Mears Homecare Limited

Mears Homecare Limited - Mary Seacole House

Inspection report

Mary Seacole House
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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 22, 24 and 26 May 2017. We arrived unannounced on the first day and informed the provider of our intention to return to the service on the second day. The third day of this inspection was announced and comprised a visit to the provider's administrative offices in a neighbouring borough. Mears Homecare Limited – Mary Seacole House provides personal care and support services to people living in their own homes in a purpose built building with 30 self-contained flats. The premises are managed and maintained by a housing association which is independent of Mears Homecare Limited. At the time of the inspection 24 people used the service and there were six vacancies. Each person is provided with 17 hours of personal care and housing related support every week, and can access a daily lunch and activities programme in the cafeteria and adjoining communal lounge area on the ground floor. The management and administration offices are located on the ground floor and all floors are accessible via a passenger lift.

A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. 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 time of this inspection the service did not have a registered manager in post. The provider had arranged for the registered manager of another service to temporarily manage the service. The provider had also seconded an experienced extra care scheme manager to deputise for the acting manager when required and provide supervision and support for the staff team.

We found issues of concern in relation to the management of people's prescribed medicines. The provider did not demonstrate that its own monitoring and auditing of the storage, administration and disposal of medicines was conducted in a thorough manner to protect people from the risks associated with unsafe medicine practices.

People informed us they felt safe living at the service. Staff understood how to safeguard people from abuse and report any concerns about people's safety and welfare.
Risk assessments had been recently revised and updated to ensure that risks to people' safety and wellbeing were identified and measures had been implemented to mitigate these risks.

People stated that there were enough staff deployed to meet their needs. Staff recruitment was properly conducted to make sure that staff were suitable to work with people who use the service.

The frequency of one to one formal supervision meetings to support staff with their duties had been disrupted, although the supervision programme had been commenced again by the interim management team. Staff had undertaken an assessment to ascertain their training and development needs and the provider's forthcoming training programme had been arranged to take account of the staff team's identified training requirements.

People told us they received the support they needed to meet their nutritional and health care needs; however, we received comments from relatives in relation to occasions when people had not been supported to attend health care appointments.

Staff confirmed they had received training and guidance about the importance of seeking people's consent and promoting people's entitlement to make decisions. The management team were aware of the actions to take if a person did not appear to have capacity to make decisions about their health and social care needs, for example the interim manager liaised with health care professionals at the local memory clinic if staff observed changes in people's cognitive abilities that could impact on their ability to make decisions.

Improvements had been achieved in regards to how people's care and support plans reflected their individual needs, wishes and circumstances. People had been consulted by the provider at their annual review meeting and new documentation recorded relevant information about people's social history, interests and family/friends support networks.

Although people were supported to participate in social activities which included chair based exercises and art sessions, there was no active approach by the provider to develop people's access to a wider range of meaningful and fulfilling activities.

People were provided with information about how to make a complaint. Records indicated that the provider had not received any complaints since the previous inspection.

The provider's record keeping system to demonstrate how people were supported by staff with their shopping and other expenditures was not accurately maintained. We found discrepancies and noted that filing was at times disorganised.

People's views about the quality of their care and support had been sought and the provider had received some positive comments.

Our findings during this inspection demonstrated that the provider needed more rigorous monitoring systems to identify and address areas for improvement.

We have identified two beaches of regulation. These are in relation to the safe management of people's medicines and the accurate record keeping for people's finances. One recommendation has been made in regards to the need to provide people with a Service User Guide that addresses their circumstances as opposed to a general document not designed for people living in extra care schemes.

You can see what actions we have asked the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not consistently receive the support they needed to safely take their medicines.

Staff understood how to protect people from abuse and how to report any concerns about people's safety and wellbeing.

Risks to people's safety and wellbeing were identified and addressed.

A sufficient number of safely recruited staff were suitably deployed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not consistently received the support and supervision they needed for their roles and responsibilities.

People were supported to make choices and their rights were protected.

People were supported to meet their health care and nutritional needs, although prior arrangements to escort people to health care appointments were occasionally overlooked.

Is the service caring?

Good

The service was not always caring.

People told us they got on well with staff and found staff kind and patient.

