Mears Care Limited

Patching Lodge Extra Care Scheme

Inspection report

Patching Lodge
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
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 26 June 2016 and was announced.

Patching Lodge Extra Care Scheme is a domiciliary care agency and is registered to provide personal care and support for people living in their own home in Patching Lodge Extra Care Scheme, a sheltered housing complex managed by a housing association. This accommodation is for people over 60 years of age and care and support can be provided to people with a physical disability or learning disability, people with a sensory loss, for example hearing or sight loss and people with mental health problems or living with dementia. Twenty four hour care, seven days a week is provided with on-site care staff and with an emergency call facility. Additional services provided include a restaurant (for main meals), organised social activities, a café, shop, library and a hairdressing salon.
There have been a number of changes to the service since the last inspection of the service. The registered manager has left and there has been a period of interim management arrangements. Care and support is now only provided to people living in Patching Lodge Extra Care Scheme and not also to people living in the community. About 35 people were being provided with personal care and support with a dedicated team of care staff who worked in the scheme.

On the day of our inspection, there was not 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. However, the registered manager from another of the provider's services had taken over the management of the service. An application had been made to the CQC to add a further location on the manager's current registration so they can manage this scheme alongside another of the provider's services.

The last inspection was carried out on 3 and 5 February 2015. We found a number of areas which required improvement. This was in relation to care and support plans and risk assessments not having been reviewed, there was a lack of continuity of staff providing the care calls and times the care and support was provided. Quality assurance systems had not been maintained to check the quality of the service provided and to help drive improvement. The provider sent the CQC an action plan stating what they would do to address these issues. We looked at these improvements as part of this inspection. However, despite the improvements identified, we were unable at this inspection to determine whether these practices were fully embedded into the service. There would need to demonstrate appropriate arrangements over a defined period of time to ensure that the sustainability of good care could be achieved for people.

Systems were in place to audit and quality assure the care provided. However, the changes made had not been fully embedded and it was not possible to evidence these systems were fully up and running and had been maintained. People were able to give their feedback or make suggestions on how to improve the service, through the reviews of their care, and through the completion of quality assurance questionnaires. There was evidence as to how any feedback was acted upon and improvements made to the service

provided. People knew who to talk with if they had any concerns. One person told us, "I have not tried to talk to anyone, but I guess if I have to I'd talk to the manager." One member of staff told us, "We are working to get this place 100 %. (Manager) is really giving this place her all, and is a very hands on manager."

People spoke well of the care and support provided. However, they told us it had been a difficult time with a number of staff changes, and a high use of agency staff to help cover the care calls. But they felt this had started to improve and care was now provided by a dedicated team of care staff working in Patching Lodge Extra Care Scheme. There was now good continuity of care staff providing their care calls during the week. However, at the weekends there were still improvements being made to the continuity of care staff covering the weekend care calls. They felt the new manager was working hard to address these areas and had listened to their concerns. People told us they always got their care call and they were happy with the care and the care staff that supported them.

Care staff told us there had been a number of changes to the staff team. However, they spoke well of the new management arrangements, and of the changes which had been made to improve the service provided. Staff told us there had been further recruitment of care staff to help cover staff vacancies and they had not now needed to use agency staff. They felt the new team was working well together and there was good communication between the team members.
People told us there had been a period of a lack of consistency of times the care calls were provided, but they felt this was now being addressed. Further recruitment of new care staff had led to the improved delivery of care at the agreed times. A system had been put in place to ensure priority in the times care calls had been made was given to people receiving personal care, or assistance with medicines. People received a weekly rota detailing the care staff covering and when care calls were arranged. Senior staff had ensured people were notified when call times had been changed. One member of staff told us, "I can see an improvement, but people need to have their calls at the time agreed, and that's what we want to achieve."

There were 16 care staff who worked in the scheme, who had been recruited through safe recruitment procedures. The operations manager told us the provider had a programme of continuous recruitment and had tried to be innovative in the recruitment of new staff. For example, they had a 'refer a friend scheme,' where people already working in the organisation were encouraged to introduce a friend to work in the service.

