taken to improve and if the action identified to retrain staff had a positive

result.

Although questionnaires were available for staff to use at care plan reviews to gain people's views of the service they received these had not been completed with the people whose care plans we looked at. The questionnaires were intended to be used at the time of the care plan review but as these had not been completed regularly, people's views had not been sought as intended by the provider. This had not been picked up in the care plan audits. However, the provider had carried out an annual survey to gain people's views. The amount of people who responded to the survey was 30. Very few negative comments were received, these included, two people who said staff arrived late and one person who said changes had not been made to their care plan. The actions identified as being required was to, 'Book care plan reviews'. There was no indication what the plan or timescales were to complete this action.

The failure to ensure the systems in place to regularly assess and monitor the quality and safety of the service were used effectively is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager held staff meeting for all staff once every six months. The last meeting had been held on 18 April 2018 and included updates from the registered manager as well as what was going well and what was not going well. An office staff meeting was held each morning for 30 minutes to plan the day and catch up on events, however these were not always recorded. This meant that items discussed and actions agreed may not always be followed up to ensure outcomes were met.

We recommend the registered manager gains advice and guidance from a reputable source how to evidence the outcomes of their meetings with staff and how to share these with the wider staff team.

The registered manager attended a number of local forums and strategic events and was developing a plan to work jointly with other local care providers.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The provider had notified CQC about important events such as deaths and safeguarding concerns that had occurred.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their ratings in the office area.

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 and registered manager failed to ensure people's care documents were accurately recorded and kept up to date in order to provide consistent care that met their needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to ensure records were updated so people received care. The provider and registered manager failed to ensure prescribed medicines were administered in a safe way.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to ensure the systems in place to regularly assess and monitor the quality and safety of the service were used effectively.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to ensure staff had the skills and competence to undertake their role in providing safe care.