Mears Homecare Limited

Mears Homecare Limited - Mary Seacole House

Inspection report

Mary Seacole House
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 26 May, 1 and 22 June 2016 and was announced. This was the first inspection since the service was registered with the Care Quality Commission. Mears Homecare Limited – Mary Seacole House provides personal care and support services to people living in their own homes in a purpose built building with 30 self-contained flats. The premises are managed and maintained by a housing association. At the time of the inspection 29 people used the service and there was one vacancy. Each person is provided with 17 hours of personal care and housing related support every week, and can access a daily lunch and activities programme in the cafeteria and adjoining communal lounge area on the ground floor. The management and administration offices are also located on the ground floor and all floors are accessible via a passenger lift.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Most people told us they felt safe using the service. Staff had received safeguarding training and understood how to report any concerns about people's safety and wellbeing. There were systems for recording how people were supported with their groceries and other personal shopping; however it was not clear how the provider monitored people's ongoing satisfaction with how staff met their shopping needs.

Risks to people's health and wellbeing had been identified and written plans had been implemented in order to reduce risks. This included liaison with physiotherapy services and referrals to the local falls clinic.

People reported there were sufficient staff to meet their needs. The recruitment process did not demonstrate that all references were verified for their authenticity. However, the recruitment had taken place when the service was managed by a different provider and Mears Homecare Limited was aware of its responsibilities in relation to appointing staff.

Systems were in place to monitor that people were appropriately supported with their prescribed medicines and staff had received training. The provider demonstrated that learning took place following medicine errors.

Staff received training and development to meet the needs of people who used the service. The provider was organising further training for staff in regards to how to support people living with dementia. Annual appraisals were conducted and staff received formal one to one supervision.

During this inspection we received predominantly positive comments about the kind and caring approach of staff. Concerns were raised earlier this year by some people who use the service, who felt that staff spoke

with them in a patronising manner which did not demonstrate that people were respected. The provider was addressing the culture of the service, however the staff training programme did not evidence specific training about how to promote people's dignity and rights.

Staff understood about the importance of seeking people's consent and whether people had capacity to make day to day decisions but did not appear clear about the principles of the Mental Capacity Act 2005 (MCA), which could impact on their ability to ensure that people's rights were upheld.

People received support to meet their health care needs, although we received mixed responses about whether staff consistently supported people to attend external health care appointments. We received feedback that staff needed training to understand people's health care needs, including how to best interact with and support people living with memory loss and dementia. The provider was participating in an integrated health project, which enabled regular direct contact with health and social care professionals involved in the health care of people with complex needs.

People told us they liked the meals served at the provider's cafeteria and were satisfied with the support they received with meals preparation. Care files showed that people were referred to health care professionals including GPs, speech and language therapists and dietitians if there were concerns about their nutritional needs.

People's care and support plans showed that people's needs were assessed and kept under review. The care and support plans did not demonstrate that people received personalised care that reflected their individual needs, wishes and circumstances.

Activities and entertainments were organised in order to provide people with social opportunities and stimulation. These activities included specific sessions to promote people's health and wellbeing, for example weekly chair based exercises and fortnightly yoga classes. It was noted that although events took place at the service such as barbeques, bring and buy sales and an annual party to commemorate the life of Mary Seacole, there were limited opportunities for people to go on outings to places of interest.

People were provided with information about how to make a complaint and the complaints logs showed that complaints were properly investigated. The complaints guidance did not include any details of local independent advocacy organisations that people could contact if they needed support to make a complaint.

Generally we received complimentary remarks about the approach of the registered manager and about the leadership they provided. In particular, relatives praised how the registered manager and the team leader were visible when they visited and kept them up to date about the welfare of their family member.

There were systems in place to seek people's views about the quality of the service and a range of audits were carried out to check that care and support was being delivered in line with the provider's policies and procedures. Findings at this inspection showed that although the provider was steadily addressing issues at the service, further actions and progress was needed in areas including staff training and supervision, personalised care planning and scrutiny of financial transactions on behalf of people who use the service.

We have made two recommendations. These are in relation to the spot checking of whether people are satisfied with staff support for shopping and dignity and respect training for staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The management team and staff understood how to identify and report safeguarding concerns but more robust systems were needed for protecting people who were supported with shopping.

There were enough staff to support people and the provider had protocols for safe recruitment.