The needs and choices of people had been clearly documented in their care and support plans. People told us that they felt safe with the staff that supported them. Detailed risk assessments were in place to ensure people were safe within their own home and when they received care and support. Where people's needs changed, people's care and support plans had been reviewed to ensure the person received the care and treatment they required. Care and support plans were in the process of being reviewed and updated using a risk based approach. People and care staff were aware reviews were happening and could tell us where reviews were planned and booked to take place. One person told us, "I do have a care plan. It was reviewed last year. "Another person told us, "I have one. I think we looked at it last week." Another person told us, "Yes we talked at length about my plan. We discussed what I wanted and I was happy with it. I think someone is coming around next week to review it." Another person told us, "We did have a care plan when I joined. It was very detailed talking about things I liked to do and the things they can help me with. The carers are very good at listening."

Consent was sought from people with regard to the care that was delivered. All staff understood about people's capacity to consent to care and had a good understanding of the Mental Capacity Act 2005 (MCA) and associated legislation. Where people were unable to make decisions for themselves, staff had considered the person's capacity under the Mental Capacity Act 2005, and had taken appropriate action to

arrange meetings to make a decision within their best interests. One person told us, "I get asked if I want a cup of tea when they come around. They ask if I'm ready for a shower."

Where required, care staff supported people to eat and drink and maintain a healthy diet.

People were supported with their healthcare needs. Medicines were managed safely and people received the support they required from staff. There were systems in place to ensure that medicines were administered and reviewed appropriately.

People told us they were supported by kind and caring staff. One person told us, "The carers are really good and they do really try their best." Care staff received a five day induction, basic training and additional specialist training where required. For example, to support people with moving and handling using a hoist. Care staff had supervision in one to one meetings and staff meetings, in order for them to discuss their role, training needs and share any information or concerns.
Where required, care staff supported people to eat and drink and maintain a healthy diet.

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 were cared for by staff who had been recruited through safe procedures. However, staff vacancies and absences had led to a period of high use of agency staff to cover care calls. This was being addressed and work completed to improve the consistency of care staff providing the care calls and the times the care calls were provided. However, the changes made had not been fully embedded and it was not possible to evidence these systems were fully up and running and had been maintained to ensure safe service delivery.

People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed.

Procedures were in place to ensure the safe administration of medicines.

Is the service effective?

Good

The service was effective.

Care staff had a good understanding of peoples care and support needs.

There was a comprehensive training plan in place. Care staff had the skills and knowledge to meet people's needs.

Care staff had an understanding around obtaining consent from people, and had attended training on the Mental Capacity Act 2005 (MCA).

Where required, care staff supported people to eat and drink and maintain a healthy diet.

Is the service caring?

Good

The service was caring.

Care staff involved and treated people with compassion, kindness, and respect. People told us care workers provided care that ensured their privacy and dignity was respected.

People were pleased with the care and support they received. They felt their individual needs were met and understood by care staff.

Is the service responsive?

Good

The service was responsive.

People had been assessed and their care and support needs identified. Care and support plans were in place, which were in the process of being reviewed.

The views of people were welcomed, and people had received information on how to make a complaint if they were unhappy with the service. They knew who to speak with if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not constantly well led.

There had not been a registered manager for the service, which had led to a period of interim management arrangements. There had been a number of staff changes. This had been a significant period of change which staff and people were working through.

Systems were in place to audit and quality assure the care provided. However, the changes made had not been fully embedded and it was not possible to evidence these systems were fully up and running and had been maintained.

The leadership and management promoted a caring and inclusive culture. Staff told us the management was approachable and very supportive.

People were able to comment on and be involved with the service provided to influence service delivery.

Patching Lodge Extra Care Scheme

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.

The last inspection was on 3 and 5 February 2015 where the service was rated as Requires Improvement.

This inspection took place on 27 June 2016 and was announced. We told the manager 48 hours before our inspection that we would be coming. This was because we wanted to make sure that the manager and other appropriate staff were available to speak with us on the day of our inspection. Two inspectors undertook the inspection, with an expert-by-experience, who had experience of older people's care services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience helped us with the telephone calls to get feedback from people being supported.

