Creative Support Limited

Creative Support - Stockport Extra Care Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 and 18 July 2016 and was announced.

We last inspected the service on 21 July 2014 when we found the service to be meeting the requirements of the regulations inspected.

Creative Support – Stockport Extra Care Services (Stockport Extra Care) provides care and support to people living in their own homes based within seven extra care housing schemes. The seven schemes were based in the Edgeley, Marple, Reddish and Heald Green areas of Stockport. The registered office for the service is located at Spey House in Reddish. At the time of our inspection the service was providing support to 132 people across the seven schemes.

At the time of our inspection there was a registered manager in post. 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 this inspection, we identified five breaches of three of the regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to; the safe management of medicines; taking actions to mitigate potential risks; ensuring the competence of staff; record keeping and effective systems to monitor the safety and quality of the service. You can see what action we told the provider to take at the back of this report. We made one recommendation, which was in relation to ensuring all members of staff receive regular supervision.

There was a reliance on the use of agency staff to ensure the service was able to meet all calls. We found there had been a high number of recent medicines errors by agency staff and there was a lack of evidence to demonstrate the provider's process for inducting agency staff had been followed. Whilst people told us they were more recently being supported by the same staff on a consistent basis, they also told us they preferred to receive support from regular staff. We saw evidence the provider was actively trying to recruit permanent staff to the service.

People expressed satisfaction with the service they received from Stockport Extra Care and talked positively about the extra care model of care. People told us they felt staff respected their privacy and promoted their independence, for example, by allowing them time to complete tasks for themselves. People told us the permanent care staff knew them and their routines well.

People who had made a complaint told us the Registered Manager had dealt with their concerns to their satisfaction. We viewed records of complaints, which demonstrated complaints had been investigated, appropriate actions taken and a response provided to the person making the complaint. Everyone we spoke with told us they would feel confident to raise a complaint.

We found medicines were not managed in a safe way. Records were not always current or accurate, and there had been a large number of medicines errors occurring in the service. Medicines audits had not been effective at consistently identifying issues or ensuring actions were taken to improve the safe management of medicines. The provider had also identified concerns in relation to medicines and shortly before our visit had requested assistance from their quality assurance team.

We found there was not always evidence that appropriate actions had been taken to ensure potential risks were mitigated following incidents. For example, a risk assessment had not been reviewed following a person sustaining a fall, and another person's risk assessment had not been reviewed following an incident involving a piece of equipment. The provider took action during our visit to rectify these issues and to improve procedures in place.

We saw staff received training in a variety of areas including safeguarding, moving and handling and dementia awareness. Staff told us the training was of good quality and that they could request to attend training they thought would help them in their role. We saw additional training had been identified by the Registered Manager, including training in pressure care and end of life care, which would help ensure an effective service was provided to people using the service. There were regular checks of staff competence, including checks in relation to specific areas such as maintaining people's dignity.

Records were not maintained consistently to evidence that people had received the support they required with aspects of care such as repositioning. We were able to cross reference these records to daily notes, which did show people had received the care they required. People told us staff would support them to contact a GP if required and we received positive feedback from a district nurse in relation to the support the service had provided to an individual's care they were involved in.

Care plans were person-centred and provided the detail staff would require to provide support in accordance with the person's needs and preferences. We saw care plans had been regularly reviewed and that reviews had involved the person and their relatives where appropriate.

People who used the service and staff told us the Registered Manager and team leaders were approachable and listened to them. Staff told us they felt valued for the work they did and there were regular staff team meetings.

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 consistently safe.

People did not always receive their medicines at the times they needed them or in a safe way. There were gaps in records of medicines administration.

Risk assessments had not always been reviewed following incidents. This meant there was a risk that adequate steps to ensure people's safety had not been taken.

Other than one report of a missed call, we found staff visited people when required and as indicated in their care plans. There was a reliance on agency staff to ensure staffing levels were adequate and the provider was actively trying to recruit additional permanent staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We saw a number of medicines errors had involved agency staff. There was a process in place to ensure agency staff were informed of local policies and procedures, but there was not always evidence this had been completed.

