

Bexley Crossroads Care Limited

Crossroads Care South East London

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

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 announced inspection took place on 10 and 11 January 2018. Crossroads Care South East London is a specialist voluntary organisation and registered charity that provides care and support to people and/or family carers living in their own houses or flats in the community. It also provides care and support to three people living in a supported living setting so that they could live in their own homes as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. The service also provides respite for some families. At the time of the inspection there were approximately 64 adults, children and/or their family carers using the service.

The service had 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 our comprehensive inspection on 28 October and 4 November 2016 we found breaches of legal requirements in respect of the monitoring of risks, management of medicines records keeping and with systems used to monitor the quality of the service. We undertook an announced focused inspection on 14 June 2017 and found that action had been taken but there was still room for improvement.

At this inspection we found that further improvements had been made to the management of medicines. There were safe medicines management systems in place and staff competencies had been assessed. Risk to people had been assessed, identified and with appropriate management plans in areas such as moving and handling, eating and drinking, medicines and behaviours that challenged. There were systems in place to continuously assess and monitor the quality of the service provided.

However, we found a breach of regulation in relation to the support staff received with training, supervision and appraisals. Staff training required updating in various courses including moving and handling and health and safety. Records we looked at showed that some staff had not received any training in these courses. The provider had a training planner which showed that training had been arranged for staff in the year 2018 to update their knowledge and skills. A supervision and appraisal record we looked at showed that supervisions and appraisals were not always carried out in line with the provider's policy. Staff we spoke with were not sure when they last had an appraisal.

Staff involvement to actively improve the quality of the service required improvement as team meetings were not being organised in line with the provider's policy. The provider had a staff zone on their website which was used to cascade important information to all staff. However feedback information we had prior to our inspection showed that two out of five staff felt their views were not taken into account and acted upon.

The provider had policies and procedures to protect both children and adults from abuse. There were arrangements in place to deal with foreseeable emergencies. Sufficient numbers of staff were deployed to support people and people told us their support staff were reliable, punctual and stayed for the full length of time. The provider had a recruitment system in place to ensure staff employed were vetted before working in social care. There were procedures in place to minimise the risk of infection. Staff told us they wore personal protective equipment when supporting people and we confirmed this with people and their family carers. Where accidents and incidents had occurred, the provider learnt from it and shared the learning with staff teams to prevent future occurrences.

People told us that staff knew them well, their preferences and what they needed support with. People's physical, mental and social conditions were assessed to ensure the service could meet their needs. New staff were provided with training and shadowing opportunities to ensure they had the skills required to undertake the role in which they had been employed. People were supported to eat sufficient amounts for their well-being.

Where required, people were supported to have access to healthcare services such as GP and district nurses. The provider worked with a range of health and social care professionals to plan and deliver care to people safely. The registered manager was aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff understood the need to seek people's consent before supporting them.

People said staff were compassionate, kind and thoughtful. They were involved in making decisions about their care and support to ensure that their needs were met. People said their privacy, dignity and independence was respected and promoted. They were provided with adequate information about the service to ensure they knew the standard of care and support to expect. Information was also presented in formats such as easy read to support people's understanding. Each person had a care plan in place which covered areas in which they needed to be supported.

People were supported to participate in activities that stimulated them both at home and in the communities. The provider had a complaints policy in place and actions were taken to resolve complaints. At the time of our inspection, no one was being supported with end of life care; however, there were arrangements in place to ensure people's end of life wishes were respected.

The provider carried out audits in areas such as medicines management staff files and care records to identify issues and take action to improve on the service. People's views were sought through home visits, telephone monitoring calls and annual questionnaires and the results were analysed to ensure that appropriate actions were taken to improve on the service provided.

There was a registered manager in post who was supported by a board of trustees and an operations manager. The provider operated an open culture and work with key organisations such as Carers Trust, the local authority and clinical commissioning groups to plan and provide quality service. Where issues were identified, lessons were learnt to improve on the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Risk to people had been assessed, identified and appropriate management plans were in place to manage risks safely.

People were supported to receive their medicines safely as prescribed by healthcare professionals.