Before the inspection, we reviewed information we held about the service. This included previous inspection reports, complaints and any notifications. A notification is information about important events which the service is required to send us by law. We did not ask the provider to complete a Provider Information Return (PIR) on this occasion. 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. We sent out questionnaires to a sample of people using the service and care staff. Feedback from these were used in this report. This helped us with the planning of the inspection. We contacted the local authority commissioning team to ask them about their experiences of the service provided.

During the inspection we went to the service's office and spoke with the manager, an operations manager a visiting officer, and five care staff. We spent time reviewing the records of the service, including policies and

procedures, 11 people's care and support plans, the recruitment records for two new care staff, complaints recording, accident/incident and safeguarding recording, and staff rotas. We also looked at the provider's quality assurance audits and service development plans.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the care provided by staff in the service. One person told us they felt safe because of, "The way they talk to you and make you feel safe."

At the last inspection in February 2015, we found areas which required improvement. This was because there had been a lack of continuity of care staff covering care calls and of the time care calls had been made. During this inspection, we found significant improvements had been made to improve the continuity of care staff providing care calls and systems were in place to prioritise the times care calls were made to ensure a safe delivery of service. However, despite the improvements identified, we were unable at this inspection to determine whether these practices were fully embedded into the service. There would need to demonstrate appropriate arrangements over a defined period of time, to ensure that the sustainability of good care could be achieved for people. We have therefore identified this is an area of practice that needs improvement.

There were now 16 care staff dedicated to providing support in the scheme. People told us it had been a difficult period with changes of care staff and use of agency staff, but they now usually got their visit from regular care staff. One person told us, "It's usually the same ones that come to see me." Another person told us, "It's the same ones every day. It can be a problem at the weekend though when they are always short staffed." Another person told us, "There are a group of carers that come around. One or two times someone different does come." Another person told us, "Whoever is on, but mainly the same people." Care staff told us they usually proved care and support to the same people. One member of staff told us, "Yes usually, but if someone goes off sick then it changes, as you have to cover as best we can, so it might be a shorter visit especially if it's a domestic call." People told us they received the care and support they needed. One person told us, "Carers do everything I ask them." Another person told us, "Don't have any bad experience of the carers. They do what they can, but always feels a bit rushed." We discussed this with the manager, who acknowledged it had been a difficult period with care staff vacancies, a high use of agency staff and difficulty in recruiting new care staff. They had been helping cover the care calls with care staff. But with a review of the rota and new staff recently recruited who were being inducted into the service they felt this would further improve the consistency of care staff covering the calls. One member of staff told us, "(Manager) is doing her best covering the calls. It's a good team here."

The manager showed us how calls were rotered. They told us the system used highlighted individuals preferences to be considered, such as if a person had specifically requested the care call be undertaken by a male or a female worker when scheduling the care calls. One person told us, "I prefer to see a female carer and it's never been an issue." Another person told us, "My carers are all women and the ones I see are all really good. "These had recently been reviewed to ensure people's preferences were up-to-date.

We looked at the times care calls were provided particularly where people needed their care calls at specific times, for example, for the safe administration of medicines, as people told us they had not always got their care at a consistent time. One person told us, "They don't have set times when they come around. In the morning they turn up at any time before 11.0." Another person told us the, "Morning carer comes between 8-12. Lunchtime is better always at 12.0 and in the evenings anytime between 5.0-9.0." Another person told us,

"They come when they can. I understand that they are busy and they are doing their best. They could do with more carers." Another person told us, "I think they are short staffed. The weekends are the worst. It can take a long time to see someone." We discussed this with the manager who acknowledged when covering for staff vacancies and absences this meant that times the care calls were made had to change for care staff to accommodate extra calls. Weekends could be particularly difficult. They told us senior staff had ensured personal care and assistance with medicines was prioritised over domestic calls and there were now systems in place to notify people of any changes in times to the care calls.

The provider used a system of telephone monitoring. This system required care staff to log in and out of their visits when they arrived and left. This system created information to detail the time the call was made and taken with each person. The manager told us that the telephone monitoring system was used by themselves and commissioners of their service to provide information on calls completed, times and where changes to rotas were required. We sampled the records of the timings of care calls provided for people who were assisted with their medicines and where this was required to be administered to ensure the safety of the person at an agreed and consistent time. The records viewed confirmed people had received their care calls between the times agreed.