Systems were in place to support people with their medicines and address any issues for improvement.

Is the service effective?

Requires Improvement

The service was not always effective.

Records showed that staff were provided with training and an annual appraisal but feedback from people and professionals indicated that more training was needed in certain areas.

Staff appeared to have some knowledge about people's day to day capacity to make choices and decisions but would benefit from guidance and support about how the Mental Capacity Act 2005 impacted on their roles.

People received support to meet their health care and nutritional needs.

Is the service caring?

Requires Improvement

he service was not always caring.

Most people told us they were happy with how staff spoke with them and supported them.

The provider was aware of prior concerns about the culture at the service and this was being addressed.

People were provided with information about the service but the guide was not tailored to the needs of people who live in extra

care schemes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Records did not indicate that people received personalised care to meet their needs and wishes.

Information from people and professionals highlighted the need for staff to have better knowledge about people's needs in relation to the ageing process, so that care and support could be more responsive.

There were systems in place to inform people about how to make complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Generally people reported that they liked the registered manager's approachable manner and helpful attitude. Staff felt suitably supported.

There were systems in place to monitor the quality of the service, which included methods to seek people's views and the opinions of their relatives and friends, if applicable.

A range of audits were conducted although the spot check monitoring visits by management staff at the service did not demonstrate that the provider had a clear agenda for the type of information and observations required during these visits.

Mears Homecare Limited - Mary Seacole House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This announced inspection took place on 26 May, 1 and 22 June 2016. The provider was given 24 hours' notice because the location provides a domiciliary care service so we needed to be sure that staff would be available at the office. The announced visit on 22 June 2016 was conducted in response to information of concern received by the Care Quality Commission (CQC) after the visits on 26 May and 1 June 2016. Two inspectors visited on the first day and one inspector visited on the second and third days. The service was registered with the CQC on 9 February 2016 and this was the first inspection.

Prior to the inspection we reviewed the information we had about the service, which included the statutory notifications the provider had sent to the CQC. A notification is information about important events which the provider is required by law to send to us. We spoke with a representative from the local authority safeguarding team and received a copy of a monitoring visit conducted by the local social services.

During the inspection we looked at the care and support plans for five people and a wide range of policies and procedures, which included whistleblowing, guidance about how to make a complaint and safeguarding. We checked five staff recruitment files and looked at records for staff training and development, appraisals and supervision. Records were viewed, which included accidents and incident forms, complaints investigations and medicine charts.

We spoke with six people who used the service, the registered manager, the team leader, the regional manager and four care staff, including a member of the care staff who organised the activities programme. We joined people during an art class facilitated by a visiting arts tutor, met people attending their

appointments at the 'in-house' hairdressing salon and observed the support people received at lunchtime in the communal cafeteria. Following our final visit to the service, we received comments from the relatives of four people, via telephone discussions and written responses. During and after the inspection we received comments from two external health and social care professionals with knowledge and experience of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. Comments from people included, "I feel safe and secure, it's a nice place to be", "It felt strange moving in but I couldn't wish for any better as my care workers are so reliable" and "If staff made me feel afraid I would tell [my relative] and I wouldn't remain here. The staff are always happy to help me." One person told us they had experienced some negative interactions with staff. Relatives stated that they thought their family members were safe, "He/she feels safe and well looked after" and "I feel quite happy that [my family member] resides in a safe place."

We noted that the provider had an up to date safeguarding policy and procedure in place to advise staff about how to identify and report any concerns about people's safety and welfare. There was also an up to date whistleblowing policy. (Whistleblowing is the term used when a worker passes on information concerning wrongdoing). The whistleblowing policy provided information to enable staff to seek independent guidance and support from an external charity and the contact details to report any concerns to external organisations, for example the Care Quality Commission (CQC). The registered manager and the deputy manager demonstrated a clear understanding of safeguarding and the protocols to follow to report any concerns to the relevant authorities, and discussions with care staff showed they were aware of how to protect people from abuse and report any concerns.

We spoke with the management team about how the provider had responded to safeguarding concerns that had been identified several months prior to the inspection. One investigation by the local safeguarding team had been completed and another was ongoing at the time of this inspection. The registered manager informed us that a range of actions were being implemented, which included plans for additional staff training and more rigorous systems for checking receipts for people who were supported by staff with their shopping and other financial transactions for people. We looked at a report produced by a visiting quality assurance officer, employed by the provider. The report noted that in a few instances people's financial sheets did not accurately correspond with their care records, in accordance with the provider's policy.