The provider had policies and procedures in place to safeguard people from abuse. Staff were aware of actions to take to safeguard people.

There were sufficient numbers of staff deployed to support people as planned for.

The provider had a recruitment process in place to ensure that staff employed could work with people using social care services safely.

Staff followed safe infection control practices when supporting people.

Accident and incidents were recorded and reported appropriately and lessons learnt were shared with staff teams to prevent similar occurrences.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Adequate support was not always in place for staff through training, supervision and appraisals to perform their role efficiently.

People's needs were assessed and care and support was planned and to meet their needs.

People were supported to eat and drink adequate amounts for their well-being.

Where required, people were supported to access healthcare

services to ensure they had safe care and treatment.

The provider worked with other health and social care organisations to plan and deliver safe care and support.

Care staff and the management team understood their role and requirements under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguard.

Is the service caring?

Good ●

The service was caring.

Staff treated people with care and compassion.

People were involved in making decisions about the care and support they received and information was presented in formats that aid their understanding.

People's privacy, dignity and independence was respected and promoted.

Is the service responsive?

Good ●

The service was responsive.

People said they received a personalised care that met their needs.

Each person had a care or support plan in place which was reviewed regularly to meet their changing needs.

People were supported to take part in activities that interests them. People were engaged in conversations to stimulate them.

The provider had a complaints policy in place and took appropriate actions to ensure that people were satisfied with the level of support they received.

People were provided with appropriate information when they started using the service.

No one was being supported with end of life care; however, appropriate systems were in place to ensure people's end of life wishes were respected.

Is the service well-led?

The service was not consistently well-led.

Appropriate systems were not in place to ensure that staff supervision and appraisals were carried out in line with the provider's policy.

Staff were not always provided with the opportunity to actively contribute to the development of the service.

Various quality monitoring checks were carried out to improve the quality of the service.

People's views were sought through telephone calls, home visits and annual questionnaires.

There was a registered manager in post who was supported by a board of trustees and the head of operations.

The provider continuously learned to improve on the quality of the service.

The provider worked in partnership with key organisations such as the local authority to plan and develop the service.

Requires Improvement 

Crossroads Care South East London

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 10 and 11 January 2018. The inspection was carried out by two inspectors and an Expert by Experience. An expert by experience is a person with personal experience of using or caring for someone who uses this type of care service. One inspector visited the office on 10 January and two inspectors visited on 11 January 2018. We gave the provider 48 hours' notice of the inspection as the service provides care and support to people living in their own homes and we needed to make sure the manager would be available to assist with the inspection.

Before the inspection we looked at all the information we had about the service. This information included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. The provider had also completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We used this information to help inform our inspection planning.

During our inspection we spoke with five people and five family carers on the telephone. At the office we spoke with the registered manager and the head of operations. We looked at eight care plans and seven staff files as well as records related to the running of the service such as policies and procedures, audits and minutes of meetings.

Following the inspection, we spoke with eight care staff on the telephone to seek their views on the support they received from the provider and the support they provided people. We also contacted the local

authorities and clinical commissioning groups that commission services from the provider to obtain their views about the service.

Is the service safe?

Our findings

People and their family carers told us they or their loved ones felt safe using the service. Their comments included, "Oh Lord yes I'm very safe with these people." Another person commented, "Yes I feel safe having people in my home because they send the same ones." A family carer told us, "Yes I am happy with the staff and how safe they keep my son."

At our comprehensive inspection on 28 October and 4 November 2016 we found breaches of regulation as risks to people were not always identified or guidance for staff was not always in place to minimise possible risks. The provider sent us an action plan and we followed up with a focused inspection in 14 June 2017. We found that action had been taken but there was still room for improvement to the frequency of medicines audits and medicines competencies had still not been assessed.