The provider had taken actions to address prior concerns about the culture at the service.

People were supported in a manner that promoted their entitlement to dignity, privacy and confidentiality.

Written information supplied to people about the service was not specific enough to address people's requirements.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Progress had been attained in relation to individual care planning that reflected people's needs and wishes.

Although people enjoyed the social activities, there was scope for developing this aspect of the service to provide people with wider choices.

People and relatives told us they knew how to make a complaint. No written complaints had been made since the previous inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The processes used to record how people were supported with their finances were not consistently effective.

People, relatives and staff felt the smooth running of the service had been disrupted due to a succession of personnel changes in the management team.

The provider had mechanisms in place to seek the views of people who use the service and their representatives.

Systems for monitoring and auditing the quality of the service were not rigorous enough.

Mears Homecare Limited - Mary Seacole House

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, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22, 24 and 26 May 2017. The first day of the inspection was unannounced and we informed the provider of our intention to return to the service on the second day. We visited the provider's administrative offices in Chiswick on the third day of the inspection in order to look at staff recruitment records. One inspector and one assistant inspector visited on the first day and one inspector visited on the second and third days.

Prior to the inspection we reviewed the information we had about the service, which included the previous inspection report and statutory notifications the provider had sent to the Care Quality Commission. A notification is information about significant events which the provider is required by law to send to us. We contacted the local safeguarding team and also spoke with a representative of the local authority's commissioning and contracts monitoring team, to find out their views about the quality of care and support provided to people who use the service.

During the inspection we read care and support plans for four people, with the accompanying risk assessments and risk management plans. We looked at a variety of policies and procedures for example safeguarding, managing medicines and information about how to make a complaint. We checked five staff recruitment files and looked at records for people's financial expenditures, the administration of medicines, and accidents and incidents.

During the inspection we spoke with seven people who used the service and one relative, four care staff, the activities organiser who also provided personal care for an agreed limited number of hours each day, a

member of the housekeeping team, a shift leader, the interim scheme manager and the interim manager. Following the inspection visits, we telephoned relatives and/or close friends of people who use the service and spoke with four people.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we found that there were systems in place to support people to safely receive their prescribed medicines. We had noted that when medicine errors had been identified, records had shown that applicable staff had received supervision and guidance to address any shortfalls in their knowledge and/or performance.

At this inspection the interim manager advised us that they had noted that individual members of staff were not adhering to the provider's medicines policy. This had resulted in focussed one to one supervision meetings and staff members had been booked in for medicines training, irrespective of whether their previous mandatory training was still valid. The provider's aim was for all staff to receive medicines training again as part of a five day induction training course.

We accompanied a shift leader in order to observe how people were supported to take their prescribed medicines within their flats. Gaps were noted on the medicines administration record (MAR) chart for the first person we visited. The person had not been given a medicine prescribed to relieve pain for three days, as the medicine could not be found. A prescribed eye drop that was no longer in use had not been removed for safe disposal to the pharmacist and another eye drop did not have the date of opening recorded, so that staff could ensure it was disposed of 28 days after it had been opened. A respiratory inhaler was positioned on top of the person's medicines cabinet; however, the person was not currently prescribed this type of inhaler. The second person we visited had gaps on their MAR chart for one medicine on four occasions and another medicine on one occasion. The third person had not received a medicine given for pain relief for eight days and the information about one specific medicine on their daily record did not accurately match information recorded on their MAR chart. Our observations showed that the storage, administration and disposal of medicines was not safely managed and subject to a satisfactory level of monitoring and managerial scrutiny.

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

We discussed these findings with the acting scheme manager, who was the person in charge on the day we checked medicines. We also spoke with the acting manager on the final day of the inspection, who informed us they had spoken with the local GP practice as there had been issues in relation to people promptly receiving the correct quantities of the medicines they required.

People told us they felt safe living at the service. Comments included, "I feel safe, there is good security here. English isn't my first language and staff take their time to make sure I have understood everything, they never shout at me or tell me to hurry up" and "I didn't want to come here but now I have got used to it. They (staff) are good women. We are well looked after and there is always a helping hand." During the inspection the service received a visit from a team of community police officers. This had been planned in advance with the provider in order to give people advice about how to protect themselves from criminal risks.