Following the first two days of this inspection we received information of concern which alleged that people were at risk of financial abuse due to fraudulent practices with people's personal shopping. The information alleged that inappropriate purchases were made for people and these items were taken by members of staff. The registered manager informed us that formal arrangements were in place at the time of the inspection to support eight people with their finances. Records showed that purchases for people by staff were covered by appropriate receipts and all purchases were ticked off against the receipts by a member of the management team. A further checking of the shopping and the corresponding receipts was then conducted with people who use the service. However, we noted that there was no active system to ensure that spot checks were conducted at a timely interval after the shopping, to determine whether people were satisfied with how they had been supported with their shopping. For example, we saw that a significant amount of money had been spent by staff to purchase clothing items for a person but there was no recorded follow-up visit by a member of the management team to check with the person and/or their representative, if applicable, about the suitability of these items.

We recommend that the provider seeks guidance from a reputable source about how to implement measures to ensure that purchases by staff for people are subject to more in-depth scrutiny.

Records showed that risks to people's health and safety had been identified and assessed. Risk management plans had been developed to address people's needs, for example guidance was in place for staff regarding how to safely support people with their moving and handling needs, and support people at risk of falls. We spoke with a visiting health and social care professional who supported people with their mobility needs. The health and social care professional informed us they carried out monthly visits to the service to assess the needs of people with complex mobility issues, and provide professional advice to people, their representatives and the staff team. They said that staff followed up on their recommended actions and had successfully supported people at risk of falls to remain living at the service. The health and social care professional stated that the chair based exercise group run by staff effectively supported people to reduce the risks associated with mobility problems.

We found that the provider had appropriate recruitment procedures in place to make sure that staff were suitable for their roles and responsibilities. Each recruitment file we looked at contained a minimum of two references, proof of the applicant's identity, confirmation of their right to work in the UK and evidence of a Disclosure and Barring Service (DBS) check. (The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people). Four out of the file recruitment files did not demonstrate that references had been verified by the provider in order to confirm their authenticity. We discussed this finding with the registered manager, who explained that due to various historic organisational changes the majority of staff had been recruited by other providers. The registered manager assured us that any new recruitment by the provider would show that all references were robustly verified.

At the time of our inspection we found there were sufficient staff to meet people's needs. One person told us, "I have two nice care workers, one in the morning and one in the evening. There is always staff around if you are in trouble. I called the alarm one night and the staff came straight to me." Another person commented, "The staff never rush getting me ready. Because of [health care condition] I can't be quick anyway. They will do everything you need, they are very good." One relative told us that there had been one or two occasions when staff shortages had meant that their family member was sent to hospital appointments without an escort. The management team had asked the relative if they could escort their family member but had given short notice. The registered manager informed us that the service had a stable staff team to enable people to receive consistent care and support, which was confirmed by the staff rotas and timesheets we looked at. Both the registered manager and the team leader stated that they supported people with their personal care if any staff unexpectedly could not attend their shift. The registered manager commented, "I routinely support staff so I am familiar with people's needs. This week I joined a member of staff to support a person with behaviour that challenges to have a bath." Staff told us that they had sufficient time to meet people's needs in line with their care plans and wishes.

Most people told us they felt safely supported with their medicines, however one person told us they were dissatisfied. The person said they had recently run out of a pain relieving medicine, which resulted in them experiencing pain and emotional distress for three days until the problem could be resolved. We discussed this issue with the team leader, who acknowledged that the provider had made an error in regards to re-ordering the medicine on time. The team leader evidenced that clear efforts were made to promptly obtain the medicine when its' absence was recognised and the incident appeared to be due to an oversight.

The provider had a medicines policy and staff had received training about how to support people with their medicine needs. Records showed that following their medicines training, staff were required to complete a

written quiz and demonstrate their competency during observations by a member of the management team. We noted that there had been five medicines errors in the past 12 months. Records showed that staff received guidance to address any shortfalls in their knowledge and/or performance following these medicine errors. The team leader showed us how they checked people's medicine administration record (MAR) charts at the end of every month in order to look for any discrepancies and we were shown the records for the disposal of medicines no longer required at the premises. The team leader explained that in addition to the provider's relationship with the dispensing pharmacy, a local NHS pharmacist attended monthly multi-disciplinary meetings at the service. This enabled the management team to seek additional advice and guidance about safe medicine practice, as required.