At this inspection we found improvements had been made and risk assessments were in place with appropriate management plans. Risk assessments were specific to people's needs and covered areas such as eating and drinking, medicines, moving and handling, behaviours that challenge and risks relating to people's home environment. For each risk identified, there were management plans in place with guidance for staff on actions to take to minimise the risk. For example, for a person at risk of choking there was guidance for staff which included ensuring the person was only given soft diets or food cut into small pieces to prevent this risk occurring. Risk relating to people's health conditions such as epilepsy and multiple sclerosis had appropriate protocols and guidance for staff about what to do to reduce risks and the support to provide in the event of an emergency. Health and safety risk assessments were completed in people's homes to check for any environmental risks. Where staff used equipment such as hoist to support people, occupational therapists had assessed and approved that the equipment was safe for use.

People's care plans included information on the level of support they required in the event of an emergency such as a fire. The care plans detailed the nearest fire exit routes to ensure staff were aware of emergency protocols. There was a business continuity plan in place which outlined the organisations operational risk areas and how these would be managed.

All the people we spoke with said they did not receive any support with their medicines because they took them independently. Where other people were supported to take their medicines, care plans included a list of medicines they were taking, what the medicine was prescribed for, dosage, time of day it should be given and any side effects people may experience. The level of support people required to take their medicines safely was included in their care plans so staff were aware of the support to provide. In some cases, people were supported by both staff and their family carers to take their medicines; this information was included in the care plans to clarify who had the responsibility for the administration of medicines. Staff had received medicines training and their medicine competencies were checked to ensure they had the right skills and knowledge to support people with their medicines safely. We checked the medicines administration records (MAR) for three out of seven people supported with their medicines and found that they were completed accurately. All MAR sheets were audited regularly to ensure people received their medicines as prescribed by healthcare professionals.

The provider had policies and procedures in place which provided guidance to staff on the processes to follow to protect both children and adults from the risk of abuse. All staff we spoke with knew of their responsibility to safeguard people from abuse and to report and record any concerns of abuse. Staff also knew about the provider's whistleblowing policy and where to raise their concerns if they were not being addressed. One staff commented, "I will report anything directly to the office and I could contact social services as well." There had been one safeguarding allegation in the last 12 months and this had been reported and investigated with appropriate actions taken to ensure people remained safe.

People told us that sufficient numbers of staff were deployed to support them. All the people we spoke with said staff were reliable, stayed for the full length of time and were punctual. One person commented, "I always have the regular girl coming, except when it is holiday time from school, where they send someone else. They always stay for the full hour, even when they finished doing the task... they sit down with me and chat." Another person said, "We get the same lady each week she's really nice; if for some reason she's not going to be able to make it she always gives us a phone call to let us know." The management team said they had enough staff to cover staff absences and staff we spoke with confirmed that enough staff were deployed to support people as planned for.

The provider had a robust recruitment system in place. Pre-employment checks included employment history, proof of identification, two references, disclosure and barring (DBS) checks and the right to work in the UK. Staff files were audited and where staff were missing information in relation to recruitment checks, such as having one reference instead of two a risk assessment was carried out which included acquiring feedback about staff from people they currently supported and/or their family carers to mitigate any risk to people.

There were procedures in place to protect people from the risk of infection. The provider had infection control policies and procedures in place which provided guidance to staff on the control measures they should take to prevent the spread of infections. People told us that staff wore personal protective equipment (PPE) when they supported them. Care records included information for staff to wear PPE when supporting people with personal care. Staff said they had been provided with PPE and knew the importance of wearing them and they could always request for more.

The provider kept records of accidents and incidents that had occurred in the service. Staff were aware of procedures to follow in recording and reporting accidents and incidents. The accidents and incidents records included details of the incident, when it had occurred, staff present at the time of the incident and any actions taken to keep people safe. All the accidents and incidents records we looked at were in relation to the support people received with their medicines. Each record had been reviewed by the operations manager and further actions were taken to improve people's safety and ensure lessons were learnt. For example, some people were supported by both staff and their family carers with their medicines. A red sheet was placed in these people's care plans to establish the provider's responsibilities so staff were aware of the support to provide. These actions had reduced the number of medicines errors and the risk of similar incidents occurring.

Is the service effective?