We saw permanent care staff received regular supervision, appraisal and observation of their practice to ensure they were competent.

We saw staff had undertaken training in a range of areas including safeguarding, moving and handling and emergency first aid.

Is the service caring?

Good

The service was caring.

People told us they got on well with the staff supporting them. People said they preferred the support of regular staff, rather than agency staff, but told us they found they were starting to be supported by the same staff on a more consistent basis.

People told us staff respected their privacy and dignity and promoted their independence.

There was evidence that people and where appropriate, their relatives, had been involved in the care planning process.

Is the service responsive?

Good

The service was responsive.

Care plans had been regularly reviewed and contained details of people's preferences in relation to the care they received.

People we spoke with who had raised a complaint told us they had been pleased with the actions taken by the Registered Manager. Everyone we spoke with told us they would be confident to raise a complaint.

People told us care staff turned up for calls on time and would work flexibly to meet their needs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were processes in place to monitor the quality and safety of the service. However, these processes did not always work effectively to ensure improvements were made. Records of care provided were not always adequately completed.

The provider took prompt action in relation to our feedback and findings to make improvements to the service.

Staff, relatives and people using the service spoke positively about the leadership of the service. Everyone we spoke with felt their views about the service were listened to.

Creative Support - Stockport Extra Care Services

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.

The inspection took place on 13 and 18 July 2016 and was announced. The provider was given 48 hours' notice. This was because the location provides an extra care service across several sites or 'schemes' and we needed to be sure that someone would be available at the office to facilitate the inspection and arrange access to records.

The inspection team consisted of two adult social care inspectors, a pharmacist inspector and two experts 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.

Prior to the inspection we reviewed information we held about the service. This included notifications that the service was required to send us in relation to safeguarding, serious injuries and other significant events. We also reviewed the previous inspection report and the Provider Information Return (PIR) that the provider had completed in January 2016. 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.

During the inspection we visited four of the seven schemes where Stockport Extra Care were providing a service. These were Spey House, St. Lesmo Court, Jubilee Court, and Smithy Croft. We spoke with 14 people who were using the service and four relatives who were visiting their family members at the time of the

inspection. Following the inspection site visit we spoke with a further two relatives of people who were living at Birch Court and Portland House.

We spoke with 11 staff. This included the registered manager, two service directors, four support workers, three team leaders and one bank support worker. We reviewed records relating to the care people were receiving including six care files, 13 medication administration records (MARs) and daily summaries of care. We reviewed records related to the running of the service such as records of meetings, quality audits, recruitment records and training and supervision records.

We sought feedback about the service from the local authority quality assurance team, commissioners of the service, Stockport Healthwatch and a District Nurse involved in the care of a person using the service. Healthwatch is the national consumer champion in health and care. We received feedback from the District Nurse we contacted.

Requires Improvement

Is the service safe?

Our findings

Our review of safeguarding notifications sent to us by the provider highlighted concerns in relation to the safe management of medicines. There had been seven notifications that related to medicines errors sent to us in the 12 months preceding the inspection. During the inspection visit, we found that appropriate arrangements for recording and monitoring medicines were not in place.

A service director told us that they had recently identified shortfalls in the way medicines were managed within the service. They told us they had requested further staff training and support from internal quality assurance teams in order to address these shortfalls and concerns. The quality assurance team had visited two days prior to our visit and the service director showed us the action plans they had developed to help the service improve the way carers supported people to take their medicines safely.

Care workers supported people to take their medicines; however, it was not always clear what support care workers needed to offer. There was not sufficient information for care workers to follow to ensure that medicines, including creams and other external products were given correctly and consistently. Without this information, people were at risk of being given too much or too little medicine or having creams applied incorrectly. Care workers sometimes failed to sign the MARs meaning that it was not possible to accurately determine whether the medicines had been used correctly. We asked the service director to look into instances of missed signatures for one person. Following the inspection they told us they had determined the medicines had been administered as required as there had been no additional pharmacy returns, and notes on the daily records of care indicated medicines had been administered.