Medicines policies and procedures were in place for staff to follow and there were systems to manage medicine safely. Care staff told us they had received medication training, and had a recent competency check completed to ensure they were following the required policy and procedures. An audit system was in place to check medicines administration and recording had been completed. We looked at a sample of the recording of medicines and saw in some cases not all medicines had been recorded when given on the medication administration records (MAR sheets) used to record support with medicines administration. However, a record had been made in the daily records and confirmed support had been given. We discussed this with the operations manager and manager, who told us they were aware of this and their audit had found this was a recording issue, not that medicines had not been given. When any errors in recording were found this had then been discussed with the care staff who had not been recording accurately during their supervision. Care staff confirmed that where recording issues had been identified care staff had been made aware of this and improvements made. Not everyone we spoke with had support with their medicines. For one person who was supported, they told us they had been happy with the care provided, "I get help with creams on an area I can't reach like my back. They do a good job and I'm thankful for it."

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them, and protect people from harm. Each person's care and support plan had an assessment of the environmental risks and any risks due to the health and support needs of the person, and these had been discussed with them. The assessments detailed what the activity was and the associated risk, and guidance for staff to take to minimise the risk. For example, where people needed help to move, there was clear guidance for staff to ensure this was done safely. Care staff were able to confirm with us they had received training, had detailed guidance in place, and of procedures they were to follow. They told us that the care and support plans and risk assessments were up-to-date and reflected the care that was being provided. The manager and visiting officer were in the process of reviewing the risk assessments. This was confirmed in the sample of records we looked at. The operations manager was then able to monitor the completion of these reviews and discuss progress in the manager's supervision meetings.

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. The manager told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. They had notified the Commission when safeguarding issues had arisen at the service

in line with registration requirements, and therefore we could monitor that all appropriate action had been taken to
safeguard people from harm. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse. One member of staff told us, "I would report anything to my line manager."
There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example, where abuse was suspected. Care staff all demonstrated knowledge of the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

Equipment maintenance was recorded, and care staff were aware they should report to senior staff any concerns about the equipment they used. Any incidents and accidents were recorded and the manager told us they kept an overview of these, and the provider was also informed and also kept an overview of these to also monitor any patterns and the quality of the care provided and provide guidance and support where needed.

Procedures were in place for staff to respond to emergencies. Care staff had guidance to follow in their handbooks and were aware of the procedures to follow. For example, care staff were able to describe the procedures they should follow if they could not gain access to a pre-arranged care call. The care staff told us they would report this to the office straight away and enable senior staff to quickly locate the person and ensure they were safe. There was an on call service available, so care staff had access to information and guidance at all times when they were working. Care staff were aware of how to access this should they need to.

There was a programme of continuous recruitment of staff for the agency. Comprehensive recruitment practices were followed for the employment of new care staff. The manager had the support of the provider's human resources department when recruiting staff. They told us that all new staff had been through a robust recruitment procedure to meet the requirements of the provider's policies and procedures. We looked at the recruitment records for two care staff recruited, and we checked these held the required documentation. New care staff had been through a recruitment process, written references had been sought, and criminal records check had been carried out by the provider to ensure that potential new care staff had no record of offences that could affect their suitability to protect adults.

Good

Is the service effective?

Our findings

People told us they felt staff understood their care needs, and provided a good level of care. One person told us, "Anytime I ask a question they help me as best they can." They had been asked to consent to their care and treatment. One person told us, "I have a few things they help me with. I do not really want to get into the details, but the carers do ask me if it's ok before they do anything." Another person told us, "Things like a wash they do ask me if I want one." Care staff told us they always asked for peoples consent before assisting with any support. One member of staff told us, "If people say no, I say ok it's your choice."

Staff demonstrated an understanding of and there were clear policies around the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). 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. We checked whether the service was working within the principles of the MCA. Staff told us they had this training. They all had a good understanding of consent, and where people lacked the capacity to make decisions about their care and welfare. One person told us, "When they are cleaning, they ask me if I want it done. But other than that it's not really an issue." Another person told us, "They tell me exactly what they are going to do and if I am ok with it." A member of staff told us, "If someone's says no, we can't force them to do anything. I ask three times during the call, and try to encourage. Then I write down and report it to the manager. I always report it." Another member of staff told us, "If a person says no to a shower, you can't force anyone to do something they do not want to do."