Our findings

People told us that staff knew them well, including their preferences and what they needed support with. They also said they felt staff had the right skills to support them. One person said, "Yes, I think they have the right skills, you don't need much training just common sense." Another person commented, "I'm not sure you need a huge amount of training to be able to deliver a lot of support that these girls deliver; the main ingredient is willingness and a caring approach."

Formal staff supervision sessions were not always taking place in line with the provider's requirements. It was the provider's policy to carry out four supervision sessions a year for each staff member. The provider told us that care staff had the opportunity to speak to office staff both on the telephone or when they came into the office to drop-in their timesheets. On the day of our inspection, a supervision matrix we looked at showed 31 of 58 staff had received one supervision session in 2017.

After our inspection, the provider wrote to tell us only 44 of 58 staff were qualified to receive supervision as 15 staff were not at work or employed long enough to receive supervision or appraisals. They said they had completed 79 formal meetings for the 44 available staff and this showed that each staff member had received an average of one to two supervision sessions in a year instead of four according to the provider's policy. Therefore staff did not always receive regular support in their role and to deliver an effective service.

Staff had not always received an appraisal in line with the provider's requirements. Appraisals were an overview of their performance and an opportunity for staff to feedback to the provider. In the year 2017, 12 staff had received an appraisals, 15 staff did not fit the criteria for having an appraisal as they were either on leave of absence or new to the service. This showed that 31 staff had still not been appraised in line with the provider's policy. The provider told us that some staff had not received an appraisal because they did not have a team leader in post and there was no one available to appraise their performance appropriately. Staff we spoke with were not sure when they last had an appraisals.

Each staff had a learning and development plan in place which had identified any required training they needed to complete in the year 2017-2018. This included the provider's mandatory training in areas such as moving and handling, health and safety, food and hygiene, fire safety, safeguarding, infection control and Mental Capacity Act. The provider told us that staff training was mostly undertaken face-to-face because most staff were not information technology (IT) literate; however, e-learning courses were available to those staff who preferred it.

We found that staff had not always completed training courses that the provider considered mandatory including health and safety and moving and handling. We reviewed 32 of 58 staff training records and we found that 18 of 32 staff had not completed any training in health and safety; ten staff were overdue therefore only four staff were up to date with their health and safety training. 21 of 32 staff had not completed any training in moving and handling, six staff were overdue, therefore only five staff were up to date with their moving and handling training. This showed that people were at risk of receiving inadequate care and support because staff knowledge and skills were not always up to date.

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Despite this, all staff we spoke with said they felt supported in their role and had received supervision a couple of times in the year and thought that it was adequate. They said if they needed further support they could always contact office staff and believed any issues raised would be addressed.

We raised these issues with the registered manager and operations manager. The operations manager showed us a risk management plan for staff training needs set out for the year 2018 and we saw that for example for the month of February, training had been planned for infection control, moving and handling, safeguarding and basic food hygiene to ensure that staff knowledge and skills were refreshed for the role in which they had been employed.

When new staff started working at the service, they were supported with an induction. The provider had an induction checklist which covered areas such as training and development, shadowing with experienced staff and some administrative processes required for carrying out the role such as record writing. The provider told us that the level of induction provided depends on the experience the staff member had already acquired in previous roles. We saw that some staff had a more tailored induction as they were transferred to the service with people they already supported. All staff we spoke with said they had an induction when they first started working for the service and felt it was adequate. However, since most staff had not received training in various mandatory courses, we could not confirm that the induction process in place was adequate to sufficiently support staff perform their duties efficiently. The provider sent us a new induction planner which was meant to be more robust in supporting new staff. We will check on this at our next inspection.

Before people started using the service, they were assessed to ensure their needs and preferences could be met. Assessments included information on people's medical conditions, physical and mental health, communication, social and personal care needs. The assessments also included people's preferences, interests, hobbies, likes and dislikes. Care plans were drawn from these assessments and provided guidance for staff on the support to provide and to ensure people's needs were met. Information from other healthcare professionals such as the occupational therapists was made available to staff on how to support people mobilise safely. All care plans were reviewed annually or when people's needs changed. The registered manager told us their aim was to provide holistic care and ensure people's needs were fully assessed and met.