We found the medicines records and information in place for care workers to follow was incomplete and inaccurate. The names of medicines were often recorded incorrectly and details such as strengths and doses were often not recorded at all. In one case, we saw a person had three inhalers listed on their MARs, but these were not included on the person's 'medication profile'. There was no way to track changes to people's medicines and it was not always clear from records exactly what medicines (including creams and inhalers) people were currently prescribed.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found assessment of risk in relation to the care people were receiving was variable. The provider had carried out assessments of risk in relation to people's care and support needs. We saw these covered a range of areas such as mobility, falls, nutrition and hydration, self-neglect and smoking. Separate risk assessments had also been carried out in relation to moving and handling where the provider had identified a need for such an assessment. However, we saw instances where potential risks had not been identified in the risk assessments and where action had not been taken to review risk assessments following incidents.

We saw an incident report in relation to a fall a person had sustained in one care file. A manager had not signed off the incident report and there was no evidence that any review of the risk assessment or care plan

had taken place following the fall. It was however, acknowledged that in this instance the measures identified to reduce potential risk from falls were still appropriate. In another person's risk assessment, we saw there had been no review of the risk assessment in relation to medicines storage following an incident, although there was evidence in a care plan review that the risk had been considered.

From our review of care documents we identified three people who would have been at risk of skin breakdown or developing pressure sores. This risk was not identified in these individual's risk assessments and there was no clear guidance for staff to follow in relation to actions they should take to monitor people's skin condition or report any concerns. The service director updated the risk assessments during the inspection and sent us a copy of a draft local policy that had been recently developed. This would help ensure the service was able to meet people's support needs in relation to pressure care in conjunction with other health professionals such as district nurses. The registered manager also told us training had been arranged for staff in relation to pressure care, and we saw evidence supporting this. We looked at a fourth care file for someone who was at risk of pressure sores. This contained adequate information in the risk assessment and care plan to help staff meet this person's needs appropriately.

We saw staff had completed an incident report for one person following an accident involving bed rails. We found there had been no assessment of any potential risks in relation to the use of bed rails carried out, and there was no evidence of any regular checks carried out by staff to help ensure they were in a safe condition. There was no action evident by the service to reduce potential risks from the use of the bed rails following this accident. We brought this to the attention of the service director who updated the risk assessment and said they would contact the appropriate services to carry out a re-assessment as to the suitability of this equipment. They told us the senior manager reviewing the incident form had identified an action for the team leader to update this person's risk assessment but that this had not been completed.

These issues in relation to the assessment and mitigation of risk were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The service director informed us Stockport Extra Care was commissioned to provide support to people between 7:00 am and 10:30pm. Outside these hours, some people had night calls commissioned from a Stockport Council service. People also had access to an emergency call service and staff carried out welfare calls for all people living at the schemes on a daily basis.

The registered manager told us there were 20 full-time equivalent vacancies for support workers across the service. They informed us shifts were first offered to regular, permanent staff, before being put to the services bank staff team. If shifts were not able to be covered with regular or bank staff they were then put out to agency staff. We looked at rotas, which showed shifts had been covered and also confirmed there was regular use of agency and bank staff. The registered manager told us recruitment of permanent staff had been challenging, particularly for the services based in the Marple area of Stockport. The provider was carrying out a recruitment campaign and had recently held an event in the local area to try and attract new staff.

Staff informed us there had been one missed call recently. We discussed this with the registered manager who informed us there had been instances when calls had been missed. They told us this was mainly due to agency staff not turning up for shifts. Care staff and people we spoke with told us missed calls were not a common occurrence. The registered manager said a shift co-ordinator monitored the completion of calls by reviewing completed staff allocation forms at the end of every shift. The registered manager and staff had taken appropriate actions in response to the reported missed call such as seeking advice from a health professional in relation to missed medicines and contacting the care agency.

People we spoke with told us they felt staff helped keep them safe. One person told us; "It's a good scheme. I couldn't manage without it. You can't rely on home care. You get help when you need it." Another person said; "I feel safe here. For example, when I am helped to get dressed, the carers make sure I won't fall." Staff had received training in safeguarding and were able explain potential signs of abuse or neglect they would look out for and report to their manager. They told us they were aware they could approach the registered manager or staff at the head office if they had any doubts that their concerns would be acted upon. The registered manager maintained a log of safeguarding concerns reported to the local authority and any actions taken in relation to the concern. This demonstrated that staff and the registered manager were identifying potential safeguarding concerns and were taking appropriate actions to ensure people were kept safe.

