The Superior Healthcare Group Ltd

Superior Healthcare

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out between 6 and 14 December 2017 and was announced. Notice of the inspection was given because we needed to be sure that people who wanted to speak to us were available during the inspection.

This service is a domiciliary care and nursing agency. It provides personal care and treatment to people living in their own houses and flats in the community. It provides a service to children, younger disabled adults and older adults. Many people using the service had significant and ongoing healthcare needs. There were 52 people receiving a service from Superior Healthcare at the time of our inspection.

The registered manager had been working at the service since July 2017 and was registered with the Care Quality Commission CQC) shortly before our inspection. A registered manager is a person who has registered with the CQC 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 the last inspection on 3 October 2016, we asked the provider to take action to make improvements to the way they assessed and mitigated risks, managed medicines and ensured that information within care plans reflected people's assessed needs and preferences.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions, safe and responsive to at least good. The provider had completed all the actions and the key questions, safe and responsive are now rated good.

The way people's medicines were managed had improved since our last inspection. Guidance was available to staff and people received their medicines as their healthcare professional had prescribed. Medication administration records contained updated guidance to staff and were fully completed. Changes in people's health were identified quickly and staff supported people and their relatives to contact their health care professionals. People were supported to eat and drink enough and prepared meals to their preferences. Staff followed safe practices to prevent infections.

People received care tailored to them. Assessments of people's needs and any risks had improved since our last inspection. Guidance was now available to staff about how to keep people safe and provide each person's care in the way they preferred. Staff supported people to take part in leisure activities they liked and played with children to support their development.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The registered manager knew when assessments of people's capacity to make decisions were needed. Staff assumed people had capacity and respected the decisions they made. When people needed help to make a particular

decision staff helped them. Decisions were made in people's best interests with people who knew them well, including their relatives. The registered manager understood their responsibilities under Deprivation of Liberty Safeguards (DoLS), and had checked to make sure no one was deprived of their liberty.

People told us staff were kind and caring and treated them with dignity and respect at all times. People were given privacy. Staff were kind and caring to people and supported them if they became anxious. Everyone was supported to be as independent as they wanted to be. People who wished to, were supported to develop their independence. People received care in the way they preferred at the end of their life from staff and health professionals.

Staff knew the signs of abuse and were confident to raise any concerns they had with the registered manager and provider. People and their representatives told us they were confident to raise any concerns they had with staff and that any concerns they had raised had been acted on. Complaints received were investigated and responded to. Action was taken to prevent to concerns occurring again and people received an apology.

Staff were deployed in teams to provide people's care and treatment. Staff deployment was based on the needs of the person and the skills and competence of staff. Staff rotas were planned in advance and any gaps of leave were covered. Staff were recruited safely and Disclosure and Barring Service (DBS) criminal records checks had been completed. Staff were supported to meet people's needs and had completed the training they needed to fulfil their role. Checks were completed to make sure training had been effective and staff were competent. Staff were clear about their roles and responsibilities and worked as a team to meet people's needs.

The provider and registered manager had oversight of the service and checked the service people received met the standards they required. People, their relatives and staff were asked for their feedback and any concerns were acted on and used to improve the service. Accidents and incidents had been analysed and action had been taken to stop them happening again.

Staff felt supported by the registered manager, they were motivated about their roles. They shared the provider's visions of a good quality service and were encouraged to be transparent in their communication with people and their relatives. An experienced member of staff was always available to provide the support and guidance staff needed, including outside of office hours. Records in respect of each person were accurate and complete and stored securely.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. We had been notified of all significant events at the service.

Services are required to prominently display their CQC performance rating. The provider had displayed the rating in their public office and on their website.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people had been identified and staff supported people to be as independent and safe as possible.

People were protected from the risks of unsafe medicines management.

Staff knew how to keep people safe if they were at risk of abuse or discrimination.

Action was taken to stop accidents and incidents happening again.

There were enough staff who knew people well, to provide the care people needed.

Staff practice prevented and controlled infection.

Checks were completed on staff to make sure they were honest, trustworthy and reliable before they worked alone with people.

Is the service effective?

Good

The service was effective.

People's needs were assessed with them and their relatives and health care professionals when necessary.

Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. People were supported to make their own decisions.