Staff demonstrated a clear understanding of the provider's safeguarding policy and procedure and knew how to identify and report any concerns in regards to people's safety and welfare. During our discussions with staff they explained about the provider's whistle blowing policy and how to report any concerns within their organisation, and externally to an appropriate authority if necessary. (A whistle blower is a person who raises a concern about a wrongdoing in their workplace).

At the time of the inspection the acting scheme manager was in the process of reviewing people's care and support plans, which included risk assessments to identify and mitigate any risks to people's health and safety whilst promoting their entitlement to be as independent as possible. The acting manager told us that this work had been prioritised for prompt attention as the risk assessments were noted to be out of date when they commenced at the service. The risk assessments we saw had all been revised and demonstrated consultation with people wherever possible. The acting scheme manager confirmed that they were making good progress with ensuring that each person using the service had up to date documentation.

Thorough practices were in place to ensure that staff were safely recruited and had appropriate experience to meet people's needs. The recruitment files we checked showed that the provider obtained references, proof of the prospective employee's identity, confirmation of their right to work in the UK and evidence of a criminal check, known as a Disclosure and Barring Service (DBS) check. (The DBS provides criminal record checks and barring functions to assist employers to make safer recruitment decisions). We noted that some employees had transferred to the provider from other organisations via the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE), which meant that in certain instances all references had not been preserved.

Discussions with people who use the service and the records we looked at showed that staff ordinarily met people's needs in accordance with their preferred times for visits. Comments from people included, "I am getting on well, some of the carers are very good. They come regularly and when I call for help" and "They get me up at 7am every day apart from Sunday when I like to have a lie-in. They get me ready for the day, sort out my breakfast and check what needs to go to the launderette." A relative told us they had spoken with the management team when they observed that although their family member was being provided with their allocated hours of support the care worker was not working in an efficient manner to ensure that the person's needs were met. The relative confirmed that this situation had improved. Staff told us there were times when they were particularly busy but felt they were able to provide a good standard of care and support. One staff member told us that one of the benefits of an extra care scheme for people and staff was that staff could return to a person's flat and offer them the care and support they needed if the person had initially declined to accept assistance because they had felt tired or had refused due to behaviours that challenged.

The acting manager informed us that new staff had been recruited to work at the service in the past few months. The provider did not use external agency staff when additional staff were required to cover unexpected absences as extra hours were offered to the permanent staff and to domiciliary care workers employed by the provider to work with people living in the local area near to the service, in order to ensure continuity for people who use the service. The acting manager was familiar with the staff working at nearby households as they were ordinarily employed at the acting manager's permanent location.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us they thought staff had the skills and knowledge to provide appropriate care and support. Some relatives expressed that they were not assured that staff received the support and guidance they needed as they felt that the changes in management had impacted on the stability of the service.

The interim manager told us that newly appointed staff were undertaking the Care Certificate. (This training sets out minimum standards that should be covered in induction training for new social care support staff). The training records we looked at showed that the provider offered staff mandatory training and other training to meet the needs of people who use the service. The mandatory training included safeguarding adults, moving and handling, health and safety, infection control and basic food hygiene. Staff had received training about how to support people living with dementia and support people at risk of falls. We were shown copies of an assessment quiz that staff had undertaken following the appointment of the interim manager, which had been designed to ascertain staff's current knowledge and understanding of relevant care topics. The interim manager informed us that the provider had analysed how staff performed in this quiz and had subsequently implemented a plan to enable all care staff to undertake a five days 'refresher' induction course.

At the previous inspection we had noted that staff received regular one to one supervision and an annual appraisal. At this inspection records demonstrated that the interim manager and the scheme manager had commenced a programme of one to one supervisions and appraisals for staff. However there were gaps in the frequency of supervision over the 12 month period since the previous inspection, as we found supervision was not taking place at a frequency in line with the provider's own policy before the arrival of the new management team in February 2017. The completed forms we saw showed that the supervision meetings looked at issues such as the employee's quality of work and their training needs.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The applications for this in extra care schemes are to be made to the Court of Protection. We found that the managers and staff had received training on the requirements of the act and understood the importance of ensuring that best interests meetings took place where people lacked capacity to make a decision.