We looked at records of staff recruitment and saw evidence that processes were in place to ensure only staff of suitable character were employed. We saw required checks had been completed prior to a member of staff starting work, such as obtaining references from former employers and applying for a disclosure and barring service (DBS) check. DBS checks tell an employer whether an applicant has a police record or is barred from working with vulnerable people. Applicants were also required to complete a health declaration and to attend an interview. We noted that none of the staff files we looked at had a current photo of the member of staff as is a requirement. However, the service director told us staff photos were taken for staff ID badges and held at the head office. On the second day of our inspection, the service director had started to print copies of staff photos to include in their personnel files held at the local office.

Staff we spoke with were aware of appropriate procedures to follow in the event of an accident such as someone sustaining a fall. For example, staff said they would contact an ambulance if required, complete an incident report and inform a manager. One relative we spoke with told us staff had waited with their family member until an ambulance had arrived when they had fallen. We saw copies of incident forms were kept in individuals' care files. Other than the one example discussed earlier in this section, these had been reviewed by the registered manager or another senior manager, and any actions required to reduce potential risk had been recorded. We saw staff had access to a thermometer and they told us they checked and recorded water temperatures prior to assisting anyone with bathing. This would help ensure the water was at a safe temperature and reduce any potential scalding risk.

The service had comprehensive business continuity plans in place that had been recently reviewed. The continuity plans detailed how the service would ensure people's safety in the event of emergencies such as fire, flood or depleted staffing levels. There was an environmental risk assessment in place for each of the schemes that showed consideration had been given as to the safety of the premises.

The housing associations that owned the different premises were responsible for the maintenance of the premises and many of the safety checks required. We saw the registered manager had checked to see that required servicing had been carried out as part of their regular audits.

Requires Improvement

Is the service effective?

Our findings

Due to our finding that a large number of agency staff were used at the service. We asked the service director how they ensured these staff had the required training and skills to meet the needs of people being supported by Stockport Extra Care. They told us the agencies used were 'vetted' by the head office and that they informed the agencies of any training requirements for each scheme, such as hoist and medicines training.

The service director told us all new staff, including bank and agency staff should have a brief induction to the service. We saw copies of forms available to use to induct new staff to the service and to ensure they were aware of key procedures and expectations. However, at the time of our inspection, the provider was unable to locate a record of induction for three of the agency staff working during the period of our inspection. Following the inspection we were sent evidence that one of the three agency staff members had completed an induction. The provider completed an induction for a second member of the three agency staff the day after our visit. However, no record of induction could be located for the third member of agency staff. We reviewed a log of medicines errors and saw eight of the 13 errors recorded in 2016 involved agency staff. Outcomes and learning detailed on the log also indicated the need to ensure adequate induction of agency staff to help ensure they were competent to carry out required tasks, and records did not support that this action had been completed.

This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) 2014 as adequate steps had not been taken to ensure temporary staff received a sufficient induction.

All permanent staff had undertaken mandatory induction training, which covered areas including medicines, first aid, moving and handling, food and nutrition, safeguarding, person centred approaches and health and safety. We saw checklists were used to help ensure staff received essential information they would require about policies, procedures and practicalities. Signed copies of these checklists were kept in staff personnel files. Staff told us they had opportunity to shadow staff that were more experienced before they started lone-working, and we saw their competency had been checked by a supervisor.

Staff told us they received adequate training to enable them to undertake their role effectively, and told us the training was of good quality. Records showed staff had completed training in areas including emergency first aid, dementia awareness, infection control, safeguarding, moving and handling and medicines. Staff told us they could request to attend training that interested them in addition to the standard training. Staff supported people with diabetes and we found applications for training in this area had been made, although staff had not completed this training at the time of our inspection. The registered manager had identified training in pressure care and provision of end of life care was also required to help ensure staff were able to provide effective support to people using the service. This training had not been completed at the time of our inspection, but we saw evidence that steps had been taken to arrange it.