Staff were supported and had the skills they required to provide the care and treatment people needed.

People were supported to eat and drink enough to help keep them as healthy as possible.

People were supported to remain healthy.

Is the service caring?

Good

The service was caring.

Staff were kind and caring to people and reassured them if they were worried.

People were given privacy and were treated with dignity and respect.

People were supported to be independent and have control over their care.

Is the service responsive?

Good

The service was responsive.

People had planned their care with staff and their relatives when necessary. They received their care and support in the way they preferred.

People participated in leisure activities they enjoyed.

Any concerns people had were resolved to their satisfaction.

People were supported to plan the care they preferred at the end of their life.

Is the service well-led?

Good

The service was well-led.

Checks were completed on the quality of the service and action was taken to remedy any shortfalls.

People, their relatives and staff shared their views and experiences of the service and these were acted on.

Staff shared the provider's vision of a good quality service.

Staff were motivated and led by the registered manager. They had clear roles and responsibilities and were accountable for their actions.

Staff worked with other agencies to ensure people's needs were met.

Superior Healthcare

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 between 6 and 14 December 2017 and was announced. We gave the service notice of the inspection site visit because we needed to be sure that people who wanted to speak to us were available during the inspection.

Inspection site visit activity started on 6 and ended on 7 December 2017. It included talking to and meeting people using the service and their carers, interviewing staff, pathway tracking and reviews of records. We visited the office location on 6 and 7 December 2017 to see the registered manager and office staff; and to review care records and policies and procedures.

We looked at five people's care and support records, associated risk assessments and medicine records. We looked at management records including five staff recruitment, training and support records and staff meeting minutes. We observed people spending time with staff. We spoke with the provider, the registered manager, five staff, and fourteen people who use the service and their relatives.

The inspection team consisted of three inspectors 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. We used information the provider had sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also 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.

Before the inspection we sent surveys to people, their relatives and community professionals who had involvement with the service and staff. We sent questionnaires to nine people and received feedback from three of them. We also received feedback from 28 staff and four community professionals. We sent

questionnaires to nine people's relatives but did not receive any responses

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe in the company of staff and with the care and treatment they received. Several people's relatives told us that they were confident their relative received safe care and treatment from staff at night and this allowed them to rest.

At our last inspection we found that people were not fully protected against the risks associated with medicines management. At this inspection we found that improvements had been made to the way medicines were managed and people were no longer at risk. People and their relatives told us they received the support they needed to take their medicines in the way they preferred.

Previously, we found clear guidance had not been provided to staff about people's 'when required' or 'as directed' medicines, such as pain relief. The registered manager had added specific guidance about each person's medicines to their medicine administration records, including the maximum dose in a 24 hour period and the time between each dose.

At our last inspection we also found that people's medicine administration records had not been fully completed and the application of topical medicines, including creams was not recorded. At this inspection we found that guidance had been provided to staff about the application of topical medicines and applications were recorded. Medicines administration records we checked were fully completed. Any changes to people's medicines were recorded, signed and dated by staff. Medicines were stored according to people wishes. Staff advised people about safe storage of medicines when needed, including medicines which were at risk of abuse.

Staff had completed medicines administration training relevant to their role, including the administration of medicines through a feeding tube directly into the stomach called a percutaneous endoscopic gastrostomy (PEG). Staff's competency to do this correctly had been assessed before they administered people's medicines. Policies and procedures had been updated since our last inspection to reflect the changes in record keeping required by the provider and the latest guidance on managing medicines for adults in community settings.

At our last inspection we found that risk associated with people's care and treatment had been assessed but detailed guidance had not always been provided to staff to support them to mitigate risks consistently. At this inspection we found that detailed guidance was now available to staff in people's homes about how to manage risks. This included the risks associated with the use of medical equipment people used to help them breathe or receive nutrition. Staff had discussed the management of risks with people and their representatives and agreed how these would be managed. For example, one person was at risk if their medicinal equipment was no longer attached to them. One staff member was completing a 12 week competency assessment to reattach the equipment. The person's relative had agreed with the registered manager that they would to be available during period to reattach the equipment if required. The person's relative told us they were satisfied with the arrangements put in place to keep their relative safe. Risk assessments were reviewed regularly and identified changes in the care people needed. Office staff

informed care staff about changes in the way risks to people were managed before each visit by phone. Changes were also recorded in people's records for staff to refer to.