People were supported by care staff who had the knowledge and skills to carry out their roles. The manager told us all care staff completed an induction before they supported people. All the care staff had recently completed the organisation's new five day induction. This was confirmed in the sample of recording we looked at. The induction had recently been reviewed to incorporate the requirements of the new care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of 'shadowing' a more experienced staff member, before new care staff started to undertake care calls on their own. The length of time new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. One member of staff told us, "I did the induction, involving a week's training. I then shadowed twice in here full shifts 7.00am-5.00pm."

Staff received training to ensure they had the knowledge and skills to meet the care needs of people living in the service. Care staff received training that was specific to the needs of people, which included moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, catheter care, dementia care and infection control. Where people had specific care needs, for example moving and handling, using a hoist or being supported with a peg feed, (this is where people receive nutrition through a

tube) additional specific training to meet people's individual needs had been provided to support care staff in this role. Care staff told us they were up-to-date with their training, received regular training updates and there was good access to training. Staff were being supported to complete a professional qualification and training records we looked at confirmed this.

The provider had a quarterly campaign to highlight key training issues with care staff. For example, a previous campaign had highlighted what to consider when moving and handling people. The next campaign, which had recently been piloted and was due to be implemented was to identify with care staff seven key concerns about people's health and what to look for. This was to ensure care staff knew what to look for with a view to improving recognition and recording.
The manager told us they had set up and provided individual supervision and appraisal for care staff. This was through one-to-one meetings. These meetings gave care staff an opportunity to discuss their performance and for senior staff to identify any further training or support they required. There was a supervision and appraisal plan in place which the senior staff were following to ensure staff had regular supervision and appraisal. Records we looked at confirmed this. Staff told us that the team worked well together and that communication was good. They had received supervision or an appraisal from their manager, they felt well supported and could always go to a senior member of staff for support. The provider had a scheme where an 'employee of the month' was identified each month in the service for particular good work completed.

Where required, care staff supported people to eat and drink and maintain a healthy diet. People were supported at mealtimes to access food and drink of their choice. Care plans provided information about people's food and nutrition needs. We saw that people were supported to go to the restaurant area to have their meal, or people could choose their meal from the selection on the day and eat this in their own room. We observed staff taking lunch orders for people who were not able to go down to the restaurant themselves. One person told us, "I make my own breakfast and for lunch I get something from the restaurant." Another person told us, "I make my own breakfast and have a meal from the restaurant. The carers find out what I want and they go and get it."The manager told us about one person and how they assisted them to ensure they had access to a frozen meal each day. For another person they needed thickeners and their food cut up. If people had been identified as losing weight, care staff told us there were food and fluid charts they could use, and these were completed to monitor people's intake. Care staff had received training in food safety and were aware of safe food handling practices.

People had been supported to maintain good health and have healthcare support. We were told by people that most of their health care appointments and health care needs were co-ordinated by themselves or their relatives. However, care staff were available to support people to access healthcare appointments if needed. One person told us, "I can ask one of the girls to call my GP and make me an appointment." Another person told us, "Someone helps me make an appointment, but I can see one whenever I need. "Care staff monitored people's health during their visits and recorded their observations. One member of staff told us of an occasion when they had noticed one person had not gone to the restaurant for their lunch. This was unusual for this person, so they went to them to check everything was alright. They saw the person was in pain and distress and they contacted the paramedics.

Good

Is the service caring?

Our findings

People told us people were treated with kindness and compassion in their day-to-day care. They told us they were satisfied with the care and support they received. They were happy and liked the staff. One person told us, "I like the carers they are always so nice and polite when they talk to you." Caring and positive relationships were developed with people. We were told of positive and on-going interaction between people and care staff. One person told us, "If someone has no family, the carers spend more time sitting with them."

Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, diversity and an understanding of the importance of respecting people's privacy and dignity. People told us they felt the care staff treated them with dignity and respect. Care staff had received training on privacy and dignity and had a good understanding of how this was embedded within their daily interactions with people. They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they treated them with respect. One member of staff told us when they assisted people with their personal care, "I ensure the door is closed when supporting people in the toilet."