Staff told us they received regular supervision and that they found this a useful form of support. Staff appraisals had been completed, although we found the appraisal documents had been completed to

variable levels of detail. We saw topics such as training, teamwork, confidentiality and any concerns of the staff member had been discussed in supervisions. 'Themed supervisions' in relation to topic areas such as safeguarding, dignity and the Mental Capacity Act had also been carried out. This would help the manager ensure that staff were competent and received appropriate support in these important areas.

There were regular checks of staff competence and practice carried out. We saw that supervisors had provided feedback and discussed areas for potential improvement with staff. This would help staff improve their practice and provide a good quality of support to people using the service. Despite our finding that staff had received adequate support and supervision, we found evidence of support and supervision for one of the team leaders was more limited. There was no evidence of any recent competency checks for the staff member, and records showed supervision had been infrequent. The service director stated that team leaders received support through regular team meetings with the registered manager. However, they also acknowledged that this staff member should probably have received supervision more regularly.

We recommend that the provider ensures all members of staff, including those with managerial responsibilities receive regular, recorded supervision.

We saw information on people's dietary requirements was recorded in their care plans and risk assessment. For example, one person's care plan indicated they required a soft diet and support to receive adequate fluid intake. Staff we spoke with were aware of this person's dietary support needs and records had been kept of food and fluid intake. We noted the intake records did not always accurately indicate how much fluid the person had received. For example, the records often indicated 'sips' or 'half cup'. It was therefore not possible to determine whether the indicated required intake of fluids had been adequate. The service director informed us other people involved in this person's care also supported them to eat and drink, which would help ensure intake had been adequate.

Staff told us any communication or instructions from health professionals would be recorded in the communication book. Staff told us they would call a GP or other professional if they had concerns in relation to someone's health, and relatives and people we spoke with confirmed this was the case. Following the inspection we spoke with a district nurse who was regularly involved in the care and support of a person using the Stockport Extra Care Service. They told us the service had done 'brilliantly' at supporting a person's health care needs, which involved regular repositioning and support with fluid intake. They told us; "They come to us straight away with any concerns, and communication is good."

Five out of six people we asked told us staff always stayed the correct amount of time on calls and completed all tasks that were expected. One person told us; "They [the staff] know what to do and they sit down and have a chat. They always complete any jobs." Another person said; "The staff are trained very well they do all they can for me and have plenty of time." One person's relative told us that whilst they thought the care provided was good and staff turned up on time that they found staff could be 'stretched'. They told us this meant their family member's calls could sometimes be cut short.

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The Registered Manager told us the service was not depriving anyone of their liberty and said that it was unlikely the service would be able to meet the needs of a person who required restrictive practices amounting to a deprivation of liberty. The Registered Manager told us they were aware further work around the MCA was required, such as identifying clearly which people may lack capacity to take certain decisions, and ensuring there were documented best interests decisions in place where required. Staff received training in the Mental Capacity Act as part of their induction and some staff had completed additional more in depth training sessions. The staff we spoke with were able to demonstrate a reasonable understanding of issues relating to capacity, consent and best interests. We saw MCA themed supervisions were scheduled to take place, and some staff had already had these supervisions.

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We saw people who were able to, had signed consent forms in relation to areas of support including key holding, support with medicines, access to records, taking photos and support with finances. These forms had been recently reviewed and indicated people's choices in relation to the level of support they received in these areas as well as their consent to such support. Staff were able to demonstrate an understanding of issues relating to capacity and consent. They told us they would always seek consent before providing care to people and people we spoke with confirmed this was the case. Staff told us they would look for non-verbal signs of consent such as body language if the person was not able to verbally communicate their consent. One staff member told us; "There are lots of different ways people can indicate consent. For example, opening their mouth [when supporting someone to eat]. I always ask and show people first." Staff told us they would record if anyone had declined support and would discuss this with a manager.

Good

Is the service caring?