Environmental risk assessments had been completed of each person's home and guidance had been provided to staff about how to manage potential risks and respond to emergencies. People who needed support to evacuate in an emergency had agreed with staff how this would be done. This included how to support people to evacuate their home and the location of essential services such as the water stopcock and electrical fuse box.

Accidents and incidents happened rarely and were used as learning opportunities. Investigations were completed to identify any patterns or trends and reduce the risk of them happening again. For example, one staff member made a medicines error which was identified by another staff member quickly. The staff member was supported to reflect on their practice, identify where things had gone wrong and develop strategies to make sure further mistakes did not occur. Plans were in place to update their training and assess their competency. There had been no further medicines errors.

People told us staff practice protected them from the risk of infection. Staff completed training around infection control annually and were provided with sufficient stocks of gloves, aprons and other equipment to protect people from the risk of the spread of infection. People told us staff wore these when they needed to. Guidance about how to identify the signs of possible infection and the action staff should take if they suspected someone had an infection were included in people's care plans for staff to refer to. Staff had completed food hygiene training when they began working at the service and this was refreshed regularly.

All of the people who responded to our questionnaire and we spoke with confirmed they felt safe from abuse and harm. People and their relatives had been given information about how to raise concerns about their safety with staff and senior staff checked if people had concerns at review meetings. Records showed that the registered manager had acted on any concerns received, had informed the local authority safeguarding teams and acted on their advice. Staff had completed training each year about different types and signs of abuse and confidently described their safeguarding responsibilities to us, including what they would do if they suspected a child or adult was being abused. They felt supported by office staff to raise concerns and were confident that any concerns would be dealt with appropriately. The registered manager was aware of their safeguarding adults and children responsibilities and followed the provider's policies which reflected local authority safeguarding procedures.

People, their relatives and community professionals told us people received their support from familiar, consistent staff. People's comments included, "Staff who come to our home have years and years of experience", "The staff have always been the same. They are well trained and very knowledgeable" and "The nurses are professional and proactive. They naturally fit in well with our family". Staff deployment was planned around people's individual care and treatment needs and the skills, knowledge and experience of staff. A dedicated team of staff with the relevant skills were employed and trained to meet people's complex care and treatment needs. Everyone we spoke with told us they and their relatives were involved in selecting the staff who supported them. Rotas were planned in advance and sent to staff.

People received a service for a minimum of six hours at a time and many people received a service over night. People and their relatives told us staff arrived on time, stayed for the required length of time and had time to meet people's needs in the way they preferred. One person's relative said, "The staff arrive on time and we know who is coming. They do not rush and I have nothing but good words to say about them". Records we looked at showed that staff deployment was planned in advance and action was taken to cover any gaps. Staff worked together in teams to provide each person's service and cover for sickness or holidays

was provided by another staff member who knew the person and had the skills and knowledge to meet their needs, including the registered manager and lead nurse. People and their relatives were informed of changes promptly. An on call system was in operation to support staff at night and at weekends.

Checks were completed on staff to make sure they were honest, trustworthy and reliable before they were employed. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. New staff did not begin working at the service until all the checks had been completed and they had completed training essential to their role. People's needs and wishes were taken into consideration when new staff were recruited, for example, the registered manager actively advertised for staff who could communicate with people for who English was not their first language.

Good

Is the service effective?

Our findings

The registered manager or lead nurse met with people, their relatives and healthcare professionals where necessary, to talk about their needs and wishes before they received a service. An assessment was completed which summarised people's care and treatment needs and how they liked their support provided, including their daily routine, the support provided by their relatives and religious and cultural beliefs. This helped the registered manager make sure staff could provide the care and treatment in the way the person wanted.

Further assessments of people's needs had been completed, such as moving and handling assessments and using specialist healthcare equipment including equipment to help people breathe. These were reviewed regularly with people and their relatives to identify any changes in their needs or guidance from their doctors. Information from the assessments was used to plan people's care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had received training in relation to the MCA. We checked whether the service was working within the principles of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). Where people are at risk of being deprived of their liberty and live in their own homes applications must be made to the Court of Protection. No one had a DoLS authorisation in place. The registered manager understood their responsibilities under DoLS.