Staff told us people were encouraged to influence their care and support plans. Care staff told us how they knew the individual needs of the person they were supporting. They told us they looked at people's care and support plans and these contained information about people's care and support needs, including their personal life histories. People consistently told us they were happy with the arrangements of their care package. They had been involved in drawing up their care plan and with any reviews that had taken place. They felt the care and support they received helped them retain their independence.

Care records were stored securely at the service's office. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all care staff and was also included in the staff handbook. People received information around confidentiality as well. Care staff were aware of the importance of maintaining confidentiality and could give examples of how they did this.
For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available in the information guide given to people. The manager was aware of who they could contact if people needed this support.

Good

Is the service responsive?

Our findings

People told us they felt included and confirmed they or their family were involved in the review of their care and support. People told us they were listened to and the service responded to their needs and concerns. The care staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service.

A detailed assessment had been completed for any new people wanting to use the service. This identified the care and support people needed to ensure their safety. People told us they had been involved in developing their care plans, and felt they had been listened to. One person told us, "The carers look after me. They created a care plan and it has information about the way they will help me." The care and support was personalised and care staff confirmed that, where possible, people were directly involved in their care planning and in the regular review of their care needs. The care and support plans were detailed and contained clear instructions about the care and support needs of the individual and the outcomes to be achieved. Individual risk assessments had been completed. Care staff told us that people's care and support plans were up-to-date and gave them the information they needed. Care and support plans were in the process of being reviewed, but if there were any changes to people's care and support needs care staff would ask for the information to be updated. They told us they had a communication book to inform each staff shift of the care provided, and had a handover meeting between staff shifts to ensure care staff remained up-to-date with people's care needs and of the care which had been provided. They told us this worked well and was informative.

Care staff supported people to access the community and minimise the risk of them becoming socially isolated. For example, we saw people were supported to participate in activities and use the facilities provided as part of the scheme. Care staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service.

People and their relatives were asked to give their feedback on the care provided through spot checks, reviews of the care provided and through quality assurance questionnaires which were sent out annually. A quality assurance questionnaire was in the process of being sent out, so the outcome had not yet been collated. We were shown the completed questionnaires that had already been returned. One person told us, "Last week someone came around and asked me these same questions." Another person told us, "Sometimes we get a survey, (person's name) did one last week." Another person told us, "Yes, recently someone asked me some questions about how carers were treating me. It was only recently, so nothing has changed."

Where people had concerns they were made aware of how to access the complaints procedure and this was available in the information guide given to people. The complaints policy gave information to people on how to make a complaint, and how this would be responded to. The policy set out the timescales that the representatives of the service would respond in, as well as contact details for outside agencies that people

could contact if they were unhappy with the response. The information provided to people encouraged them to raise any concerns that they may have. Care staff told us they would direct people to raise any issues that they may have with directly the manager.

We looked at how people's concerns and complaints were responded to, and asked people what they would do if they were unhappy with the service. People told us that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. One person told us, "I would talk to the manager she was down here last week asking questions, but I do not remember her name. So far so good not had any issues. The carers try their best." One member of staff told us, "Any problems (manager) goes straight down to sort it out." Records showed comments, compliments and complaints were monitored and acted upon. Complaints were being handled and responded to appropriately and in line with the provider's policy. Where people had raised concerns they told us the staff had acted promptly and appropriately. The provider also kept and overview of any concerns raised and the quality of the care provided.

Requires Improvement

Is the service well-led?

Our findings

The senior staff promoted an open and inclusive culture. People were asked for their views about the service and commented they felt heard and respected. People told us there had been improvements to the management of the service. One person told us, "There's a new manager now. I'm not sure what her name is, but she seems very good." Another person told us, I have spoken to her, but I still don't know what her name is. I think she knows what she is doing." One member of staff told us, "(Manager) is a good manager, and knows what to do. She supports staff and clients like her. It's been very unsettled in the past, but better now. I am happier coming to work now. I want to come to work."