Our findings

People we spoke with told us they preferred to receive support from regular rather than agency staff. They said they found regular staff knew them and their routines better. One relative told us; "When it is regular staff, [family member] feels a lot more comfortable. The staff she tends to get [staff member names] know her really well, they are amazing. They are all committed and nice with her." Despite a high level of use of bank and agency staff within the service, people told us that more recently they had started to see the same staff on a more consistent basis. People told us they found the regular staff knew them well, and they told us all staff were respectful and caring in their approach.

Comments we received included; "There are some bank carers, but mainly I have three or four regular carers who I am happy with and I feel safe with them;" "They are mostly on time and regular, but there are some agency staff when people are sick or on holiday and they are not as good as the regulars;" "I know all the carers. They are very good, but some are more reliable than others." One relative told us they had found there was now better continuity of staff compared to when the service was set-up around two to three years previously. They told us they thought it was important for their relative to have a consistent group of care staff supporting them due to them living with dementia, and they said they could now feel settled at home knowing their relative was being well cared for. All staff we spoke with told us they would be happy for one of their friends or relatives to receive support from the service.

People told us they felt they had a say in who their main support workers were. We saw people had indicated their choice in relation to the gender of carers who provided support, which was recorded in people's care files. One relative told us; "I think [my relative] does have a say in who the main care staff are. She likes [care staff names] and [staff member] is very good with her." One person told us they had been involved in interviewing potential staff. When asked whether they felt they had had a say in the recruitment process, they confidently told us; "I'm sure I have."

Everyone we spoke with told us the staff supporting them respected their privacy and dignity. People told us staff would always announce their arrival and would treat them considerately and with respect when providing any care. We saw care plans contained information that would help staff ensure people's privacy and dignity was respected. For example, one care plan highlighted that staff needed to be aware that the person used a commode in their flat, and should ensure the person was ready for staff to enter before walking in. We saw it was recorded in a care plan review that this person had confirmed that staff were following this guidance and that they were happy with the support being provided.

People and their relatives (where appropriate), told us they had been involved in developing and reviewing care plans. People said that staff listened to their wishes and they felt they were involved in decisions about how their care was provided. We saw documented evidence of regular care plan reviews where feedback had been sought from individuals.

Staff told us they would encourage people to be as independent as possible by providing prompting and encouragement to people to complete tasks themselves. People we spoke confirmed they were provided

with an appropriate level of support that helped them maintain their independence. One person said; "They let me take my time when I am doing things;" and another person told us; "They try to let me do as much as I can, but I can't open tins. I try to be as independent as possible."

Information on people's communication support needs were detailed in their care plans, which would help staff communicate effectively with them. Staff told us they would understand the needs and wishes of people with limited verbal communication by looking for gestures and other signs of what the person wanted. We were shown a copy of a newsletter produced for the service, which had photos of events that had taken place and had news articles that would help keep people informed about developments within the service.

Good

Is the service responsive?

Our findings

People and relatives we spoke with told us care staff turned up on time, and would work flexibly and stay on longer if there was a particular need for them to do this. One person told us; "They turn up on time. The call times are agreed and set in the care plan." We saw one person's care plan highlighted the requirement for prompt calls due to the requirement of that person to receive their medicines at specified times.

Care plans were fully completed and focussed on the desired outcome of the support provided. For example, one person's care plan identified desired outcomes such as to maintain independence and to be supported to eat a healthy diet. Care plans considered a range of support needs including mobility, mental health, activities, continence, nutrition/hydration and daily living skills. Staff told us they found care plans contained sufficient information to allow them to understand how to meet people's needs. Regular care staff we spoke with told us they had opportunity to review people's support plans before providing support. One person told us; "They do ask me how I want things, but they know what to do and the instructions are on the sheet." However, two other people using the service we spoke with commented that they didn't think agency staff always reviewed their care plans as they would sometimes have to tell them what needed to be done. We saw that staff 'allocation sheets' contained a brief summary of the support people required, and this would help ensure all staff were aware of people's support needs.

Care plans had been regularly reviewed, and any amendments to the care plan had been clearly recorded. We saw reviews had taken place when there had been a change in a person's needs, such as following a hospital admission, and also on a routine basis to ensure they were still reflective of the person's needs and preferences. Staff told us they would always offer people choices, such as what they prepared for people's meals. People we spoke with gave us examples of how staff worked flexibly, such as staff asking if they were ready for bed and coming back later if they weren't. One person we spoke with said; "They are very good carers who go the extra mile for me."