People's care and support plans contained information and guidance for staff in regards to how people wished to be supported to meet their nutritional needs. Records showed that people required varying levels of support and they were encouraged to maintain as much independence as possible with tasks such as preparing drinks and/or snacks. The ground floor cafeteria provided a midday meal and during the inspection we spoke with people at lunchtime. People told us they were offered a choice of main course and dessert by staff, which we observed. Comments about the quality of the food included, "It's alright, we pick

what we want" and "It's good, I like it. I don't like anything too spicy but there is always something I can have." We noted that there was a friendly and supportive atmosphere during the mealtime and staff engaged in conversations with people.

People and their relatives said staff were helpful and followed the guidance in their care and support plans in relation to their day to day health care needs. However at the previous inspection we had received one comment from a relative to state that their family member had been sent to one or two health care appointments without a staff escort. Discussions with relatives following this inspection confirmed that this practice had occasionally continued to occur. The information we received suggested that this was due to planning errors by the provider, as relatives stated they had spoken with senior staff well in advance of appointments and had been given assurances that their family member would receive the support they required.

Good

Is the service caring?

Our findings

At the previous inspection we had received mainly positive views from people about how they were treated by staff; however, we had also received some unfavourable comments. At this inspection people stated they were happy using the service and were fond of the staff team. Comments from people included, "Everybody here has different personalities and characters. I used to work [in a care setting] and I get on with everyone. The carers are good to me and I have no complaints" and "I like my own way and I am getting everything I want. I would recommend it here, they know how to look after me."

During the previous inspection we had spoken with the provider about concerns that people had reported to the local authority during a 'customer engagement exercise' visit, which had taken place prior to the previous Care Quality Commission inspection. Some people who used the service had reported that they did not feel as if they were treated with respect, patience and compassion, and their views were not valued. The provider had informed us that they had identified a culture whereby some staff had developed friendship circles or 'cliques' which potentially inhibited employees from speaking out against poor practice. Prior to this inspection we spoke with a local authority representative who had recently conducted a monitoring visit to the service. They informed us that people had reported improved levels of satisfaction in relation to how staff interacted with them and people had referred to the caring attitudes shown by their favourite members of staff. During our discussions with members of the care staff team, staff told us they were committed to speaking out against poor practice and felt dedicated to providing people with a high standard of care and support.

We observed that there were systems in place to ensure that people's privacy and dignity was upheld. For example, staff told us how they always made sure that they closed doors, pulled curtains and shut windows if necessary when they supported people with their personal care. People were consulted about whether they wished to speak with us during the inspection and if they wanted to meet us in their own flat or a communal space. When we accompanied a shift leader to check how people's medicines were stored within their flats, the staff member sought people's permission for this observation and reassured them that they were entitled to decline. All confidential information about people was securely stored.

People were provided with written information about how to make a complaint within a Service User Guide, however this document was generic and had not been tailored to meet the needs and expectations of people living at Mary Seacole House. This finding was identified at the previous inspection.

We recommend that the provider seeks guidance from a reputable source about how to ensure that people are provided with information that is relevant to their circumstances.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with how staff provided their care and support. Comments included, "I have been here for years. I like the staff, they go with me to my hospital appointments. The food is average. I like [the activity organiser's] quizzes and get the answers right, people joke that I am a bit of a brain box. I like to come down to talk with [activity organiser] and [member of staff present], we have a cup of tea and pass the time together" and [Staff member] is my favourite, we go out shopping together, she is lovely. They ask me if I am happy with the food. I like making pictures with [activity organiser], we have a laugh." Relatives informed us they felt their family member was settled and provided with suitable care and support. One relative told us that staff had encouraged their family member to become more active and outgoing since moving into Mary Seacole House, as they had previously been isolated and unhappy living on their own. Another relative said they observed their family member was comfortable and received the support they needed with personal care, laundry and hairdressing, as maintaining their appearance was important for the person's self-esteem. People and their relatives expressed that the premises were well maintained and pleasant to live in, which enhanced people's sense of wellbeing and general satisfaction.

