We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Affinity Trust - Domiciliary Care Agency West Kent

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Date of Inspections: 15 July 2014
14 July 2014

Date of Publication: July 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

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<td>Care and welfare of people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>✓</td>
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## Details about this location

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<th>Registered Provider</th>
<th>Affinity Trust</th>
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</thead>
<tbody>
<tr>
<td>Registered Managers</td>
<td>Mr Simon Paul Golding</td>
</tr>
<tr>
<td></td>
<td>Mrs Karli Ann Williams</td>
</tr>
<tr>
<td>Overview of the service</td>
<td>Affinity Trust – Domiciliary Care Agency West Kent provides personal care and support for adults with learning disabilities who live in their own homes. It is part of Affinity Trust, which is a national charity providing support for people with learning disabilities throughout the UK.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Domiciliary care service</td>
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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 July 2014 and 15 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information given to us by the provider and talked with other authorities.

What people told us and what we found

This inspection visit was carried out in response to concerns raised during June and July 2014.

We carried this inspection out over two days. This included a visit to the agency's offices on the first day; and a visit to a person receiving support on the second day. We talked with two staff as well as with the manager and the agency's Divisional Director.

We viewed a variety of documentation, which included two care plan files, risk assessments, staff training programmes, safeguarding protocols, and management of accidents and incidents.

We looked at the answers to five questions: Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led?

Is the service safe?
The manager and staff knew and understood their responsibilities to report any safeguarding concerns. The manager liaised appropriately with the local authority safeguarding team for any support or advice; and informed them of any suspicions of abuse. This was in accordance with the multi-agency safeguarding vulnerable adults' protocols and guidance for Kent and Medway. We saw confirmation that all of the staff had been trained in safeguarding vulnerable adults. We spoke to staff who gave clear explanations of the different types of abuse to be aware of, and who knew the action to take in the event of any suspicion of abuse.

Staff had been trained in regards to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). It had not been necessary to submit any DoLS applications.

We saw that the agency had implemented thorough risk assessments for individual people. These contained clear directions and guidance for staff, and explained how to take action to minimise the different risks identified.
We viewed medication policies and procedures, and saw that staff were appropriately trained prior to administering any medicines.

Is it effective?
We looked at two people's care plans in the agency's office, using an agency computer; and we then viewed one of these in the person's own home. We saw that people or their representatives were invited to be fully involved in their care planning and in decisions about their day to day activities.

We saw that people's support plans were put into formats which enabled them to engage with the processes about their care planning. These included the use of pictures, photographs and symbols, to encourage people to take an interest in them. We saw that people's preferences were recorded and were adhered to in regards to their individual care.

People's support plans were fully reviewed every six months, or more frequently if changes were implemented during that time. This ensured that staff were using up to date information.

Is it caring?
We saw that care plans identified people's own preferences, such as the name they preferred to be called by. The staff we spoke to were fully aware of the needs and wishes of the person they were supporting, and worked in accordance with the guidance in the care plan.

We saw that staff knew how to relate to the person in their care. We visited someone who had non-verbal communication, and staff recognised the signs that the person was making, and informed the inspector of their feelings and comments. Staff acted in a friendly and caring manner towards the person.

Is it responsive?
The care plans reflected different lifestyles and activities according to people's choices and wishes. The staff provided support with all aspects of people's needs, such as household tasks; personal care; going out into the community; making and keeping friends; hobbies and interests; and keeping the person safe from harm.

Staff that we spoke to demonstrated that they recognised when the people in their care had worries or concerns, as they saw changes in their behaviour which alerted them that something was not right. This enabled staff to inform senior staff and identify the cause of their changed behaviour, and provide appropriate support to individuals.

Is it well-led?
Staff said that they felt well-supported by the management, and could contact them at any time. Support staff were allocated to people who had similar interests or characters so that they could form suitable working relationships with the people in their care.

Staff had individual supervision with their line managers which enabled them to discuss any training needs or raise any issues. They were also supported through yearly appraisals and through team meetings. Each person receiving care had their own team of support staff, who met together at regular intervals to share changes and ideas about the things that worked well, or any areas of concern.

The manager was able to answer questions about the people being supported, showing
his knowledge and understanding of the people receiving services. He provided documentation without any delay in response to our requests. We saw that the agency had systems in place to protect people’s confidential information, using password protected computers. Staff were taught about the importance of maintaining people’s confidentiality as part of the induction programme.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

| Care and welfare of people who use services | Met this standard |
| People should get safe and appropriate care that meets their needs and supports their rights |

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We viewed two people's care plans in the agency office, viewing them on one of the office computers. We followed this up by viewing the copy in the person's own home. We saw that the copies being used were the same, showing that care plans were kept up to date on the computer system, as well as in the person's own home. The copy in the person's own home was supplemented with an additional 'person-centred plan' which was designed in a format suitable for the person concerned. This included photographs, pictures and symbols to enable the person to take part in their care planning.