People's preferences in relation to the support they received were recorded in the care plans. For example, one person's care plan documented that they liked staff to prepare their lunch during the morning call so they could choose to eat before their mid-day call if they wished. We also saw records of people's life histories, interests, likes and dislikes were recorded in one page profiles. This would help staff get to know the people they were supporting and would also provide potential topics for discussion. Regular staff we spoke with were able to tell us about the needs and preferences of the people they supported, and this matched what was recorded in the care plans.

Three people we spoke with told us they had raised complaints in the past. All three people said the registered manager had dealt with their complaints effectively and to their satisfaction. One person told us they were happy with the actions taken in response to their complaints and added; "We got a written letter of apology from [the Registered Manager], which I thought was good and it was dealt with properly." We saw a record of complaints and investigations was kept, along with a summary of any complaint raised and the actions taken to address the concern. The Registered Manager told us they had recently received training in relation to complaints and told us there was an emphasis on dealing with complaints promptly to avoid the

need for any escalation of concerns. All relatives and people using the service we spoke with told us they would feel confident to raise a complaint with the Registered Manager or a member of staff if they had any concerns.

The service director told us Stockport Extra Care staff were able to support some activities within each scheme. We saw rolling rotas of activities were in place, which included events such as chip shop lunches, tai chi, yoga and coffee afternoons. Staff told us they had also recently held a race night, men's night and an event to celebrate the Queen's 90th Birthday, which was also pictured in the newsletter. Tenants associations at the different schemes arranged additional activities and events. People we spoke with talked positively about the activities on offer. One relative told us; "They do nice things like meals downstairs and they encourage people's involvement." This would help the service ensure that people's social needs were met alongside any other identified support requirements.

Tenants meetings were held by the housing associations at the different schemes. A staff member from Stockport Extra Care also attended these meetings to help ensure effective communication and to address any issues arising in relation to the support service provided. We saw minutes from these meetings and saw they were primarily related to issues in relation to the building. However, people told us they had adequate opportunity to express their views in relation to the service directly to staff and the team leaders.

Requires Improvement

Is the service well-led?

Our findings

There was a Registered Manager in post at the time of our inspection. The Registered Manager had joined the service in January 2016 and had previously shared the management of the service with another senior manager. The service consisted of seven schemes located across four geographical sites in the Stockport area providing support to around 130 people. We asked the Registered Manager about their workload now that the management of the service was not shared with another senior manager. They told us the workload was 'massive' but that they were using systems of audit and quality assurance along with support from team leaders to ensure the effective running of the service. There was one team leader in post for each of the four geographical areas. The team leaders worked 'off rota', which allowed them time to complete local level checks, quality reviews and to manage the support worker teams.

There were systems and processes in place to monitor and improve the safety and quality of the service. However, these had not always resulted in effective action being taken to address issues. Medication records were not always returned to the office on a regular basis and there was no effective system in place to check medicines and records within people's own homes. This meant that errors, discrepancies and concerns had not been consistently identified and addressed. We also found staff had not consistently followed the provider's policies in relation to actions taken to address medicines errors at all of the schemes. We saw issues in relation to the safe management medicines had been highlighted during an audit in January 2016 and had also been discussed at a team meeting in April 2016. As we found on-gong issues in relation to the management of medicines, this indicated actions taken to address these concerns had not been effective.

This was a breach of Regulation 17 (1) in relation to the effective operation of systems and process to monitor the quality and safety of the service.

We acknowledged that the provider had recognised the on-going issues and had asked for support from their internal quality assurance team whom had visited two days prior to our inspection. We saw evidence that the attendance of this team had been requested prior to us announcing our inspection. The provider also shared copies of their immediate action plans and a revised medicines audit that had been developed to help address the issues in relation to medicines management.