Some of the people we spoke with confirmed that they had visited the premises before they moved in and we saw that a pre-admission visit had been arranged for a prospective resident during the inspection. People were referred to Mary Seacole House following a comprehensive assessment of their needs, which was coordinated by a social worker from the local social services. We noted that the assessment by a person's social worker along with any other pre-admission information from professionals including occupational therapists and doctors was used by staff to ensure that the care and support plans reflected people's relevant past medical history and current health and social care needs.

We had found at the previous inspection that some of the care and support plans developed by the provider lacked sufficient detail to demonstrate how staff supported people in an individual way, for example people's preferences, routines, social history and interests. At this inspection we found that the provider had introduced a 'This Is Me' section, which demonstrated consultation with people about their needs and wishes, and discussions with relatives and friends where appropriate in order to seek their contributions to the care planning process. For example, one care and support plan we looked at stated that a person used to have a creative occupation and we later met the person participating in an art group facilitated by the activities organiser.

At the previous inspection we had been informed that the provider used to receive charitable grants from large organisations such as retail companies but this had now stopped due to general financial pressures. The registered manager had informed us that they would apply to the provider's social fund for additional resources to renew the outings. At this inspection we did not find any evidence to demonstrate that new sources of funding had been secured. The activities organiser told us that the weekly art group taught by an external art tutor was no longer in place; however people we spoke with enjoyed the internally arranged twice weekly arts and crafts sessions. Discussions with people, their relatives and the activities organiser confirmed that people were supported to take part in gardening, quizzes, a weekly breakfast club that served a cooked breakfast, listening to and singing along to music, manicures and knitting sessions. People

were invited to attend a weekly chair based exercise group run by the activities organiser, who had completed an accredited course to show people techniques to strengthen their mobility and reduce the risks of falls.

Although people and relatives spoke keenly about the activities arranged by the activities organiser, and their inclusive and encouraging approach, we did not find evidence of current initiatives by the provider to develop this aspect of the service and create more fulfilling social opportunities to stimulate and entertain people. For example, at the previous inspection we noted that an external yoga instructor provided a fortnightly class but this was no longer happening. One person who uses the service told us they liked visiting the residents' shop within the premises but this service was temporarily suspended, however we were informed that this measure was temporary until a financial audit was conducted by a senior auditor within the organisation.

The provider had a complaints policy and procedure, and the people and relatives we spoke with knew how to make a complaint. The complaints folder was empty, which indicated that the provider had not received any complaints since the previous inspection.

Requires Improvement

Is the service well-led?

Our findings

During the previous inspection we had received information of concern which alleged that people were at risk of financial abuse due to fraudulent practices with people's personal shopping. The information had alleged that inappropriate purchases were made for people and these items were taken by members of staff. We had found that records demonstrated that purchases for people by staff were covered by appropriate receipts and all purchases had been ticked off against the receipts by a member of the management team. This process was followed up by a further checking of the shopping and corresponding receipts with people who use the service. However, we had noted that there was no active system to ensure that spot checks were conducted at a timely interval after the shopping in order to determine if people had been satisfied with how they had been supported with their shopping. For example, we had seen that a significant amount of money had been spent by staff to purchase clothing items for a person but there was no recorded follow-up visit by a member of the management team to check with the person and/or their representative, if applicable, about the suitability of these items.

At this inspection we looked at the financial records for three people who had given their consent for care staff to do shopping for them. Each person had a blue and red folder but it was not clear to us regarding the distinction between the two folders. It appeared as though one folder was meant to be used for the storage of historical receipts and the other for more recent receipts; however, all of the folders we looked at contained a mixture of historical and recent receipts. We noted various administrative discrepancies, which we discussed with the manager. For example, we found in one person's blue folder that receipts were available up until 11 May 2017; however, the financial records documentation did not extend beyond 16 February 2017. The person's red folder contained more recent financial records documentation but did not have all the correct receipts. Although our check of the person's financial records documentation and receipts demonstrated that their expenditures were appropriately accounted for and they consistently received the correct change, we found that none of the receipts were filed in an orderly manner which made it difficult and time-consuming for us to track back transactions.