Some people were able to make decisions about all areas of their lives without support from staff or others. Staff assumed other people had capacity and supported and encouraged them to make choices, including how they spent their time. Decisions about the care and treatment children received were made by their parents when necessary. One parent told us their child was fully involved in planning how their day to day care needs were met and they made more complex decisions with their child and staff. People's ability to make complex decisions was assessed when necessary. When people were not able to make a decision, decisions were made in their best interests by people who knew them well, including staff, their relatives and health care professionals.

People who were unable to eat or drink received their nutrition through a feeding tube directly into the stomach called a percutaneous endoscopic gastrostomy (PEG). Staff had received training around the use of the PEG and information was available in people's care plans for them to refer to. Information from people's healthcare professionals showed that they were receiving adequate nutrition to meet their needs and for children to grow and develop. One parent told us their child's health care team had recommended a change in the type of 'feed' their child had. They told us they had been reassured about the change when they had

discussed it with the nurses who cared for their child each day. Some people were not able to take anything by mouth, staff knew this and it was clearly recorded in their records. Other people who used a PEG were able to eat a little by mouth to aid their development and were supported to do this safely by staff and their relatives.

Other people told us staff prepared the food and drink they liked, in the way they preferred. One person told us, "I shop online and staff cook what I want. They provide a good cooked meal. They know how to make a nice cup of tea".

Information about people's health needs and treatment was obtained from their health care professionals before they began using the service to make sure it was provided consistently, including how often equipment needed replacing and how this was done. Detailed information about people's health needs and the support they required from staff was included in their care records. Information was also included about people's usual health, such as their usual blood oxygen levels, so changes could be identified quickly and reported to their relatives or healthcare professionals.

Staff supported people who did not have an advocate to make referrals to health care professionals. For example, staff had noted that one person was confused at times had referred them to their GP. They were waiting for an appointment at the time of our inspection. When required, staff accompanied people to see their healthcare professional and stayed with them to offer reassurance.

People and their relatives told us staff had the skills they required to meet people's needs. Their comments included, "Staff are well trained and know what they are doing" and "I think the staff have a good understanding of an older person with dementia".

Staff had received the training they needed to undertake their roles and meet people's individual needs. This included the safe use of tracheostomy and ventilator equipment. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe to help the person breathe. Some people had a ventilator connected to the tube to help them breathe. When staff began working at the service they completed an induction, including shadowing the lead nurse and other experienced staff to get to know their role, the person and how they required their care and treatment provided. Staff's competency to complete each task was assessed to check they had the required skills. For example, staff were assessed by the lead nurse changing a person's tracheostomy tube at least twice before they were deemed as competent. Staff did not work alone until the person, their relative, lead nurse and staff member were all confident that they had the skills needed to meet the person's needs.

Staff had completed the Care Certificate, an identified set of standards that social care workers adhere to in their daily working life. Some care staff also held recognised adult social care vocational qualifications. Vocational qualifications are work based awards that are achieved through assessment and training. To achieve vocational qualifications staff must prove they are competent to carry out their role to the required standard. All staff received regular training and updates. Refresher training for practical skills such medicines administration, prevention and control of infection and meeting people's complex health care needs was arranged to keep staff skills up to date. All nurses, including the lead nurse and registered manager, were supported to develop and maintain their clinical competence and maintain their professional registration. One staff member told us, "I have always found the provider very supportive, providing all the help and training I need to carry out my role efficiently and to a high standard".

All the staff who completed our questionnaire told us they received regular supervision and appraisal which enhanced their skills and learning. Staff we spoke with told us and records confirmed that staff found these

sessions helpful and their confidence had improved. Records of staff supervision we viewed included feedback from the person or their relative and the staff member's line manager, as well as any issues of concern, including stress. Staff discussed the culture of the service, such as treating people with dignity and respect at supervision meetings. They also reflected on what had not gone so well and planned with their supervisor how they could improve their practice, for example additional training.

All staff had an annual appraisal with their line manager when they discussed the staff member's development and identified any training needs. Staff told us they received the training required to develop. For example, one staff member had requested training in care of people living with epilepsy, which they had completed. The staff member told us, "Out of all the places I've worked, this place has supported me the most".

Good

Is the service caring?