The Registered Manager carried out audits at each of the schemes on a bi-monthly basis. These covered aspects of service provision including health and safety, staffing, supervisions, accidents and care plans. We saw the Registered Manager had also sought feedback from people using the service. Findings from these audits were used to develop action plans, and we saw progress against these plans was monitored on a regular basis. The service director and the quality assurance teams had carried out additional in-depth audits of the service within the past year, including an assessment of the service against CQC's key questions. Other local level checks included daily spot checks of records and quality assurance reviews where people using the service were asked for feedback on the service. A questionnaire had also been sent to people using the service, and we saw basic feedback from the findings of the survey had been shared with people.

A log of accidents and incidents was kept at each scheme. The Registered Manager told us the team leader would maintain an overview of this log to monitor for any trends or patterns in accidents occurring. However, we found the accident log had not been updated for the previous month at St. Lesmo Court. The Registered Manager told us this lapse would have been picked up at the forthcoming 'social care governance meeting', which they told us were held on a monthly basis, and we saw evidence of these meetings taking place. The social care governance meetings were held to help review the safety, quality and management of services.

We saw staff kept records of the care and support they provided to people. However, these were not always fully and accurately completed. As well as the gaps we found in medicines records, we found records of fluid intake did not always provide a clear indication of the amount of fluid the person had received as actual volumes of fluids were not always recorded. We also found some daily records hard to read due to the handwriting. Records of repositioning for one person were incomplete and indicated staff had not supported them to change their position as frequently as required in order to reduce the risk of pressure sores. We cross-referenced these records with daily notes kept by the care staff. This showed that staff had provided the support this person required with repositioning, but they had not maintained full and accurate records.

This was a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to maintaining accurate and complete records of care provided.

The provider and Registered Manager were aware of many of the issues we raised during the inspection and were in the process of taking action to make improvements. For example, the service director sent us policies that had been developed in relation to pressure care and end of life care, there was a recruitment drive taking place and action plans had been developed in relation to improving medicines management. The Registered Manager told us they planned to introduce 'champions' to lead improvements and highlight good practice in relation to areas such as end of life care and diabetes. Staff we spoke with confirmed the Registered Manager had discussed these plans with them. The provider and Registered Manager were responsive to feedback we gave during the inspection and took prompt actions to make improvements such as updating risk assessments and developing a new medicines audit.

People using the service, relatives and staff all told us they found the Registered Manager and Team Leaders to be approachable, and they told us they felt they were listened to. Staff we spoke with said they felt valued for the work they did and told us they were happy in their job roles. One relative told us; "I think [the Registered Manager] has made a big difference. They are good at liaising with us and listening to us." Staff told us they were always able to contact a more senior member of staff for advice if required, including outside normal office hours. Relatives also told us they had no difficulties contact staff by phone if they needed to speak with anyone.

Staff told us they attended staff team meetings, which were held monthly. They told us they were able to add items to the agenda, which was displayed in the offices in advance of the meetings. We looked at minutes from these meetings, which showed topics of discussion had included record keeping, incident reporting and policies and procedures. We also saw there had been reflection of incidents where points for learning and improvement had been discussed with the staff teams. This showed the service was learning from experience to make the service safer and more effective. Records we looked at showed there was regular contact between Stockport Extra Care staff and staff working for the housing associations who managed the buildings. This included regular meetings as well as contact about specific housing related issues. This would help ensure a well-coordinated service was provided to people.

People we spoke with expressed an overall satisfaction at the service they received from Stockport Extra Care and spoke positively about the extra care model of support. Comments we received included; "[Team Leader] is great and this place is ideal for me, I can't really knock it. It is just what I need. It is a nice place with a good feel about it," "I am glad to be here and I am the envy of everyone who visits me," and "Overall it is better than I expected. I feel safe, secure and happy and my family say they have seen a difference in me health wise."

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being managed safely. Regulation 12(2). The provider was not adequately assessing risk or doing all that was practicable to mitigate risk. Regulation 12(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not operated effectively to ensure the quality and safety of the service was adequately monitored. Regulation 17(1) Accurate records of care provided were not consistently maintained. Regulation 17(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not adequate support and induction provided to temporary workers to ensure they were able to carry out their duties effectively. Regulation 18(2)