Where required people were supported to eat and drink sufficient amounts for their well-being. People told us that the support they received was adequate and met their needs. One person said, "They make my lunch every day, it depends on what's in the fridge and what they prepare. But I'm always asked what I'd like and how I'd like to eat it." Another person said, "Yes, they make my tea every night, sometimes I just have soup to make it easier." Care plans included information on people's nutritional needs and the support they required to eat safely. For example one person's care plan stated they needed a lot of fluid and staff should support them drink without spilling it and also ensure their food was pureed before feeding them. Daily support notes showed that people were supported to eat and drink safely as planned for.

People were supported to have access to healthcare services where required. The provider told us they supported people to contact their GP and/or pharmacist to ensure they received the appropriate support required. Records showed that people received care and treatment from a range of healthcare professionals including physiotherapist, district nurses and occupational therapists to ensure their needs were met.

The provider worked with a range of health and social care organisations including the local authority and a clinical commissioning group to plan and deliver safe care and support. Where required, the provider liaised with the NHS to ensure people received the care and treatment they required. For example in December a staff member noted that a person's mental health had deteriorated. The provider contacted the appropriate mental health teams to ensure the person received adequate care and treatment that met their 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 was in their best interests and legally authorised under the MCA. If the service wished to restrict the liberty of any person an application would have to be made to the Court of Protection. We checked to see whether the service was working within the principles of the MCA.

Records showed that where people lacked capacity to make specific decisions for themselves, a mental capacity assessment had been undertaken and where required decisions were made in their best interest in line with the requirements of MCA. Capacity assessments had been completed for people in areas such as care and support, medicines, eating and drinking and bedrails. Best interest decisions were made by staff, health and social care professionals and with people's family carers where applicable.

People told us that staff sought their consent before supporting them. Records showed that consent was obtained from people and their family carers when they started using the service and on on-going basis whilst delivering the care. Consent was also sought from people to enable the provider share their information with health and social care professionals such as the CQC. Staff told us they ask people if it was alright with them before providing any support they required.

Is the service caring?

Our findings

People and their family carers spoke positively on the level of compassion shown to them by staff. People said the staff were caring, thoughtful and supported them in ways that met their needs. Comments from people included, "The staff are very good, nothing to complain about, unlike some of the people I know who have really bad experiences with care providers, I'm very happy, no complaints." Another person said, "Staff are very friendly, they are there for you, they are just wonderful. I can't fault them, they come every day and give me my support, I have a wonderful support team and wonderful family." A third person commented, "All the staff that have been sent have been really good, but the one that comes regularly is exceptionally good, she's very caring, helpful and friendly." A family carer said, "I'm very happy with his support, the staff are very good, [staff] is really good with him, [Staff] is like our family. They are caring and really nice." Another family carer said, "She [Staff] is like a second mum, she listens to [our loved one] and she is easy going."

Staff understood people's needs with regards to their race, disabilities, sexual orientation, gender, religion and cultural backgrounds and supported them in a caring way. The provider told us that they treat people with respect irrespective of their background and that they try to match staff of similar backgrounds and beliefs with people. People's care plans included information about their ethnicity, religious beliefs and the gender of staff they would prefer to support them. The provider supported people in same sex marriages and staff that supported them respected their preferences in life. People were also supported to practice their faith for example by staff reading the bible to them.

People said they had been consulted about their support needs and were involved in the care planning and had agreed to it. One person said, "They came and asked me lots of questions about what I liked and didn't like". Another person commented, "Yes I'm involved in my care planning." A third person commented, "Yes we've done some planning, but the regular staff know me well, they don't need to look at the plans." People had signed their care plans to show they were involved and that they had agreed to the support they would receive. The provider told us that the service was flexible and people were able to change the time or day their support was being delivered. People and their relatives we spoke with confirmed this.

People said their privacy and dignity was respected. Comments from people included, "I can't believe how sensitive she [staff] is around my privacy..." another person commented, "They treat me and my house with respect." Staff we spoke with knew the importance of privacy and dignity and gave examples of seeking people's permission before attending to them, closing curtains before providing personal care to maintain dignity. Staff knew the importance of promoting people's independence and told us they encouraged people to do as much as they could for themselves. People said staff encouraged them to maintain their independence. One person said, "I try and help them in as many ways as I can by preparing things before they come, I enjoy keeping busy."