Our findings

People and their relatives told us staff were friendly, kind and caring. One person's relative told us, "The staff are caring and the nurses are wonderful". Another person's relative told us the nurse was "like one of the family". Staff told us they had the time they needed to get to know people well.

Staff treated people with dignity and respect. People were referred to by their preferred names and were relaxed in the company of staff. Each person had recently been sent a new folder containing their medicines records and care plans. The folders had been sent to children, rather than their parent as they were the people receiving the service. People had been informed about the new records by senior staff when they visited or spoken to them, everyone we spoke with knew about the new records and what was in them.

Staff knew people well and understood what was important to them, such as looking after pets or spending time in their garden. Staff learnt this from people, their relatives and experienced staff when they began working with the person and did not work with people alone until everyone was confident that they knew the person well. On staff member told us about a child's favourite DVD, their parent confirmed this was their favourite. The child was enjoying watching it when we visited them. Information about people's life histories preferences and aspirations was available for staff to refer to in people's care plans.

They knew what caused people to become anxious and supported them to remain calm. One person's relative told us, "[My relative] gets worked up and can get distressed. The carer provides reassurance and talks to [my relative] nicely and kindly". Staff supported people to understand why inspectors were calling or visiting them. People had been asked about the gender of carer or nurse they preferred to support them. Where people had expressed a choice this was respected.

Staff supported people to develop independent living skills or remain independent for as long as they wanted. Information about what people were able to do for themselves was available for staff to refer to in people's care plans, along with any support or encouragement they needed to develop new skills. One person told us, "The carers ask me what help I would like beforehand". Another person's relative told us, "The staff encourage my relative to have a shower and to do it for them self. They encourage my relative to get dressed. They make sure my relative has got their stick and they encourage them to walk". Staff described to us how they supported one person to control the hoist during moving and positioning.

Staff knew how people let them know about the care and support they wanted and how to chat with them. Staff understood how each person communicated including facial expressions and signs. Other people used technology such as tablet computers or pictures to tell staff what they needed. One person's relative told us, "My relative can't speak. Having a regular carer helps because they can get used to my relative's mannerisms". We observed staff respond appropriately to what people told them. For example, one person became distressed when they saw a staff member. Their relative told us this was because they associated the staff member with complex treatment they did not like. The staff member agreed, explained to the person they were visiting and would not perform any treatment and moved away from them. This reassured the person who calmed and smiled.

People and their relatives told us staff gave people the privacy they wanted, such as leaving the room when requested. They also told us staff closed doors and curtains when supporting people with their personal care, left people alone when they preferred and responded when they called for assistance. One person told us, "They [staff] let me take my calls in private". Personal, confidential information about people and their needs was kept safe and secure. Staff completed training in maintaining confidentiality as part of their induction, and this was refreshed regularly.

Staff had asked people about their cultural and spiritual beliefs and supported people to follow these when they wanted to. Staff respected people's cultural needs when visiting their home. The registered manager had worked with people and their relatives to make sure staff were safe and respected people's cultural needs. For example, it was one person's culture not to wear shoes in their home. Staff needed to wear shoes to help them move the person safely. The person had agreed with staff that they keep a pair of 'indoor' shoes at the person's home which they only wore there. Another person's relative told us staff respected their religion and the way they had chosen to live.

People who needed support to share their views about their care and treatment were supported by their representatives. The provider and registered manager knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Good

Is the service responsive?

Our findings

At our last inspection we found that the provider had failed to ensure that information in people's care plans reflected their needs and preferences. At this inspection we found that the care plans we looked at had been updated and reviewed to make sure staff had up to date information about people.

People and their relatives told us they had been involved in planning their care with staff and this had improved since our last inspection. One person told us, "The arrangement is about what we want and I am more in the driving seat". People and their relatives had taken part in regular reviews and told us staff reviewed people's care when their needs changed. One person's relative told us, "We are involved in planning care. When anything changes we let them know". People now had detailed care plans in their homes which were accessible to staff at all times. These contained information about people's needs and the support they required. This included what people were able to do and how they preferred their support provided by staff.

Parent's told us they worked with staff to provide the care and treatment their children needed. This was clearly recorded in people's care plans so care staff knew what they were responsible for and when to check with people's relative about care that had been provided. Parents and staff also maintained details records of care so each party was clear about the support the child had received, for example how much they had eaten. This was important as some people were on strict eating and drinking programmes to support growth and keep them as well as possible.