The folders for a second person contained automated teller machine (ATM) receipts with two different card numbers. Following discussion with the manager it was ascertained that one of the card numbers belonged to a different person and should not have been in the person's folders. We found a hand written note from a care worker stating money had been spent for another person who used the service, which was confirmed by the manager to be a misfiled document. There were other hand written notes by care workers in regards to the shopping tasks they had undertaken but some of these notes were not dated, and on three separate occasions in March and April 2017 we found evidence of receipts which did not have corresponding financial records documentation. Two receipts for purchases in April 2017 contradicted the information in the financial records documentation.

The folders for a third person showed that some handwritten receipts by care workers had been stapled to the wrong formal shop receipts as the dates and costs did not match. Receipts up until October 2016 had been archived in an envelope but there were loose receipts from February 2016 and one receipt that dated back to April 2015.

We did not find any evidence of missing monies but due to the disorganised nature of these folders the provider could not be assured that people's finances were properly accounted for at all times. The financial records we looked at did not demonstrate how the provider met people's needs by operating a safe and accurate system to manage their finances. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection the service was managed by a registered manager, who was supported by a team leader. At the time of this inspection Mary Seacole House did not have a registered manager in day to day charge of the service and the team leader no longer worked there. The service was being managed by an interim manager, who was the registered manager of another local service operated by the provider. The interim manager was transferred to the service in February 2017 and was supported by an interim scheme manager who had been seconded from another extra care scheme managed by the provider. The interim manager and interim scheme manager both had extensive prior experience of managing and working within similar services and had achieved some improvements during their secondments, for example the implementation of staff training assessments, and the reviewing and updating of people's care and support plans. The interim manager informed us that a new manager had been appointed and was due to commence at the service soon after this inspection. We were advised that the provider proposed to also recruit a new team leader as the interim scheme manager was scheduled to return to their own permanent position.

These changes meant that people who use the service and relatives were not able to comment on how the service was being managed. Some people we spoke with said they missed the former management team. They confirmed they knew the temporary managers and had felt supported by them if they had any concerns. Relatives informed us that the change of managers had been disruptive and they were now hoping to establish a relationship with the new permanent manager. For example, two relatives told us there had been issues in relation to their family members receiving the support they needed to attend external appointments and meet other aspects of their daily care and support needs, and they thought the turnover of management staff had been a contributory factor.

We received mixed comments from staff about the managerial changes. Many of the staff we spoke with told us they did not feel consulted and updated about changes at the service. We were also told by several staff that they had read the previous Care Quality Commission inspection report and wanted the service to improve but did not feel that the provider shared with them how it planned to achieve positive progress. Records showed that the interim manager had organised team meetings in February and May 2017; however, several of the staff we spoke with told us they were unaware of these meetings. One member of staff explained to us that care workers had been given less shifts each week when the service had a higher level of vacant flats a few months ago, hence there was a lower than usual staff attendance at the February meeting.

Records demonstrated that the provider had sought people's opinions about the quality of their care and support during individual review meetings and through questionnaires. People and their relatives if applicable, had been asked to complete a 'service user feedback form' as part of their annual review meetings, which had been taking place in April and May 2017. This process had not yet been completed at the time of the inspection although the feedback forms we looked at showed that people were satisfied with how the provider met their needs.

The provider had not advanced with some of the issues for improvement noted at the previous inspection. For example, we had previously noted that staff had not been issued with a care workers' handbook, which is customary for staff working in services that are registered by the Care Quality Commission (CQC) to

provide people with personal care. The interim manager stated that they had discovered significant gaps in how the service was managed when they took over and had therefore prioritised specific management tasks, for example carrying out monitoring visits and spot checks as this type of auditing had not been occurring at a frequency in line with the provider's own policies and procedures. We noted that these checks were being carried out by the scheme manager. However, the issues of concern we identified in relation to the safe management of medicines showed that the provider's own monitoring of the service was not sufficiently robust.

The interim manager and the scheme manager were aware of the legal necessity to inform the CQC about events that needed to be reported to us and other statutory bodies, in order to ensure people's safety and wellbeing. However, we saw that a notification about an event that occurred on 12 May 2017 and should be reported to CQC 'without delay' was being prepared for our attention on 24 May 2017.

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 The registered person did not ensure the proper and safe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not maintain securely an accurate, complete and contemporaneous record in respect of each service user. Regulation 17(1)(2)(c)