Staff said that people did not always take an interest in their support plans. However, the staff still put the plans into an easy-read format to encourage people to view them, as they might change their mind and take an interest in the future. We saw that this was documented in their plans with statements such as "Support staff have explained to me about my plan but I do not have the capacity to understand it"; or "I do not show any interest in my support plan."

We saw that people's care plans contained comprehensive information which included a finance plan, health action plan, behaviour support plan, and communication profile. For example, the health plans provided details of people's medical history; current health concerns; eating a balanced diet; ability and inclination to take exercise; ability to tell staff if they were in pain; and external health professionals involved in their care.

We found that person-centred plans included information about people's background and family contacts; their religious and cultural needs; how to support them with personal care; managing domestic tasks and shopping; and details of work, leisure, and accessing the community.
We saw that plans contained specific preferences, such as: "X likes regular staff, does not like unfamiliar faces"; and "Let me have a bath when I want one." The plans showed if people could make everyday decisions, and if they needed support for making complex decisions.

People had a weekly activities list with a plan for each morning and afternoon. The weekly plans were flexible in relation to people's moods, behaviour and health needs. They included items such as shopping, going for walks, going to the beach or places of interest, visiting the library, going bowling, carrying out laundry, house cleaning, and preparing meals or drinks. We found that these reflected people's on-going development; for example one person had recently learnt how to help to make their own bed, make a cup of tea, and turn on the radio.

We viewed people's risk assessments and found these contained clear information and identified people's individual risks. For example, some people were at risk in the community as they had no road awareness; or were at risk in the kitchen due to equipment such as electrical items and sharp knives. The risk assessments showed how to minimise the risks for the person concerned.

The staff kept daily records of people's activities and behaviours, writing these in a book for each day and night. The provider may find it useful to note that we identified that entries for one person did not contain much detail of incidents during night shifts. The Divisional Director showed that he had already noted this for the person concerned. For example, the staff member had written how the person had behaved, but had not included any actions that they had taken as a staff member to deal with the behaviour.

People were encouraged to socialise and to make and maintain friendships. One of the staff teams had recently initiated a weekly coffee morning at different people's houses to promote more socialisation. This was being well received and enjoyed by the people taking part.
Safeguarding people who use services from abuse  ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

Reasons for our judgement

The provider responded appropriately to any allegation of abuse.

We found that the provider responded promptly to any concerns and carried out thorough investigations in response to concerns raised. For example, a concern in regards to the management of medicines in a person's home had been thoroughly investigated within 24 hours.

The provider contacted the local Kent safeguarding team in regards to any concerns raised which could be abusive. We found that the agency liaised appropriately with the safeguarding team, and fully cooperated with them in investigating any possible abuse.

We viewed the staff training matrix, and this confirmed that all staff were given training in safeguarding vulnerable adults as part of their induction. The first training session was a six hour course, with refresher training as a three hour course. Initial training was followed up with a written 'safeguarding competency assessment'. This included questions for staff to answer in regards to knowing how to access the multi-agency protocols; awareness of legislation and organisational requirements; understanding the definition of a vulnerable adult and what makes them vulnerable to abuse; recognising the signs and symptoms of abuse and neglect; and following appropriate procedures for reporting and recording concerns of abuse. Staff were required to pass this test with a high percentage mark before they were permitted to care for people unsupervised. We saw that staff had regular refresher training in this subject.

We saw that staff training included other relevant subjects, such as managing challenging behaviour; and managing people's finances. People who had behaviour which challenged the service had detailed support plans in place, so that staff knew how to support them effectively. Staff training was 'NAPPI' training – 'non-abusive psychological and physical intervention.' This meant that it relied mostly on distraction and de-escalation techniques, and safe methods of resolving conflict. It protected people from potentially reactive behaviour from staff, as the staff knew how to deal with situations appropriately.
People were protected from financial abuse by detailed money management in accordance with people's different levels of ability. Each person had a financial assessment which identified people's different needs. For example, the assessment might state "X has no numeracy skills and cannot count"; or "X has some numeracy skills, but has no understanding of the concept of money, and does not recognise the different values of notes and coins." We saw that detailed systems were in place to protect people's bank accounts and cash withdrawal; and managing personal monies, budgeting and paying bills. People were encouraged to make their own decisions as much as possible. For example, they might help to choose items for food shopping and put them in the trolley; but needed staff assistance to pay for the goods. All financial receipts were retained and recorded. People's finances were checked weekly by the support manager responsible; and were then checked monthly and six monthly by the manager and senior staff. The agency also brought in external auditors to check people's finance management was being applied correctly.

Staff completed accident and incident reports for any unusual occurrences, such as falls or bruises. These were seen by the staff member's line manager; and all incident reports were reviewed by the manager. This enabled the manager to identify any trends or frequency in regards to accidents and incidents, and to take any appropriate action to follow these up.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✅ Met this standard

This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

❌ Action needed

This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

❌ Enforcement action taken

If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.
**Contact us**

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<th>03000 616161</th>
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<tr>
<td>Email:</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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