Requires Improvement

Is the service effective?

Our findings

People told us that staff understood how to meet their needs. One person said, "Sometimes I feel a bit fed up and can be in a bad mood but the staff are welcoming and know how to help me." Another person felt that staff needed more training about how to speak with people in a respectful way. One relative told us, "All the carers always make time to update me about [my family member] when I visit." Another relative told us they had observed that staff needed additional training to meet the needs of their family member and this had been arranged.

We checked a random sample of staff training records and noted that staff had been provided with induction training when they commenced employment and had attended a range of mandatory training, which included moving and handling, health and safety, basic food hygiene, infection control and dementia awareness. The registered manager informed us that the provider recognised that staff needed additional training to understand and meet the needs of people living with dementia, and arrangements were being made with a local dementia care specialist nurse for the delivery of this training. Safeguarding allegations, and other information of concern received by the Care Quality Commission and the local safeguarding team, indicated that some staff did not consistently treat people with dignity and respect. The registered manager told us that she had spoken with staff in the daily handover discussions and at staff meetings about how to provide compassionate and respectful care, however we did not find evidence of a dedicated staff training programme in place to address these issues.

We recommend the provider seeks guidance from a reputable source about training and support for staff in relation to providing care that promotes people's entitlement to dignity and respect.

Systems were in place to provide staff with support and guidance to carry out their duties. We saw that staff received one to one supervision and had received annual appraisals. Staff were observed providing personal care and support to people twice a year, and given feedback on their performance. Records showed that when matters arose for individual staff, recorded conversations called 'informal counselling' took place to address issues of practice, medicine errors and queries about employment related topics.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The applications for this in extra care schemes are to be made to the Court of Protection. Discussions with the registered manager identified that the service had not needed to make any applications to the Court of Protection. People's care files showed that their capacity had been assessed. Staff demonstrated a basic understanding about how to work within the principles of the MCA, for example the necessity to seek people's consent prior to providing support and the importance of supporting

people to make choices about the day to day lives.

People told us they were pleased with the quality of the meals served in the cafeteria. One person told us, "The food is good, superb at times" and another person said, "The food is nice, better than my cooking." A third person told us about their daily routine in relation to their meals, "I do my own breakfast, have lunch in the diner where we get a choice and my care worker helps me with a small meal in the evening. I have seen the dietitian to improve my appetite." A relative commented, "The chef deserves a special mention."

People's care and support plans showed the level of support they needed to meet their nutritional needs. We observed that the lunchtime meal in the cafeteria was well attended and people told us they liked the sociable environment. One person said, "It does me good to come out of my flat and mix with people. There is always a choice, the staff will come and ask us what we would like." People's care and support plans contained relevant information for staff to support people to meet their dietary needs. For example, one person was at risk of unintentional weight loss and there was written guidance in their file to advise staff about the risk of malnutrition and the actions they should take to support the person to achieve a satisfactory diet.

People and their representatives were generally positive about how the provider supported them to meet their health care needs. One person told us, "I get help to go over to the GP surgery; I had my eyes tested last week." A relative told us, "They attend to his/her personal care and health care needs and keep the family informed." Another relative confirmed that the provider met their family member's health care needs, but their family member had been sent to one or two health care appointments without a staff escort. At the time of the inspection, the service was taking part in an integrated care pilot project. The registered manager, the team leader and a visiting health and social care professional all commented on how this pilot project had brought positive outcomes for people who used the service. Local health and social care professionals attended a monthly meeting at the service in order to discuss the care and support requirements of people with complex needs.

People's care and support plans demonstrated that there were systems in place to support people to meet their health care needs. We noted that people's files contained details about people's past medical history and current health care conditions to enable staff and visiting professionals to access relevant information. Records demonstrated that the management team liaised with health care professionals to support people to attend appointments and where necessary, to ensure that health care for guidance for people was understood and followed by staff.

Requires Improvement

Is the service caring?