Is the service responsive?

Our findings

People said they received personalised care that met their needs. One person said, "Yes I have a care plan." Another person said, "Yes, I have a huge care plan here which is re-looked at I think yearly." Staff we spoke with knew well the people they supported. We found that some people had been using the service for decades and had built relationships with the staff that supported them. One person told us, "I have a wonderful relationship with her she's very kind and helpful and friendly and always make sure everything is okay before she leaves."

Each person had a care or support plan in place which was developed based on an assessment of their needs. Care plans included information on the support people required and covered areas such as personal care, mobility, communication, eating and drinking, continence management, medicines and any social, religious and/or cultural activities people were involved in. It also included information on people's likes and dislikes, choices, independence, emotional wellbeing and the things that were important to them. People's care plans included guidance for staff on how best to meet their needs. Copies of people's care and support plans were kept at the provider's office to ensure office staff were familiar with people's needs and had easy access to their information in the event of an emergency.

People told us they or their loved ones were supported to take part in activities that interested them. One person said, "Yes they take my son out to activities; we are just starting to plan going swimming." Another person commented, "They sometimes stay home and do things around the house, like pool, table tennis, art, and homework if he is behind." People's care support plans included information on things that interest them such as chatting, reading or watching television. For example we saw that one person liked to talk about current affairs and there was instruction for staff to engage in conversations that stimulated them. One person told us, "When she's [staff] finished giving me my wash she sits down with me and we have a lovely chat, I'm housebound and don't get out very often. I so look forward to her coming not just because she provides my support, but because we get to sit and chat about things."

The provider had a complaints policy in place and people were given compliment and complaints leaflets so they knew how to complain if they were unhappy with the service. All the people we spoke with told us they knew how to complain and that they would contact the provider's office. However, all the people said they did not have any complaints at the time of this inspection. One person said, "They've been coming to my home for 12 years and not needed to complain once." Another person said, "I've never had a problem or needed to complain, if I did I wouldn't have a problem speaking out". The provider had a complaints monitoring log in place. We saw that where people had made comments or raised a complaint the provider took action and resolved the matter. Where required people were contacted and the outcome and the date the complaint was closed was recorded to ensure that people were satisfied with the actions taken.

When people started using the service, they were provided with a service user guide which included information on the support available, terms and conditions, equal opportunities, complaint and compliments so they were aware of the level of support to expect. People's level of communication was included in their care support plans to ensure that staff were aware of how to support them. Information

was also presented in formats such as easy read and with pictures to support some people's understanding. Staff were provided with guidance on how to support people's communication needs such as using simple words and being patient when supporting them.

At the time of this inspection, no one was being supported with end of life care. Care files included information on resuscitation and if people had any advanced decisions in place. Where people did not wish to be resuscitated, a Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms had been completed and signed by people, their relatives [where appropriate] and their GP to ensure people's end of life care wishes would be respected.

Is the service well-led?

Our findings

At our comprehensive inspection on 28 October and 4 November 2016 we found a breach of regulation as aspects of the service had not been consistently monitored for quality and safety. Staff training and recruitment records were not monitored adequately and we had found gaps in these records. Care plans and medicines records had not been audited on a regular basis to check for any problems or changes. The provider sent us an action plan and we followed up with a focus inspection on 14 June 2017. We found that action had been taken but there was still room for improvement.

At this inspection we found that improvements had been made and gaps in staff recruitment had been identified and accounted for. Staff training was being monitored and each member of staff had an individual training planner in place to identify training courses that needed to be completed.