Some people used medical aids or equipment to help them manage their health needs during the day and night. Guidance was included in people's care plans about how to use these correctly and photographs of the people using the aids were included for staff to refer to. People and their relatives told us staff supported people to use the aids safely.

Each person had a log book in their home where staff detailed the care and support people had received each day. People and their relatives told us the information in the log books was "very clear" about the care they had received. Staff used the log books to handover important information to the next member of staff. Staff were informed of changes to people's care by the office staff or 'out of hours' support staff.

People's care and treatment routines were included in their care plans. This was important as some people needed specific care at particular times each day. Information was also provided to staff about the flexibility of people's daily routines. For example, one person enjoyed playing computer games with staff when they found it difficult to sleep.

People were supported to continue to participate in activities and leisure pursuits they enjoyed, such as shopping, going out for meals and attending local clubs and day centres. People and their relatives told us this was important to people and they enjoyed going out.

Staff played with children to help them develop. Staff knew children's preferred games and toys and told us

about activities they did together such as painting and 'sensory play'. Information about what children liked to do was included in their care plan for staff to refer to. One child liked staff to sing nursery rhymes to them, details of their favourite rhymes were included in their care plan and their parents confirmed that staff sung them to the child. Another parent told us, "The carer also makes our other children feel really good, they chat to all the children and read them stories".

Staff had planned people's end of life care with them, their family and health care professionals, including consideration of their cultural and spiritual preferences. No one using the service was having support at the end of their life. Staff described to us how they had supported people to stay at home at their end of their life when they preferred. Staff had worked with health care professionals including palliative and community nurses to support people to be comfortable and reduce any pain. Staff knew what gave people reassurance and comfort and made sure they had these things when they wanted them. The provider had an end of life policy and procedure which staff followed.

People and their relatives told us they were confident to raise any concerns they had with the registered manager and staff. One person's relative told us, "I can't fault the quality assurance director, who addresses any concerns I have and is always straight on it". A complaints policy and procedure was available to people and their relatives and had been followed by staff. Four complaints had been received in the 12 months before our inspection and three had been addressed to the complainant's satisfaction. People told us they received an apology from the registered manager and provider when things went wrong. The provider and registered manager used learning from complaints to improve the service people received. We saw that when a complaint had been made about staff not providing care to the standard expected, action was taken to prevent this from happening again, including redeployment or retraining of staff.

One complaint remained on-going. The manager investigating the complaint had kept in contact with the complainant and informed them of each stage of the investigation. The reasons for the shortfall in the expected level of service had been explained and an action plan was in place to reduce the risk of the shortfall occurring again.

Good

Is the service well-led?

Our findings

At our last inspection the service had not had a registered manager since in May 2015. A director of the company was registered to be the manager after our last inspection. A new manager began working at the service in July 2017 and was registered in December 2017. They understood the role of the Care Quality Commission (CQC) and the requirements of the fundamental standards. The registered manager was supported by a lead nurse and the provider. People, their relatives and staff told us the registered manager was approachable. One person told us "I have been very impressed with [registered manager]". A staff member said, "The service is managed well; no improvement is needed".

Since our last inspection action had been taken to improve the effectiveness of the systems and processes used to check the quality of the service. The registered manager and lead nurse led by example and supported staff to provide the service as they expected. This included checking staff were providing care to the required standards by working alongside them and observing their practice and completing competency checks on staffs skills and practice, such as how medicines were administered and how specific care and treatment tasks were completed. Any shortfalls were addressed immediately and discussed at staff supervision meetings.

One of the providers led on quality assurance and visited approximately five people and their families each week. They discussed the quality of the service and encouraged people to raise any concerns they had. Ways to improve the service were agreed with people at the meeting and the provider shared these with office and care staff for action. Changes were checked at the next visit to make sure they had been effective. Records we saw showed that people and their relatives were satisfied actions agreed to improve their care had been taken. People and their relatives confirmed that the provider and other members of the management team visited them to talk about the care they receive and check that it was to the standard they required. One person told us, "I have known [the providers] for a lot of years and we get on well. I have a nice chat with anyone who comes to see me. They have always been quite open. I think the quality is very good."