Our findings

During the inspection we received mainly positive views from people about how they were treated by staff. Comments included, "Here is fabulous, everyone here is so nice, the staff are great", "I am happy here, they (staff) are very good" and "The staff are happy to help you." One person told us, "There was a party yesterday but I didn't go as I had a visitor. Afterwards the staff brought up cakes to me. I would recommend to people, they would be very happy here." Comments from relatives included, "[Staff member] is remarkable and has gone out of their way to give moral and social support" and [Staff member] has unfailing humour and patience, from day one our family has felt supported by all of the staff."

We also received some unfavourable comments. One person told us they were happy but had experienced different problems with the smooth delivery of their care and support. The person told us they attended some social activities and did not have any concerns about staffing attitudes and approaches. Another person expressed they were dissatisfied with how staff spoke with them and thought that staff did not provide care and support that was respectful and mindful of people's rights in relation to privacy and confidentiality.

Concerns were identified earlier this year in regards to how people were treated by staff. Specific concerns were received by the Care Quality Commission and the local authority, and other information was obtained from people who use the service during a 'customer engagement exercise' visit conducted by the local authority. Some people reported during the customer engagement exercise that they did not feel as if they were treated with respect, patience and compassion, and their views were not valued. During the inspection we spoke with the registered manager and the regional manager about the provider's investigation in relation to concerns about staffing attitudes. We were informed that the provider had identified a culture whereby some staff had developed friendship circles or 'cliques', which potentially inhibited employees from speaking out against poor practice. It was noted during this inspection that the provider had focussed on making improvements since the concerns were recognised and this work was ongoing.

Some people told us they had been involved in the planning of their care. For example, one person was very specific about what type of activities they wished to attend, which was reflected in their care and support plan and respected by staff. People had been consulted about whether they had a preference about receiving their personal care from a male or female care worker. However, we otherwise found limited written evidence to demonstrate that people were actively consulted about their needs, preferences and aspirations.

Staff informed us that they made sure that people's privacy and dignity was respected when they provided personal care. We were given examples of how this was undertaken, for example staff said they ensured that doors were closed and curtains were pulled if they were supporting a person with their personal care needs. Throughout the inspection we observed that staff knocked on the front door of people's flats and checked if it was alright to enter. Confidential written information was kept securely.

Information was displayed on communal noticeboards, for example about how to make a complaint and

information about the housing provider. We noted that the provider had issued people with a Service Users' Handbook but the information was primarily intended for people who received domiciliary care and did not live in extra care schemes. The handbook was therefore potentially confusing for people who use the service.

Requires Improvement

Is the service responsive?

Our findings

People told us they were pleased with how the provider met their needs. One person told us, "[Staff member] looks after me; he/she has a very good sense of humour. I have no complaints" and another person said, "[Staff member] sorts out my pads, helps me take a shower, cleans the place up lovely and does the weekly shopping in [local supermarket]." A relative commented, "I have been very impressed. We don't live near and the staff told us what [our family member] needed when he/she moved in and keep us informed in between visits. We notice that [our family member] is helped with hair care and looking after his/her feet and nails." Another relative stated they were happy with the activities offered to their family member but had observed that sometimes their family member was given other people's laundered clothes, even though the relative had applied name labels.

Some of the concerns expressed earlier this year were in relation to how people were supported with personal care. For example, a few people stated that they did not receive the personal care they needed to maintain their personal hygiene, comfort and emotional wellbeing. Anonymous information of concern sent to the local social services and the Care Quality Commission indicated that some staff did not respond appropriately to people's needs as there was a perceived belief by some staff that people should be more independent with their personal care needs, because they were living at an extra care scheme as opposed to a residential care home or a care home with nursing. We spoke with an external health and social care professional who told us they had identified staffing approaches that needed to improve, so that people could receive personalised care and support that was responsive to their needs. They told us that staff needed to have better underlying knowledge and understanding about people's health care and cognitive needs, and how these needs impacted on them, in order to provide personalised rather than task orientated care.

One person told us they visited the service before moving in and another person said that a relative went on their behalf to check the suitability of the service as they were frail and in hospital at the time. We noted that people's needs were fully assessed before they moved in by their allocated social worker and other relevant professionals. The provider carried out their own initial assessments and this information was combined to develop care and support plans. We noted that the care and support plans lacked sufficient detail to demonstrate how the staff supported people in an individual way. This observation was also noted by other professionals. For example, one person's care and support plan had no useful information about the person's social history, interests and hobbies. Another person's care and support plan was noticeably detailed in relation to their life history and guidance for staff about how they wished to be supported; we saw that a relative had provided helpful information.