At the last inspection in February 2015, we found areas which required improvement. This was because quality assurance checks had not always been completed to ensure the quality of the service provided had been maintained. For example, formal reviews of the care provided were not up-to-date and carried out in the timescale as detailed in the provider's policies and procedures. Supervision and appraisal of care staff had not in all cases been regularly provided. Staff training records were not up-to-date. Staff meetings had stopped for a period and care staff told us these were important to keep care staff up-to-date and fully informed. Audits on a number of aspects of the service, for example, the completion of care records and medication records had not been maintained. This had not ensured where improvements were required these had been identified and rectified. We found significant improvements had been made and action taken to address the issues highlighted. However, despite the improvements identified in relation to quality monitoring, we were unable at this inspection to determine whether the current audit arrangements are fully embedded into practice. There would need to be demonstrated appropriate quality monitoring arrangements over a defined period of time, to ensure that the sustainability of good care could be achieved for people. We have therefore identified this is an area of practice that needs improvement.

There had been a period of change of senior staff managing the service. There was a clear management structure with identified leadership roles. A new manager had recently started to manage the service at Patching Lodge Extra Care Scheme. They were supported by a part time visiting officer. A new full time visiting officer who would also be the deputy manager had just been recruited and was about to start their induction. Care staff told us they felt the service was well led and that they were well supported. One member of staff told us, "We can raise concerns with (Manager). She's brilliant it's what we needed in here. She's someone to turn to, she's sorting things out like rotas. She's tremendous support and she helps out." Another member of staff told us, "(Manager) is amazing, 10/10 she is doing her best. I have a lot of respect for her."

Policies and procedures were in place for staff to follow. Senior staff were able to show up how they had sourced current information and good practice guidance, which had been used to inform the regular updates of the services policies and procedures.

Senior staff monitored the quality of the service by speaking with people each day to ensure they were happy with the service they received, completing reviews of the care provided, and undertaking visits/spot checks to review the quality of the service provided. This included arriving at times when the care staff were

there to observe the standard of care and to obtain feedback from the person using the service. These visits were also used to review the care records kept at the person's home to ensure they were appropriately completed. If any concerns were identified during spot checks care staff told us this was discussed with individual staff members during one to one meetings with their manager. Additionally, any issues identified, for example, relating to the recording of medicines this had been discussed with the care staff team as a topic at staff meetings.

The vision and values for the service was recorded for people to read, and discussed with new care staff in their induction. The aim was, 'To respect our customers' privacy, dignity and lifestyle in the way we work with them. Our care will be provided in the least intrusive way possible. We will treat the service user and everyone connected with them with courtesy at all times. Our workers are sensitive and responsive to race, culture, religion, disability, gender and sexuality and that of the service users family and representatives. Our ethos is to carry out tasks with the customer rather than for them wherever possible, to help maintain independence and autonomy". Staff demonstrated an understanding of the purpose of the service, the importance of people's rights and individuality, and an understood the importance of respecting people's privacy and dignity. We were told by care staff that there was on open culture at the service with clear lines of communication. All the feedback from people and care staff was that they felt comfortable raising issues and providing comments on the care provided in the service

Staff meetings were scheduled to be held monthly. These were used as an opportunity to both discuss problems arising within the service, as well as to reflect on any incident that had occurred. One member of staff told us how care documentation in people's flats were checked as part of the quality assurance visits completed and said, "(Manager) keeps a note of any problems at raises at the meeting." Staff told us they felt they had the opportunity if they wanted to comment on and put forward ideas on how to develop the service. For example, recent feedback had led to changes in the the on-call service for care staff to access. Staff received a quarterly magazine from the provider with updates on the organisation.

The manager had regular support from the operations manager, and completed weekly monitoring reports to be sent to the operations manager, which was then used to inform the provider and enable them to monitor the care provided. The manager also met regularly with other registered managers within the organisation. They told us this was an opportunity for the registered managers to be updated and share information, for example, on the new Care Act and its impact on the service provided. Also on practices to be followed, for example, changes to the provider's policies and procedures. They had then been able to bring this information back and discuss with care staff any changes to be made in their work.

The manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. There was a policy and procedure on people's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. We discussed this with the registered manager during the inspection, who demonstrated an understanding of their responsibilities.