Checks of records were completed by the lead nurse and other support staff every month. Any improvements needed were discussed with staff and further checks were completed to make sure improvements had been made. This had been effective as we noted that records we reviewed from the previously three months had improved and were complete. People's relatives confirmed that records of the care their loved one received were correct. The registered manager had developed an action plan with the provider to address shortfalls at the service noted at our last inspection. The planned action had been taken, for example medicines management processes had been improved and now reflected recognised guidance. Staff had easy access to information about people's medicines and they were administered in the way people preferred.

The provider continued to be a member of the Kent Integrated Care Alliance and subscribe to the Quality Compliance System. They used these and information from recognised sources on the internet such as the National Institute for Health and Social Care Excellence to keep up to date with good practice and changes in legislation. Staff were informed about changes in the provider's policies and systems by letter and at

training when required. For example, the provider had recently made changes to their medicines policy. Staff had been informed about the proposed changes before they were made by letter. All staff were completing refresher medicines training which included the changes in policy and practice, including new codes on medicines administration records to show when medicines had been administered by peoples' relatives.

The providers and registered manager met weekly with the lead nurses and other office staff to discuss day to day operations and any changes implemented. Care staff met in teams with the people they supported and their relatives when there had been shortfalls noted by either by people or managers. Staff were reminded about what was required at these meetings and improvements in practice were agreed.

It was the provider and registered manager's aim to continually improve the service. For example, plans were in place to introduce a new electronic care planning process to improve the efficiency of communication about people's needs and the quality of the records. People and their relatives had been asked if they would like to trial the new system and six had agreed. Plans were in place to train staff and trial the new system in 2018. The provider was also considering transferring all staff to guaranteed hours contracts of employment. This was to offer loyal staff additional employment security and improve staff retention.

The provider and registered manager had a clear vision of the quality of service they required staff to provide. This included involving people in planning their service, supporting them to be as independent as possible and providing compassionate, dignified care. The provider's visions was shared with staff during their induction and training and discussed as supervision meetings. Staff shared this vision and provided the service as the provider required.

There was a culture of openness; staff and the registered manager spoke to each other and to people in a respectful and kind way. The provider told us it was important that all staff were open and transparent in their communication with people and their relatives. This included telling people at the earliest opportunity about challenges in the service and keeping people informed about action they were taking. One person's relative told us that improvement was required in the communication of some office staff. The provider and registered manager were aware of this and had taken steps to improve the communication skills of all staff. They monitored staff's communication with people and their relatives to make sure improvements were made and were maintained. Staff told us they were clear about their roles and understood what was expected of them. They were reminded at team meetings and during one to one meetings.

Staff were motivated and enjoyed working at the service. They told us they felt valued and appreciated. When compliments where received about a staff member they were passed on to the relevant staff member. Staff told us they were confident to raise concerns and felt sure they would be appropriately addressed.

Staff told us the provider and registered manager were supportive, approachable and open to discussion about the service and suggestions they made. One staff member told us, "I feel very supported in my role, and if there were any problems the office staff would sort it out straight away". Staff members said it was reassuring to have access to support outside of office hours and that they received useful guidance and support when they needed it.

People, their relatives and staff were asked for their feedback about the service each year as well as during quality assurance visits. In July 2017 the registered manager sent a short survey out to a small number of people about the quality of the service they received. They identified that the response had been low and did not give them reliable information about trends and patterns. They planned to send a more

comprehensive survey to everyone in January 2018 using people's preferred communication methods including email and letter. The results for the 2016 service user survey were positive, and any concerns were addressed promptly. For example, comments were made about the training for staff to support people with complex needs. All staff now completed a days training on complex needs as part of their induction. The results of the staff survey were very positive and indicated that staff were confident and felt well supported in their roles. One staff member said, "The staff are included in everything".

The registered manager worked in partnership with local clinical commissioning groups and continuing healthcare assessors to ensure people's needs were identified and resources were allocated appropriately. For example, sharing information about people's changing needs.

Services that provide health and social care to people are required to inform the Care Quality. Commission (CQC), of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. The registered manager knew when notifications needed to be sent and we had received notifications when they were required.

Services are required to prominently display their CQC performance rating. The provider had displayed the rating in the public office and on their website.