Care plans were audited monthly to ensure that any issues identified were addressed promptly. People were consulted regularly to find out if the care provision was meeting their need and were given opportunities to make changes if they wish to. Office staff reviewed MAR sheets weekly for any gaps and to ensure people were taking their medicines as prescribed. Medicines audits took place monthly and any issues identified were addressed promptly. For example we saw that the provider sent information to all staff responsible for administering medicines to follow the direction for use of the medicine and adhere to best practices because they found one person's evening medicine was being administered in the morning. Staff that supported people with their medicines had their competencies assessed to ensure they had the right skills and knowledge to support people take their medicines safely.

However, staff training, supervision and appraisals were not always up to date and/or carried out in line with the provider's policy. It was also the provider's policy to support staff with team meetings throughout the year; however, this was not being undertaken in line with their policy. The provider told us that feedback was sought from staff through questionnaires and on a staff zone section on their website. They said the staff zone was interactive and staff could ask questions or leave comments on the platform. The registered manager told us that staff meetings were not held because this did not work for their organisation due to staff working shift patterns which prevented them from attending such meetings. Feedback information we had from staff prior to our inspection showed that two out of five staff felt their views were not taken into account and acted upon. Therefore we could not confirm adequate support was in place for staff in their lone working role in relation to training, supervision, appraisals and were given opportunities to contribute actively to develop the service. This areas required improvement.

Other quality checks carried out by the service included accidents and incidents, safeguarding, client records, staff files, client visit logs and monthly outcome forms. Where issues were identified, actions were taken to improve on the quality of the service. However, the monitoring checks were not always robust as they did not identify the issues relating to staff supervision and appraisals.

Quality monitoring checks had also been carried out by external organisations that commissioned the service including the local authority. Audits were carried out in areas such as medicines management and

staff recruitment. Where issues were identified such as gaps in staff recruitment records, these issues had been addressed by the time of our inspection.

People's views were sought through telephone monitoring calls, home visits and annual questionnaires. Annual questionnaires were sent to people, their adult family carers or parent family carers who support their children. Results of the annual questionnaires for the various groups of people had been analysed. 16 out of 21 questionnaires were returned from people. The feedback was positive; for example, all 16 people said they were involved in planning their care and were happy with the support they received; 15 of 16 people said their care support workers supported them as it had planned for and people said their support staff arrived on time.

There was a registered manager in post who understood their responsibilities under the Health and Social Care Act 2008 and was aware of relevant legal requirement including CQC registrations and submission of statutory notifications. The registered manager was supported by a board of trustees who held regular meeting to discuss how the quality of the service could improve in areas such as finances, staff resources and risk and opportunities that could be explored by the organisation. The registered manager was supported by the operations manager who was responsible for the day-to-day management of the care and support people received. The provider had a three year strategic plan in place aimed to improve their efficiency and effectiveness across a range of services they provided.

The provider's mission statement stated, "Our purpose is to improve carers' health and emotional well-being so they could live fulfilled lives within their communities." The management team told us their values included respect, trust, honesty and integrity and to deliver high quality person centred care. Staff we spoke knew of the provider's values and vision and told us they liked working at the service.

The provider operated an open and inclusive culture and organised annual general meeting where the various shareholders could attend including people and their relatives for information about the service. The provider also produced an annual report for the year 2016-2017 to update their various shareholders in areas such the services they provided, finance, opportunities for volunteering, and included the progress they had made and any future plans they had.

The service worked in partnership with key organisations including Carers Trust, Age UK, Alzheimer's Society, and Bexley Mencap, Mind, local authority and the clinical commissioning group to plan and develop the service. We saw that the provider shared information with relevant parties such as the local authority to improve the quality of the service. We also had feedback from the contract monitoring group on checks they had carried out to support the provider improve on the service delivery. The registered manager attended several meetings, conferences and seminars relating to the health and social care sector to ensure they were kept updated.

The provider continuously learned to improve on the quality of the service. The operations manager told us they supported one person who had an obscure health condition. They said in the process of researching on their condition, they felt it would be good practice to include people's health conditions in their care plan. At this inspection information on people's health conditions and medicines were included in their care support plans and this ensured that information was readily available to staff in the event of an emergency.

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	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>Staff not always completed training considered mandatory by the provider and had not always received supervision and annual appraisals in line with the provider's policy.</p> <p>Regulations 18(1)(2)(a)</p>