Most people told us they enjoyed the activities programme offered by the provider. We met people during their weekly art group, which was taught by an external art tutor. At this session, people were drawing famous bridges and for some participants it provided opportunities to reminisce about places they knew in London or had travelled to. We also met people who regularly booked an appointment with the visiting hairdresser, which was described as an enjoyable event. The hairdresser visited once a fortnight and a room had been converted into a salon environment in order to give people a more authentic experience. Other

activities included bingo games, quizzes, coffee mornings, a fortnightly yoga session from an external instructor and a gardening group at weekends, which was organised by relatives. The activities organiser told us they had attended a four days accredited training course to provide chair based exercises and techniques to support older people to strengthen their mobility and reduce the risk of falls, and they held a weekly exercise group. Comments from people and relatives indicated that people had limited opportunities for activities away from the premises. The registered manager told us that the provider used to receive charitable grants from large organisations such as retail companies but this had now stopped due to general financial pressures. These grants had been used to subsidise day trips and other entertainments. The registered manager confirmed that she would apply to the provider's social fund for additional resources to renew the outings.

People had opportunities to attend external day centres and at the time of the inspection four people went out to day centres. Cross-generational art activities took place with older children from a local senior school and people were invited to a Christmas party at the school. The provider had developed links with a theatre in the borough and people were supported to attend plays as guests of the theatre. The activities organiser informed us that there was sufficient time available in their schedule to visit people in their flats if they did not wish to attend group activities but wished to have a one to one chat.

The provider had an up to date complaints policy and the people we spoke with knew how to make a complaint. We looked at the complaints log and the corresponding complaints investigations, and found that the complaints had been investigated in accordance with the provider's policy and timescales. The complaints guidance for people and their relatives did not provide any information about local independent advocacy organisations that people could seek support from when making a complaint.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff made positive remarks about the registered manager's approachable manner and helpful attitude. Comments included, "[The registered manager] is very nice and checks that I am alright and not having any troubles" and "I am very happy with the quality of the care that [my family member] receives…we feel welcomed and supported. This spreads from the [registered manager] and the head of carers (team leader) to all of the carers." Another relative said that "The management help keep me informed." A staff member told us, "[The Registered Manager] is approachable and we can speak openly to get things sorted out."

We noted that some people had previously not expressed positive views about how the service was managed. During the inspection we met a small number of people and staff with mixed views about the way the service was managed and the approach of the registered manager. The provider's investigation into concerns earlier this year identified that some staff felt they were not getting support from the registered manager and the team leader when the service was short staffed.

Records showed that the provider sought the people's views about the quality of the service through surveys and during individual review meetings. Staff meetings were held to share information and the registered manager informed us that the provider was setting up tenants meetings.

We found that audits had been conducted in January 2016 to check medicine administration records, staff recruitment files, training certificates and people's financial logs. The audit had identified that some staff files were missing references and training certificates. The registered manager told us that these findings had been addressed. The team leader carried out periodic spot check visits to the service when they were not rostered to be on duty and made notes about their findings. Any areas detected for improvement were discussed with the staff team, or individual members of staff if applicable. We noted that the observations from these spot checks were written in note form as the provider did not have a template for management staff to use. This meant that an employee carrying out a spot check did not have a standardised form with designated issues to check on as specified by the provider, and additionally we found there was no analysis of findings to check for any emerging themes of concern. There was evidence of learning from incidents and complaints, for example clear actions were taken if people were at risk of falls in order to reduce the risk of recurrence.

We spoke with the registered manager about how they were working towards improving the service. For example, staff had not been issued with a care workers' handbook, which is customary for staff working in services that are registered by the Care Quality Commission to provide people with personal care. The registered manger told us she had discussed this with senior management and had been advised that the provider was developing a handbook with suitable information to support its' staff employed in extra care schemes. Following the first two days of the inspection, we had highlighted the absence of personalisation in people's care and support files. On the third day of the inspection the registered manager showed us additional information that had been added to one care file to demonstrate that care staff provided care and support that reflected the person's known preferences and needs.

The registered manager understood their legal responsibilities in regards to informing the Care Quality Commission about events that needed to be reported to us and other statutory bodies, in order to ensure people's safety and wellbeing.